NOTICE OF REGULAR COUNCIL MEETING

In accordance with §38-431.02 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 Regular City Council meeting at 7:00 p.m., Wednesday, June 24, 2020. 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 recordings. Parents in order to exercise their rights may either file written consent with the City Clerk to such recordings, 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 REGULAR

De acuerdo con los Estatutos del Estado de Arizona A.R.S. §38-431.02, se le informa a los miembros del Cabildo y al público en general que el Alcalde y el Cabildo, tendrán una Junta Regular a las 7:00 p.m., el día Miercoles, 24 de Junio del 2020. 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 qua 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, Actuaria de la Ciudad

AMENDED AGENDA
6/23/2020

AGENDA
Regular Meeting
San Luis City Council
San Luis Council Chambers
1090 E. Union Street
San Luis, AZ 85349
June 24, 2020
7:00 p.m.

The June 24, 2020, Regular Council meeting will be closed to members of the public in-person attendance.

However, members of the public may listen to the meeting's live audio stream on the City of San Luis' website https://sanluisaz.gov/listenlive. Recordings of the meetings will be available on the City's website https://sanluisaz.gov/listenlive after the meeting.

Open meetings conducted remotely through technological means are permissible under the March 13, 2020, Arizona Attorney General opinion titled, "Re: Concerns Relating to Arizona's Open Meeting Law and COVID-19" and following the Mayor's March 18, 2020, Continued Declaration of Emergency and Amended Order-Coronavirus Disease-19 and City Council's Order 2020-7 which closed all city buildings and facilities (except the Municipal Court) to public access, to protect the public health and safety and reduce the transmission of the Coronavirus Disease 2019 (COVID-19). City Council Chambers will be closed to the public.

La Junta Regular del Cabildo del día 24 de Junio del 2020, estará cerrada al público.

Sin embargo, los miembros del público pueden escuchar el audio en vivo de la reunión transmitido en el sitio web de la Ciudad de San Luis https://sanluisaz.gov/listenlive . Las grabaciones de las reuniones estarán disponibles en el sitio web de la Ciudad https://sanluisaz.gov/listenlive después de la reunión.

Las reuniones abiertas realizadas de forma remota a través de medios tecnológicos están permitidas bajo la opinión del Fiscal General de Arizona del 13 de marzo de 2020 titulada "Re: Preocupaciones relacionadas con Open Meeting Law de Arizona y COVID-19" y después de la Declaración de Emergencia Continua del 18 de marzo de 2020 del alcalde y Orden modificada-Enfermedad de Coronavirus-19 y Orden del Ayuntamiento 2020-7 la cual cerró todos los edificios e instalaciones de la ciudad (excepto en la Corte Municipal) al acceso público, para proteger la salud y la seguridad pública y reducir la transmisión de la Enfermedad de Coronavirus 2019 (COVID- 19). Las Sala del Cabildo del Ayuntamiento estará cerrada al público.

PLEASE TAKE NOTICE THAT MEMBERS OF THE CITY COUNCIL WILL ATTEND EITHER IN PERSON, TELEPHONE, OR VIDEO CONFERENCE COMMUNICATION. THE MAYOR OR ACTING MAYOR FOR THIS MEETING MAY CHANGE THE ORDER OF THE ITEMS; IF AUTHORIZED BY LAW AND BY A MAJORITY VOTE OF A QUORUM OF CITY COUNCIL MEMBERS PRESENT, AN EXECUTIVE SESSION WILL BE HELD IMMEDIATELY FOLLOWING THE VOTE IN ACCORDANCE WITH A.R.S. §38-431.03(A) AND THE MEETING WILL BE TEMPORARILY RECESSED WHILE THE CITY COUNCIL RETIRES TO EXECUTIVE SESSION WHICH WILL NOT BE OPEN TO THE PUBLIC.

PLEASE TAKE NOTICE THAT MEMBERS OF THE CITY COUNCIL WILL ATTEND EITHER IN PERSON, TELEPHONE, OR VIDEO CONFERENCE COMMUNICATION. THE MAYOR OR ACTING MAYOR FOR THIS MEETING MAY CHANGE THE ORDER OF THE ITEMS; IF AUTHORIZED BY LAW AND BY A MAJORITY VOTE OF A QUORUM OF CITY COUNCIL MEMBERS PRESENT, AN EXECUTIVE SESSION WILL BE HELD IMMEDIATELY FOLLOWING THE VOTE IN ACCORDANCE WITH A.R.S. §38-431.03(A) AND THE MEETING WILL BE TEMPORARILY RECESSED WHILE THE CITY COUNCIL RETIRES TO EXECUTIVE SESSION WHICH WILL NOT BE OPEN TO THE PUBLIC.

1. CALL TO ORDER/ROLL CALL

2. PLEDGE OF ALLEGIANCE

3. INVOCATION

4. PROCLAMATION

4. A. Proclamation of Yuma County, City of Yuma, City of San Luis, City of Somerton, and Town of Wellton urging all county residents to follow the Centers for Disease Control and Prevention Guidelines to combat the spread of COVID-19.

5. 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.

5. A. MINUTES OF

- Regular Council meeting held May 13, 2020
- Work Session held May 14, 2020
- Special Council meeting held May 14, 2020

5. B. DISBURSEMENTS FROM JUNE 1, 2020 THROUGH JUNE 12, 2020.

Total Disbursements $981,671.89
(Nine Hundred Eighty-One Thousand, Six Hundred Seventy-One Dollars and Eighty-Nine Cents)

6. DISCUSSION AND POSSIBLE ACTION ITEMS:

6. A. Discussion and possible action on any and all matters regarding a contract between the City of San Luis and Greater Yuma Port Authority in participating in the Economic Strength Program Grant (ESP) from the Arizona Department of Transportation (ADOT) and Arizona Commerce Authority (ACA) for the construction of infrastructure improvements to the Magrino Industrial Park. **(Jenny Torres, Economic Development Manager)**

6. B. Discussion and possible action on any and all matters regarding authorization for employee vacation accrual payout. **(Tadeo A. De La Hoya, City Manager)**

6. C. Discussion and possible action on any and all matters regarding Order No. 2020-13. 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 2020-2021 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, Acting Director of Human Resources)**

6. D. Discussion and possible action on any and all matters regarding Order No. 2020-15. An order of the Mayor and City Council of the City of San Luis, Arizona approving and adopting an amendment to the February 26, 2020, Development Agreement with Comite de Bien Estar, Inc. to create a lot split and to share responsibility for the construction of a street. **(Kay Marion Macuil, City Attorney)**

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

8. ADJOURNMENT

PROCLAMATION

Regular City Council Meeting **4. A.**

Meeting Date: 06/24/2020

Title:

Proclamation of Yuma County, City of Yuma, City of San Luis, City of Somerton, and Town of Wellton urging all county residents to follow the Centers for Disease Control and Prevention Guidelines to combat the spread of COVID-19.

Attachments

Joint Proclamation

PROCLAMATION OF YUMA COUNTY, CITY OF YUMA, CITY OF SAN LUIS, CITY OF SOMERTON, AND TOWN OF WELLTON URGING ALL COUNTY RESIDENTS TO FOLLOW THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) GUIDELINES TO COMBAT THE SPREAD OF COVID-19.

The Chairman of the Board of Supervisors of Yuma County, Arizona, and the Mayors of the Cities of Yuma, San Luis, Somerton and Wellton, Arizona, find:

1. WHEREAS, the Governor of Arizona, in response to the COVID-19 pandemic issued a Declaration of Emergency on March 11, 2020;

2. WHEREAS, Yuma County and all its communities are facing health challenges as a result of the COVID-19 pandemic, and as of June 10 the Yuma County Public Health District has confirmed 2,588 COVID-19 positive cases and 39 deaths in Yuma County;

3. WHEREAS, Yuma County is experiencing increased community spread and the threat of infection remains high;

4. WHEREAS, the spread of COVID-19 can lead to severe respiratory illness, disease complications, and death for Yuma County residents, particularly people of any age who have underlying medical conditions and people who are 65 or older;

5. WHEREAS, COVID-19 can be spread by people who do not have symptoms and do not know they are infected;

6. WHEREAS, the best way to prevent illness is to avoid being exposed to the virus;

NOW, THEREFORE, WE JOINTLY URGE THE FOLLOWING:

SECTION 1. That all members of our community take action to ensure they are protecting themselves, their families, their coworkers, and their friends to combat the spread of COVID-19.

To minimize the spread of COVID-19, residents should follow the CDC guidelines by adopting these actions:

1. Wash your hands often with soap and water for at least 20 seconds, or, if soap and water are not available, use a hand sanitizer that contains at least 60% alcohol;

2. Clean surfaces that you or others touch often with an EPA registered household disinfectant daily;
3. Wear a facial cover or mask whenever you go out in public, regardless of whether you are six (6) feet apart or not, and keep in mind that wearing a mask does not eliminate your need to keep six (6) feet apart;
4. Avoid gatherings of 10 or more people at all times; and
5. If you are sick or not feeling well, stay home and contact your medical provider as soon as possible.

SECTION 2. It is critical to slow the spread in our community for the protection of our most vulnerable populations, ensure our healthcare system is not negatively impacted, and to enable businesses to remain open in a safe and healthy manner.

PROCLAIMED JOINTLY AT Yuma County this 12th day of June, 2020.

MARCO A. "TONY" REYES, Chairman
Yuma County Board of Supervisors

DOUGLAS J. NICHOLLS
Mayor, City of Yuma

GERARDO SANCHEZ
Mayor, City of San Luis

GERARDO ANAYA
Mayor, City of Somerton

CECILIA C. MC COLLOUGH
Mayor, Town of Wellton

AGENDA ITEM REVIEW FORM

Regular City Council Meeting **5. A.**

Meeting Date: 06/24/2020

Summary

MINUTES OF

- Regular Council meeting held May 13, 2020
- Work Session held May 14, 2020
- Special Council meeting held May 14, 2020

Attachments

5/13/2020 RCM

5/14/2020 WS

5/14/2020 SCM

M I N U T E S
Regular Council Meeting
San Luis City Council
San Luis Council Chambers
1090 E. Union Street
May 13, 2020
7:00 p.m.

1. CALL TO ORDER/ROLL CALL: Mayor Gerardo Sanchez called the Regular City Council meeting to order at approximately 7:15 p.m.

Mayor, City Council, and some members of staff participated remotely.

PRESENT: Mayor Gerardo Sanchez
Vice Mayor Maria Cecilia Cruz
Council Member Mario Buchanan Jr.
Council Member Africa Luna-Carrasco
Council Member Jose Ponce
Council Member Matias Rosales
Council Member Gloria Torres

OTHERS PRESENT: Tadeo A. De La Hoya, City Administrator
Sonia Cornelio, City Clerk
Kay Marion Macuil, City Attorney
Axel Chayra, Information Technology Technician
Derek Dueñas, Manager of Information Technology
Francia Alonso, Assistant to Council/PIO
James Einwaechter, Assistant Director of Public Works
Jenny Torres, Economic Development Manager
Jorge Mungaray, Information Technology Technician
Jose L. Cisneros, Executive Assistant
Jose Guzman, Director of Planning & Zoning
Ralph Velez, City Consultant (remotely)
Richard Jessup, Chief of Police
Elizabeth Carpenter, Realtor

2. PLEDGE OF ALLEGIANCE

Council Member Gloria Torres led the Pledge of Allegiance.

3. INVOCATION

Mr. Richard Jessup, Chief of Police, led the invocation.

4. PROCLAMATIONS

4.A. PROCLAMATION
- Bike Month May 2020

Mrs. Sonia Cornelio, City Clerk, read the proclamation in its entirety.
Mayor Gerardo Sanchez stated bike month is something the city has been working on and added that riding a bicycle is healthy and the City of San Luis will continue to promote biking.

Vice Mayor Maria Cecilia Cruz congratulated the Yuma Region Bicycle Coalition because they donated scholarship funds from the event they just held, totaling $4,457.20.

4.B. PROCLAMATION
- Building Safety Month - May 2020

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

Mayor Gerardo Sanchez thanked staff from Building Safety, especially building inspectors and engineers, as they are the ones reviewing the different plans. Over the years the city has updated its building codes and has made construction much safer for the City of San Luis.

5. CONSENT AGENDA

5. A. MINUTES OF
- Regular Council meeting held March 25, 2020
- Work Session held April 1, 2020
- Special Council meeting held April 1, 2020
- Regular Council meeting held April 8, 2020
- Special Council meeting held April 15, 2020

5. B. DISBURSEMENTS FROM APRIL 11, 2020 THROUGH APRIL 30, 2020.
Total Disbursements $1,101,244.80
(One Million, One Hundred One Thousand, Two Hundred Forty-Four Dollars and Eighty Cents).

5.C. Discussion and possible action on any and all matters regarding Rancho Los Oros Roadway Improvement (CDBG Contract #113-20) Change Order No. 1. (Jenny Torres, Economic Development Manager; Eulogio Vera, Acting Director of Public Works and Mary French-Jones, Grant Writer)

MOTION: Council Member Gloria Torres/Council Member Jose Ponce to approve the Consent Agenda except for Item No. 5C as it was removed from the Consent Agenda for further discussion. Motion passed unanimously.

The vote was as follows:

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

Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

6. DISCUSSION AND POSSIBLE ACTION ITEMS:

Item No. 5.C. was removed from the Consent Agenda for further discussion.

5.C. Discussion and possible action on any and all matters regarding Rancho Los Oros Roadway Improvement (CDBG Contract #113-20) Change Order No. 1. (Jenny Torres, Economic Development Manager; Eulogio Vera, Acting Director of Public Works and Mary French-Jones, Grant Writer)

Ms. Kay Macuil, City Attorney, explained there was a mistake in the amount on the motion; this is the item where the underground work had to be slowed down because people were home and due to the stay at home order. The actual amount of the increase was $32,266.46.

Mr. Ralph Velez, City Consultant, asked why item no. 1 on the change order showed $18,220.00 and the second amendment is $38,000.00.

Ms. Jenny Torres, Economic Development Manager, responded part of that amount is coming from contingency from the construction contract amount, so the only additional funding needed is $32,000.00. This is a change order to do some additional work that was unexpected totaling $18,220.00 and the additional $38,969.00 was the amount the contractor requested in order to get more staff and perform the work at a slower pace due to the COVID-19. Overall, the project is over $50,000.00 and since there is a contingency amount in the construction contract, staff decreased that and the net increase totals $32,000.00.

Council Member Gloria Torres asked if there has been any issues with the residents in that area on this project.

Ms. Torres responded there was one (1) complaint from a resident as some of the dirt was being placed at a drive way and the dirt was removed quickly, there have been no complaints on the portable potties placed, the project is moving smoothly.

MOTION: Council Member Matias Rosales/Vice Mayor Maria Cecilia Cruz to approve the change order as presented in the amount of $32,266.46. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye

Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

This item was later discussed further and motion above was rescinded, please refer to item number 5.C. before adjourning the meeting.

6. A. Discussion and possible action on any and all matters regarding the ratification of a cost increase for the Cesar Chavez Bridge Repair Project. (Eulogio Vera, Acting Director of Public Works)

Mr. James Einwaechter, Assistant Director of Public Works, explained staff is requesting approval of the ratification of $40,800.00 cost increase to the recently completed Cesar Chavez Boulevard bridge repair project. During the course of executing the project, there were some challenges that entailed additional work and additional costs to properly finish this project. He proceeded to summarize the changes and added that this task was performed on an emergency action.

MOTION: Council Member Gloria Torres/Council Member Jose Ponce to approve and ratify the Cesar Chavez bridge repair contact modifications for $40,800.00 and the total contract cost of $117,300.00 and also waive formal purchase procedures due to the urgent need to repair the bridge. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

6. B. Discussion and possible action on any and all matters regarding a proposed change order number 1 for the Los Portales Del Alamo Roadway Paving project (to add Adobe Street and Aquila Street (between Merrill Avenue and Hidalgo Avenue) and Ajo Avenue. (Eulogio Vera, Acting Director of Public Works)

Mr. James Einwaechter, Assistant Director of Public Works, stated staff presented this item at a special council meeting on March 29, 2020 to request approval for the contract award of Los Portales Del Alamo roadway paving project. When presenting this agenda item to the City Council, Mr. Eulogio Vera, Director of Public Works, emphasized that extremely favorable bid prices would make it beneficial for the city to fund the paving of additional roads now, subject to the availability of funds. Adding paving of the proposed three (3) streets via change order to the city's contract with DPE would require an additional $198,000.00. Public Works suggests using residual HURF salary funds (that were not used this fiscal year), possibly complemented by resources from the General Fund (if required). If this change order is approved and funded, only Desierto Avenue

and a small portion of San Felipe Street and Rio Sonora Street would remain to be re-paved, with envisioned completion within the next couple of years (budget permitting).

Mayor Gerardo Sanchez thanked the Public Works Department and mentioned that the streets are getting fixed little by little by repaving and resurfacing those streets.

Vice Mayor Maria Cecilia Cruz thanked and congratulated the Public Works Department for their hard work.

Council Member Matias Rosales thanked the Public Works Department and added he is happy this is getting done.

MOTION: Council Member Matias Rosales/Vice Mayor Maria Cecilia Cruz to approve modification number 1 to the contract with DPE Construction, Inc., for the Los Portales Del Alamo roadway paving project in an amount of $198,000.00. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

6. C. Discussion and possible action on any and all matters regarding Order No. 2020-11A. An order of the Mayor and City Council of the City of San Luis, Arizona, correcting a scrivener's error in the legal description of the property subject to the City's Order No. 2020-11. (Kay Marion Macuil, City Attorney)

Ms. Kay Macuil, City Attorney, commented Order No. 2020-11 authorized staff to proceed with condemnation of County 23 ½ if it is necessary and that the legal description had the southeast quadrant twice, so this order is just taking off one of the southeast quadrants references from the legal description. There was also a map describing the area, it was not that City Council was confused as to what they were approving but she wanted the record to be very clear as this may go to court.

Mayor Gerardo Sanchez said it is very important that it is specific and clear. This is to make sure the order is properly written and its description is a valid one.

MOTION: Council Member Gloria Torres/Council Member Jose Ponce to approve Order No. 2020-11A as presented. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye

Vice Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

6.D. Public hearing followed by discussion and possible action on any and all matters regarding Resolution No. 2128. A resolution of the Mayor and City Council of the City of San Luis authorizing the submission of application for FY 2020 State Community Development Block Grant State Special Projects funds (CDBG-SSP), certifying that said application(s) meet the community's previously identified housing and community development needs and the requirements of the State CDBG Program, and authorizing all actions necessary to implement and complete the activities outlined in said application(s). (Jenny Torres, Economic Development Manager and Mary French-Jones, Grant Writer)

A. Open public hearing

MOTION: Council Member Africa Luna-Carrasco/Council Member Gloria Torres to open the public hearing. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

1. Staff presentation

Ms. Mary French-Jones, Grant Writer, explained the Arizona Department of Housing released their Notice of Funding Availability (NOFA) for the Community Development Block Grant Funds State Special Projects Account. The State's Special Projects (SSP) is a competitive round. The NOFA for the SSP was released on January 27, 2020 and the application deadline is June 17, 2020.

The focus of the Community Development Block Grant (CDBG) funds is to meet the requirements of low and moderate income benefits for activities considered as benefiting low and moderate income persons. As part of the state's process, staff advertised and conducted a community meeting on Tuesday, February 25, 2020.

Staff received one (1) proposed project during the community meeting. The second meeting is conducted through the public hearing process during a regularly scheduled City Council meeting. Initially, the CDBG public hearing was scheduled for the April 22,

2020 City Council meeting, but due to extenuating circumstances was revised to meet the current public attendance process and advertised for another month, slating it for tonight's meeting. Staff recommends submitting the Rancho Los Oros Roadway Improvements Project Phase 2 for submission to the Arizona Department of Housing CDBG SSP Project funds.

Rancho Los Oros Roadway Improvements Project Phase 2 represents the mid-phase within the Rancho Los Oros Subdivision. The project is considered shovel ready (environmental complete, engineered and bid ready) and will advance upon ADOH notification and award. The current anchor project is scheduled for completion mid-June. Staff would like to thank the City Council and administration for their support and give a special shout out to the residents within the current work zone for their patience and support during the construction improvements.

Ms. Jenny Torres, Economic Development Manager, added this project was started with Phase 1 and this will be the second application to the state for Phase 2. Eventually, there will be a Phase 3 based on the amount award that is needed in that area. Phase 1 was about $700,000.00, another $700,000.00 for Phase 2 and approximately $500,000.00 will be needed for Phase 3 as this is a huge project.

Mayor Gerardo Sanchez thanked staff involved in this task and added that he hopes the city is able to obtain the funding for this important project.

2. Call to the public on this item

Mrs. Sonia Cornelio, City Clerk, stated her office did not receive any comments from the public on this item.

Ms. Jenny Torres, Economic Development Manager, mentioned her office did not receive any public comment on this item either.

B. Close public hearing

MOTION: Council Member Gloria Torres/Council Member Mario Buchanan Jr. to close the public hearing. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

C. Approval of and adoption of Resolution No. 2128

MOTION: Council Member Gloria Torres/Council Member Jose Ponce to approve and adopt Resolution No. 2128. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

6.E. Discussion and possible action on any and all matters regarding Resolution No. 2129. A resolution of the Mayor and City Council of the City of San Luis, Arizona, County of Yuma, committing local funds as leverage for FY 2020 Community Development Block Grant State Special Projects (CDBG-SSP) application. (Jenny Torres, Economic Development Manager)

Ms. Mary French-Jones, Grant Writer, indicated this item has been budgeted for the next fiscal year and because this year SSP had $500,000.00 available, that is where the city's match became more significant as this is the leverage part. This portion of the application is what advances the project to the 4Front with the Department of Housing.

MOTION: Council Member Africa Luna-Carrasco/Council Member Jose Ponce to approve Resolution No. 2129 as presented, committing city funds for Community Development Black Grant State Special Projects application as presented. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

6.F Public hearing followed by discussion and possible action on any and all matters regarding Rezoning Case No. 2020-068 and Ordinance No. 398. 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 18.44 acres from Light Industrial (L-I) to Medium Density Residential (R1-6) for property located on the southeast corner of Avenue E 1/2 and County 24th Street. (Jose A. Guzman, Director of Planning and Zoning)

A. Open public hearing

MOTION: Council Member Gloria Torres/Council Member Jose Ponce to open the public hearing. Motion passed unanimously.
The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

1. Staff presentation

Mr. Jose Guzman, Director of Planning and Zoning, explained this is a request by Vega & Vega Engineering, on behalf of Sam Group Investment Company, owner, to rezone 18.44 acres from Light Industrial (L-I) to Medium Density Residential (R1-6). The subject property is located on the east mesa of the City of San Luis on the southeast corner of Avenue E 1/2 and County 24th Street.

The purpose of the rezoning is for the construction of a new residential subdivision to be called Belleza del Desierto Phase 2 Subdivision. This subdivision will consist of 18.44 acres to be divided into approximately 88 lots with minimum size of 6,000 square feet and 1 tract for water retention. Staff recommends approval with the condition that any development of the property, or portion thereof, and/or the approval of any subdivision plat, be conditioned upon payment to the city the sum of $260.00 per acre, or any portion of an acre, as a proportionate contribution for a traffic signal at the intersection of County 24th Street and Avenue E.

2. Call to the Public on this item

Mrs. Sonia Cornelio, City Clerk, stated her office did not received any public comment on this item.

Ms. Elizabeth Carpenter, Realtor, mentioned this is 88 lots and is located south of the current subdivision they are doing the improvements on and added that this subdivision will have natural gas and CenturyLink.

B. Close public hearing

MOTION: Council Member Africa Luna-Carrasco/Vice Mayor Maria Cecilia Cruz to close the public hearing. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Cruz	Aye

Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

C. Approval of Reading of Ordinance No. 398 by title only
(City Clerk to read the ordinance by title only)

MOTION: Council Member Gloria Torres/Council Member Africa Luna-Carrasco to approve Reading of Ordinance No. 398 by title only. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

Mrs. Sonia Cornelio, City Clerk, read Ordinance No. 398 by title only.

D. Action on Ordinance No. 398

MOTION: Council Member Africa Luna-Carrasco/Council Member Jose Ponce to approve and adopt Ordinance No. 398. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

7. SUMMARY OF CURRENT EVENTS

Mayor Gerardo Sanchez reported the state is currently going through testing blitz by the governor, there will be over 250,000 tests performed throughout the state, there have been tests in Yuma through Sunset, San Luis Walk-In Clinic, and hospital. Once tests are being done, there will be high numbers due to the people coming back positive. As of this evening there are 283 confirmed cases in Yuma County and out of these 283 there are 54 residents within the City of San Luis. The vast majority of people that are getting infected are between the ages of 20-44, it can be because they are not

protecting themselves or because they are doubting this is true; numbers are rising dramatically.

Mayor Gerardo Sanchez added that wearing a mask will not protect one 100% but it will create a barrier for one to be exposed. As of May 15, 2020, the governor is lifting the stay at home executive order, this does not mean that people should start going back to normal, there are some recommendations by the CDC. He emphasized the City of San Luis will not open its facilities and the Police and Fire Departments will continue to work on the Phase 3/4 plan to protect its first responders. The situation will be reassesed at the end of May. He has received phone calls from local business owners and have stated that they will not be opening as they are not ready. It is important that local businesses guarantee a safe environment for their employees and make sure that their customers feel safe in their establishments when they are ready to re-open.

He added that there are parents that are using a mask or covering their face but their children are not wearing any type of protection. The CDC will be issuing warning to parents who neglect to protect their children; children are vulnerable to COVID-19 in a different way. COVID-19 is very contagious and eventually we will all be exposed but he reminded everyone to minimize exposure.

He also reported that the legacy of Cesar Chavez donated 5,000 masks to Yuma Regional Medical Center.

Council Member Jose Ponce reported he does not foresee any relief in the future on CO-VID 19; he has seen employees at stores not wearing the proper PPE (personal protective equipment) and that makes him feel unsercure and uncomfortable; the numbers are going up. When Germany re-opened their businesses, they saw some spikes in their numbers. He added that something should be done to make face masks mandatory in the entire state and if not followed for people to be fined just like it was done in New York.

Mayor Gerardo Sanchez mentioned that different states and have different laws, however in the governor's executive order it defined/limited certain restrictions by local governments.

Vice Mayor Maria Cecila Cruz congratulated the Planning & Zoning Department as they applied for the Rapid Response grant through the National League of Cities and that grant was awarded to the city in the amount of $15,000.00 for efforts to make sure every resident of the community is counted. She added the census response rate is still low at 8.2%, it is the lowest in the county. She also thanked all those who participated in the National Day of Prayer.

Mr. Tadeo De La Hoya, City Aministrator, reported San Luis is at an 8.3% response, Somerton is at 21.8%, Wellton is at 20% and Yuma is at 48.6%. The City of San Luis began on 5/12/2020 the Todos Contamos Sweepstakes and will end on July 30 at 5:00 p.m. People will need to send the proof of their census submission. He mentioned the prizes to be given away and thanked the sponsors Ramirez Advisors and Realty One Group.

Mr. De La Hoya also said that since there will be no graduation ceremony for the Class of 2020, the city will be highlighting graduates through the city's social media platforms, from 5/15-5/29.

Mayor Gerardo Sanchez congratulated the Class of 2020.

Ms. Kay Macuil, City Attorney, informed the Mayor and City Council that Mr. Ralph Velez, City Consultant, alerted her and Ms. Jenny Torres, Economic Development Manager, of an issue with item no. 5.C. and asked to revisit this item on the agenda.

DISCUSSION AND POSSIBLE ACTION ITEM:

5.C. Discussion and possible action on any and all matters regarding Rancho Los Oros Roadway Improvement (CDBG Contract #113-20) Change Order No. 1. (Jenny Torres, Economic Development Manager; Eulogio Vera, Acting Director of Public Works and Mary French-Jones, Grant Writer)

Ms. Kay Macuil, City Attorney, stated Mr. Ralph Velez, City Consultant, alerted staff that theF work before the contigency would alert the auditors, so another motion is needed on this item. The City Council needs to approve the change orders even though there was a contigency amount in the original contract, that even when there is a cushion approved, the auditors like to see that the City Council actually approved the change order to explain the cushion. That is why the first part of the motion is the full amount of the change order and show the increase with the $32,266.46.

Mayor Gerardo Sanchez asked if the motion can be amended; Ms. Macuil responded yes, but recommended to rescind the motion and do a new one.

MOTION: Vice Mayor Maria Cecilia Cruz/Council Member Matias Rosales to rescind the previous motion on this item past earlier. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

Ms. Jenny Torres, Economic Development Manager, added the $57,189.51 will be deducted from the original bid contingency amount of $24,923.05 and the difference applies to the change order to the contract.

Council Member Africa Luna-Carrasco recommended that staff and the attorney double check their agenda items and make sure that when they present items like this they

have it down before the City Council votes on something that can come back and bite the city.

MOTION: Council Member Matias Rosales/Council Member Jose Ponce to approve change order number 1 in the amount of $57,189.51 for the net amount of $32,266.46 after the contigency deductions. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

Vice Mayor Maria Cecilia Cruz congratulated Council Member Matias Rosales as he is the number 1 realtor in this region and top 10 in the lation agents.

8. ADJOURNMENT

MOTION: Council Member Africa Luna-Carrasco/Council Member Mario Buchanan Jr. to adjourn the Regular Council meeting at approximately 8:43 p.m. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

APPROVED:

_____
Gerardo Sanchez, Mayor

ATTEST:

_____
Sonia Cornelio, City Clerk

CERTIFICATION

I hereby certify that the foregoing minutes are a true and correct copy of the minutes of the Regular City Council meeting of the City Council of the City of San Luis, Arizona, held on May 13, 2020. I further certify that the meeting was dully called and held and that a quorum was present.

_____
Sonia Cornelio, City Clerk

M I N U T E S
Work Session
San Luis City Council
San Luis Council Chambers
1090 E. Union Street
San Luis, AZ 85349
May 14, 2020
6:00 p.m.

1. CALL TO ORDER/ROLL CALL

Mayor Gerardo Sanchez called the Work Session to order at approximately 6:02 p.m.

Mayor, City Council, and some staff members participated remotely due to COVID-19.

PRESENT:
Mayor Gerardo Sanchez
Vice-Mayor Maria Cecilia Cruz
Council Member Mario Buchanan Jr.
Council Member Africa Luna-Carrasco
Council Member Jose Ponce
Council Member Matias Rosales
Council Member Gloria Torres

OTHERS PRESENT:
Tadeo A. De La Hoya, City Administrator
Sonia Cornelio, City Clerk
Kay Marion Macuil, City Attorney
Axel Chayra, I.T. Technician
Derek Dueñas, Information Technology Manager
Eulogio Vera, Acting Director of Public Works
Francia Alonso, Assistant to Council/PIO
James Einwaechter, Assistant Director of Public Works
Jorge Mungaray, I.T. Technician
Lizandro Galaviz, Director of Parks & Recreation
Miguel Ramirez, Accountant
Monica Castro, Director of Finance
Ralph Velez, City Consultant
Richard Jessup, Police Chief

2. AGENDA ITEMS:

2. A. Continuation of discussion, review, and possible directions to staff on any and all matters regarding the proposed City of San Luis Fiscal Year 2020-2021 Budget. (City Council and City Staff)

Ms. Monica Castro, Director of Finance, presented a spreadsheet that includes the deficits presented during the Budget Retreat. The following were the funds discussed, General Fund a deficit of $1,000,000, HURF with a deficit of $900,000 and Solid Waste with a deficit of $152,000. She mentioned that after the Budget Retreat meeting, she met with Mr. Tadeo A. De La Hoya, City Manager and Mr. Ralph Velez, City Consultant, and review the project and came up with an additional $49,000 in the General Fund for a Field Station for the Fire Station. The San Luis Fire Department requested this project. A copy of the spreadsheet is in file with the complete agenda packed filed in the City Clerk's Office. Furthermore, Ms. Castro presented the Mayor and Council with the Capital Projects Budget Fiscal Year 2021. A copy of this listing is included in the complete agenda packet filed in the City Clerk's Office. Ms. Castro asked the Mayor and Council to review the project listing and selected what will be subsidized during Fiscal Year 2021 Budget. She explained that she is proposing three (3) different option to reduce the deficit, Option #1 is if Council wants to do all projected submitted in HURF, then the total reduction needed in the General Fund will be $823,930.00; Option #2, if Council decides not to subsidize HURF, then the total reduction needed is $672,930.00; and Option #3 is the General Fund can subsidize HURF only if there are projects in excess of $500,000.00 that are a priority to Council.

Mayor Gerardo Sanchez stated that he sees no problem subsidizing the HURF project and make the cuts in the general fund, as the projects included here are important.

Ms. Castro replied that Mayor Sanchez would be option #3 from the options presented. She stated that it is up to City Council what will be funded and added that HURF funds are not increasing, and will most likely not increase because of the pandemic.

Mayor Sanchez suggested subsidizing $300,000.00 for HURF and cut $300,000.00 from the General Fund, and streets are very important for the community.

Ms. Castro asked if the 10th Avenue traffic signal light can be phased out.

Mr. Vera replied that this is an option; it is just that the city will have to commit funds in the Fiscal Year budget 2020-2021 and 2021-2022.

Mayor Sanchez asked City Council if they agree on phasing out the traffic signal light on 10th Avenue, there be no objections from City Council.

Mr. Vera, Director of Public Works, suggested to phase-out the 10th Avenue Traffic Signal Light. He stated that this project could be started during Fiscal Year 2021 and finish it in the next fiscal year, as there will a delay in permits; the right-of-way will hold this project.

Council Member Gloria Torres suggested Council Members concentrate on projects that will benefit the community and not the city.

A discussion was held, and Mayor, City Council and staff addressed comments.

Mayor and City Council review the spreadsheet, discussed, and recommended approval of the following Capital Projects for Fiscal Year 2020-2021.

GL ACCOUNT	DEPARTMENT	DESCRIPTION	ADOPTED	TOTAL
100-110-80005	Eco. Dev.	Economic Development Incentive Policy	100,000	
				100,000
100-182-80000	Fire Dept.	(3) Warranty for Zoll Cardiac Monitors	22,000	
				22,000
100-999-70025	Facilities	Asphalt Rehab/Preservation	4,410	
100-999-70025	Facilities	Asphalt Rehab/Preservation	2,700	
100-999-70025	Facilities	Asphalt Rehab-Bldg. West Community Ctr.	1,940	
100-999-70025	Facilities	Asphalt Rehab-Community Center	9,690	
100-999-70025	Facilities	Asphalt Rehab-Police Station	7,470	
100-999-70025	Facilities	Asphalt Rehab-Fire Station	3,790	
100-999-70025	Facilities	Asphalt Rehab-City Hall	12,130	
				42,130
100-999-89000	Facilities	5 ton trane package unit H/P (4 units in case A/C breaks down)	31,320	
				31,320
100-999-90000	Building Sfty.	2020 Chevrolet Silverado CC10753 Double Cab PU	27,380	
100-999-90000	Parks	(2) John Deere X734	24,000	

100-999-90000	Parks	(1) John Deere DPX615E	10,500	
100-999-90000	Cultural Ctr.	Cultural Center Projector & Screen	28,900	
100-999-90000	Police	(10) Ford F-150 PU 4x4 with Police Package	180,000	
100-999-90000	Police	Full Riot Gear/Active Shooter	99,580	
100-999-90000	Fire	SCBA's Fill Station	49,000	
100-999-90000	Facilities	2020 Chevrolet Silverado Crew Cab 2WD	31,140	
				450,500
100-999-90000	Municipal Pool	Replaster/remodel existing pool gutter	85,000	
100-999-90000	Municipal Pool	Remove/replace cooling decking around pool and seating area	20,000	
100-999-90000	Police	(1) Vehicle evidence garage	30,000	
				135,000
100-999-90015	Admin	City Hall Expansion	115,000	
100-999-90015	Dev. Svcs.	Engineering design to add bicycle lane to existing streets	10,000	
100-999-90015	Dev. Svcs.	Aerial Ortho imagery 3in and 9in resolution	18,000	
100-999-90015	Eco. Dev.	Land for hotel development	369,860	
100-999-90015	Eco. Dev.	Public infrastructure	130,140	
100-999-90015	Eco. Dev.	Downtown redevelopment designation	25,000	
100-999-90015	Eco. Dev.	Downtown redevelopment master plan	50,000	
100-999-90015	Eco. Dev.	Design of Mesa Street improvements for RA application	35,000	
100-999-90015	Parks	Design and cost estimate	15,000	
100-999-90015	Fleet Svcs.	New Fleet Services Shop	292,500	
				1,060,500
100-999-90020	Police	Brazos rapid extension framework PDA	63,770	
100-999-90020	IT	Phone system replacement	150,000	

100-999-90020	IT	Rum fiber optic from FY20	18,000	
100-999-90020	IT	Run fiber optic from FD to YC	5,000	
100-999-90020	IT	Server, storage surveillance software, licensing & cameras	15,000	
100-999-90020	IT	PC/laptop, monitors, keyboards, mounts, licensing	50,000	
100-999-90020	IT	Replace wall timeclock machines with HID readers	31,900	
100-999-90020	IT	Upgrade Council Chamber video, audio & new voting system	18,000	
				351,670
200-210-8900	HW Users	Pavement Preservation Project FY21	350,000	
				350,000
200-210-90010	HW Users	New traffic signal and expansion @ County 22nd Street and 4th Avenue	150,000	
200-210-90010	HW Users	Traffic signal light on 10th Avenue and Cesar Chavez Blvd.	250,000	
200-210-90010	HW Users	Widening of Intersection of Sidewinder Rd. and County 22nd Street	120,000	
				520,000
200-210-90010.806	HW Users	4th Avenue/Cesar Chavez Blvd. Improvements Phase 2 and Traffic Signal	900,000	
				900,000
255-135-90015.221	Eco. Dev.	Senior Center Expansion Project	459,770	
255-135-90015.221	Eco. Dev.	Senior Center Expansion Project	200,000	
				659,770
255-210-90010	Eco. Dev.	Rancho Los Oros Improvement Phase II	500,00	
255-210-90010	Eco. Dev.	Rancho Los Oros Improvement Phase II	223,000	
				723,000

300-300-70020	Water	Entrance gate for Public Works Yard	18,500	
				18,500
300-302-89000	Water	Horizontal split-case pump baseplate and 40 HP motor at WS#3	20,000	
				20,000
300-302-9000	Billing & Collections	Pitney Bowes folder and inserter machine	7,070	
				7,070
300-302-90015	Water	Water storage tank rehabilitation project WS#5	425,000	
300-302-90015	Fleet Svcs.	New Fleet Services Shop	56,250	
300-302-90015	Water	Land 2 acres	80,000	
300-302-90015	Water	Well site, storage tank and manganese removal system	1,210,000	
				1,771,250
310-311-89000	Wastewater	Gadsden Lift Station Pump	36,500	
				36,500
310-311-90000	Wastewater	Kubota L3901 HST	34,000	
310-311-90000	Wastewater	Z-34 Self-Propelled Articulating Boom	52,000	
310-311-90000	Wastewater	Ford F-150 4x2 crew cab	26,500	
310-311-90000	Wastewater	Ford F-150 4x4 crew cab	35,000	
				147,500
310-311-90015	Fleet Svcs.	New Fleet Services Shop	56,250	
				56,250
300-311-90015.350	Wastewater	Remaining Utility Bond S2013	1,320,000	
				1,320,000
320-321-90015	Fleet Svcs.	New Fleet Services Shop	45,000	
				45,000
340-341-80000	Ambulance	4-warranty for Zoll Cardiac Monitors	30,670	
				30,670
340-341-90000	Ambulance	New ambulance 2020 Dodge 4500	211,280	
				211,280
806-860-90000.181	Police	Complete addition of full equipped dispatch console	120,000	
				120,000

806-860-90005.145	Parks	Construct restroom facility for recreational area	60,000	
806-860-90005.145	Parks	Land 20-acre community parks	680,000	
806-860-90005.145	Parks	20-acre community parks amenities	500,000	
806-860-90005.145	Parks	Plan for new parks, pathways and bicycle line on existing and future growth area	75,000	
				1,315,000
806-860-90015.182	Fire	Fire Station #2	250,000	
				250,000
		TOTAL CITY WIDE	**10,273,190**	**10,723,190**

Mayor Gerardo Sanchez thanked everyone present during this meeting and asked to continue working together amongst departments.

3. ADJOURNMENT

MOTION: Council Member Gloria Torres/Council Member Mario Buchanan Jr. to adjourn the meeting at approximately 9:28 p.m. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice-Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

APPROVED:

_____
Gerardo Sanchez, Mayor

ATTEST:

_____
Sonia Cornelio, City Clerk

Certification

I hereby certify that the foregoing minutes are a true and correct copy of the minutes of the Work Session for the City Council of the City of San Luis, Arizona, held on May 14, 2020. I further certify that the meeting was duly called and held and that a quorum was present.

_____
Sonia Cornelio, City Clerk

M I N U T E S
Special Council Meeting
San Luis City Council
San Luis Council Chambers
1090 E. Union Street
May 14, 2020
7:00 p.m.

1. CALL TO ORDER/ROLL CALL: Mayor Gerardo Sanchez called the Special City Council meeting to order at approximately 9:43 p.m.

Mayor, City Council, and some members of staff participated remotely.

PRESENT: Mayor Gerardo Sanchez
Vice Mayor Maria Cecilia Cruz
Council Member Mario Buchanan Jr.
Council Member Africa Luna-Carrasco
Council Member Jose Ponce
Council Member Matias Rosales
Council Member Gloria Torres

OTHERS PRESENT: Tadeo A. De La Hoya, City Administrator
Sonia Cornelio, City Clerk
Kay Marion Macuil, City Attorney (remotely)
Angel Ramirez, Fire Chief
Axel Chayra, Information Technology Technician
Derek Dueñas, Information Technology Manager
Enrique Lopez, Assistant Fire Chief
Eulogio Ver0a, Acting Director of Public Works
Francia Alonso, Assistant to Council/PIO
Mary French-Jones, Grant Writer
Richard Jessup, Chief of Police

2. PLEDGE OF ALLEGIANCE

The Pledge of Allegiance was led by Vice Mayor Maria Cecilia Cruz.

3. DISCUSSION AND POSSIBLE ACTION ITEM:

3.A. Discussion and possible action on any and all matters regarding authorization to the City Manager to provide a Guarantor letter and related documents confirming the City of San Luis will act as Guarantor, on a pro-rata share basis, along with the City of Yuma and Yuma County, for the Greater Yuma Port Authority refinance loan. (Kay Marion Macuil, City Attorney)

Ms. Kay Macuil, City Attorney, explained this item is for the guarantor letter, the City of Yuma and Yuma County have already approved them through their public body. What this letter does is, it refinances a loan that the Greater Yuma Port Authority has and it changes the terms. Currently the loan they have is interest only and the new one will be both principal and interest paid down each month. The interest rate offered through First Bank is the low rate of 4% interest but they require a guarantor letter to obtain that rate.

Council Member Matias Rosales stated the Port Authority is refinancing the loan and the bank has requested guarantee letters from the members; the loan is valued at 60% of the loan. When he first joined the Port Authority there was a $2.8 million debt and the Port Authority is in a position where they can re-adjust their budget and finances and be able to pay some interest and principal. They are planning to have some developed lots, which there is a waiting list for clients, and their goal is to pay this loan in approximately two (2) to three (3) years. This will not cost the city anything financially, worst case scenario if Greater Yuma Port Authority defaults on the loan, there is land to sell.

Mayor Gerardo Sanchez commented the fact that the City of Yuma and Yuma County are willing to do this says a lot. Refinancing this loan is a smart thing at this point as it is an investment that is paying off.

MOTION: Council Member Gloria Torres/Vice Mayor Maria Cecilia Cruz to approve the guarantor letter as presented. Motion passed unanimously.
The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

4. ADJOURNMENT

MOTION: Council Member Matias Rosales/Council Member Gloria Torres to adjourn the Special Council meeting at approximately 9:51 p.m. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Maria Cecilia Cruz	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye

Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

APPROVED:

_____
Gerardo Sanchez, Mayor

ATTEST:

_____
Sonia Cornelio, City Clerk

CERTIFICATION

I hereby certify that the foregoing minutes are a true and correct copy of the minutes of the Special City Council meeting for the City Council of the City of San Luis, Arizona held on May 14, 2020. I further certify that the meeting was dully called and held and that a quorum was present.

_____
Sonia Cornelio, City Clerk

AGENDA ITEM REVIEW FORM

Regular City Council Meeting **5. B.**

Meeting Date: 06/24/2020

Summary

DISBURSEMENTS FROM JUNE 1, 2020 THROUGH JUNE 12, 2020.
Total Disbursements $981,671.89
(Nine Hundred Eighty-One Thousand, Six Hundred Seventy-One Dollars and Eighty-Nine Cents)

Attachments

Disbursements

City of San Luis
Finance Department

COUNCIL MEETING JUNE 24, 2020
Disbursement Reports from 6/1/2020 to 6/12/2020

Bank Accounts	Check Date	Amount	Schedule
Payroll Check Account	6/4/2020	$ 4,477.10	Schedule A
Accounts Payable Check Account	6/4/2020	$ 127,273.74	Schedule B
Payroll Check Account	6/9/2020	$ 346,042.55	Schedule C
Accounts Payable Check Account	6/11/2020	$ 444,319.98	Schedule D
Payroll Check Account	6/11/2020	$ 59,558.52	Schedule E

Total Disbursements: $ 981,671.89

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

Prepared by Angelica V. Castro: Angelica V Castro

Verified by Director of Finance: C Cortes 06.16.2020

For Council approval on: _____

Mayor: _____

Council: _____

_____

_____

_____

_____

_____

RECEIVED
JUN 17 2020
Office of the City Clerk
City of San Luis, Arizona

Schedule A

Pay Day Register

Pay Date Range 06/01/20 - 06/30/20
Pay Batch 202006M

Pay Batch 202006M Total
Employees in Pay Batch 7
Female Employees in Pay Batch 3

Hours Description	Hours	Gross
102 - SALARY	.0000	7,550.00
806 - TELEPHONE STIPEND	.0000	200.00
Total	0.0000	$7,750.00

Withholdings and Deductions		Gross Base
Gross	7,750.00	
Imputed Income		
FEDERAL TAX WITHHOLDING	115.13	5,676.50
SOCIAL SECURITY TAX	480.50	7,750.00
MEDICARE	112.39	7,750.00
STATE WITHHOLDING	154.15	5,676.50
Council Retirement EORP	588.50	5,750.00
Dental Council	143.51	.00
EODCRS - COUNCIL	132.00	900.00
EODCRS - DISABILITY	2.00	900.00
GARNISHMENT	221.11	.00
Medical Council	1,155.61	.00
MISCELLANEOUS	116.12	.00
Vision Council	51.88	.00
Net	$4,477.10 ✓	

Benefits		Gross Base
Dental Council	257.36	.00
EODCRS - COUNCIL	99.00	900.00
EODCRS - DISABILITY	2.00	900.00
EODCRS/EORP LEGACY RATE	914.04	900.00
Health Council	6,358.99	.00
Retirement Council EORP	3,532.23	5,750.00
Vision Council	79.03	.00
Total	$11,242.65	

Workers' Comp		Gross Base
MUNICIPAL/ TOWN/	135.65	7,750.00
Total	$135.65	

Direct Deposits	Amount
1st Bank Yuma	729.53
Chase Bank	677.02
Federal Credit Union	889.73
REALTORS FED CRED UNION	22.54
Sunbank	919.48
WASHINGTON FEDERAL	809.34
Wells Fargo	429.46
Total	$4,477.10
Check	$0.00

Prepared by: Debora Luna 6/4/20
Date:

C Cortés 06-09-2020
Approved by

Schedule B

City of San Luis

Payment Register

From Payment Date: 6/1/2020 - To Payment Date: 6/4/2020

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source	Payee Name	Transaction Amount	Reconciled Amount	Difference
94256	06/04/2020	Open			Accounts Payable	YUMA PRINTING & GRAPHIC DEPT.	$1,556.82		
Type Check Totals:					38 Transactions		$127,273.74		

1BYPAYABLE - 1st BY Accounts Payable Totals

Checks	Status	Count	Transaction Amount	Reconciled Amount
	Open	38	$127,273.74	$0.00
	Reconciled	0	$0.00	$0.00
	Voided	0	$0.00	$0.00
	Stopped	0	$0.00	$0.00
	Total	38	$127,273.74	$0.00

All	Status	Count	Transaction Amount	Reconciled Amount
	Open	38	$127,273.74	$0.00
	Reconciled	0	$0.00	$0.00
	Voided	0	$0.00	$0.00
	Stopped	0	$0.00	$0.00
	Total	38	$127,273.74	$0.00

Grand Totals:

Checks	**Status**	**Count**	**Transaction Amount**	**Reconciled Amount**
	Open	**38**	**$127,273.74**	**$0.00**
	Reconciled	**0**	**$0.00**	**$0.00**
	Voided	**0**	**$0.00**	**$0.00**
	Stopped	**0**	**$0.00**	**$0.00**
	Total	**38**	**$127,273.74**	**$0.00**

All	**Status**	**Count**	**Transaction Amount**	**Reconciled Amount**
	Open	**38**	**$127,273.74**	**$0.00**
	Reconciled	**0**	**$0.00**	**$0.00**
	Voided	**0**	**$0.00**	**$0.00**
	Stopped	**0**	**$0.00**	**$0.00**
	Total	**38**	**$127,273.74**	**$0.00**

Prepared By:
Angelica Castro
6/4/2020

Miguel Ramirez
06/04/2020

City of San Luis

Payment Register

From Payment Date: 6/1/2020 - To Payment Date: 6/4/2020

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source	Payee Name	Transaction Amount	Reconciled Amount	Difference
1BYPAYABLE - 1st BY Accounts Payable									
Check									
94219	06/04/2020	Open			Accounts Payable	ALSCO, INC	$165.79		
94220	06/04/2020	Open			Accounts Payable	ANGEL'S TOWING SERVICE/AUTO SALES	$75.00		
94221	06/04/2020	Open			Accounts Payable	ARIZONA BRAKE & CLUTCH SUPPLY	$21.74		
94222	06/04/2020	Open			Accounts Payable	ARIZONA SOCIETY OF CPAs	$215.00		
94223	06/04/2020	Open			Accounts Payable	AUTOZONE STORES, INC	$426.40		
94224	06/04/2020	Open			Accounts Payable	BERKELEY RESEARCH GROUP LLC	$45,030.39		
94225	06/04/2020	Open			Accounts Payable	BILL ALEXANDER FORD	$374.42		
94226	06/04/2020	Open			Accounts Payable	BLT READY MIX CONCRETE LLC	$5,130.40		
94227	06/04/2020	Open			Accounts Payable	CORDOVA LAW, PLC	$2,600.00		
94228	06/04/2020	Open			Accounts Payable	DESERT WATER	$16.60		
94229	06/04/2020	Open			Accounts Payable	FDC RESCUE, LLC	$5,237.55		
94230	06/04/2020	Open			Accounts Payable	GOVERNMENT FINANCE OFFICERS	$250.00		
94231	06/04/2020	Open			Accounts Payable	GUTIERREZ, JUAN, F	$1,500.00		
94232	06/04/2020	Open			Accounts Payable	HANSBERGER REGRIGERATION & ELECTRIC CO	$3,166.00		
94233	06/04/2020	Open			Accounts Payable	HARVARD AVIATION INVESTMENT, INC	$8,167.50		
94234	06/04/2020	Open			Accounts Payable	HERNANDEZ, JERRY	$1,200.00		
94235	06/04/2020	Open			Accounts Payable	INTERNATIONAL BUSINESS INNOVATION ASSOC	$120.00		
94236	06/04/2020	Open			Accounts Payable	ITURBIDE, VANESSA, C	$50.00		
94237	06/04/2020	Open			Accounts Payable	LAW OFFICE OF KELLY A SMITH	$1,200.00		
94238	06/04/2020	Open			Accounts Payable	MARTIN'S CUSTOM CABINETS, LLC	$13,201.00		
94239	06/04/2020	Open			Accounts Payable	MCNEECE BROS. OIL COMPANY, INC	$17,827.24		
94240	06/04/2020	Open			Accounts Payable	MGM INTERNET SOLUTIONS, INC	$53.00		
94241	06/04/2020	Open			Accounts Payable	O'REILLY AUTO PARTS	$14.38		
94242	06/04/2020	Open			Accounts Payable	ORDUNO-CROUSE, CANDICE	$2,600.00		
94243	06/04/2020	Open			Accounts Payable	ORTIZ, JUAN, C	$102.45		
94244	06/04/2020	Open			Accounts Payable	PURCELL TIRE CO.	$107.00		
94245	06/04/2020	Open			Accounts Payable	QUINONEZ, FRANCISCO	$75.00		
94246	06/04/2020	Open			Accounts Payable	RAMIREZ ADVISORS INTER-NATIONAL,LLC	$4,166.66		
94247	06/04/2020	Open			Accounts Payable	RWC INTERNATIONAL LTD	$685.27		
94248	06/04/2020	Open			Accounts Payable	SHRM	$219.00		
94249	06/04/2020	Open			Accounts Payable	SMITH, RALPH E. SR.	$2,210.00		
94250	06/04/2020	Open			Accounts Payable	SYNOVIA SOLUTIONS, LLC	$456.14		
94251	06/04/2020	Open			Accounts Payable	THOMSON WEST PUBLISHING CO.	$1,028.55		
94252	06/04/2020	Open			Accounts Payable	UNIVERSAL BACKGROUND SCREENING INC	$505.97		
94253	06/04/2020	Open			Accounts Payable	VCA ANIMAL HOSPITALS, INC.	$3,880.06		
94254	06/04/2020	Open			Accounts Payable	WAXIE SANITARY SUPPLY	$1,349.72		
94255	06/04/2020	Open			Accounts Payable	WITMER PUBLIC SAFETY GROUP, INC.	$2,288.69		

Schedule C

Pay Day Register

Pay Date Range 05/23/20 - 06/05/20

Pay Batch 202012

PSPRS POLICE DB RATE - TIER	3,603.64	47,106.11
PSPRS POLICE DB RATE - TIER	2,966.79	25,466.15
PSPRS POLICE DB RATE - TIER 2	1,245.71	10,692.86
PSPRS POLICE DB RATE - TIER 3	2,377.74	23,920.88
STANDARD LIFE ADDTNL	918.03	.00
TRANSWESTERN MEXICAN	96.76	.00
U.S. MEX DENTAL - EE &	595.37	.00
U.S. MEX DENTAL - EE &	102.65	.00
UNITED WAY	14.00	.00
US & MEX DENTAL= FAMILY	771.00	.00
US & MEX HEALTH = C	5,124.24	.00
US & MEX HEALTH = FAMILY	6,532.20	.00
US & MEX HEALTH = SP	996.38	.00
VSP - VISION FAMILY	719.55	.00
Net	$346,042.55	

Workers' Comp		Gross Base
ANIMAL CONTROL OFFICERS	70.10	3,115.36
ATTORNEY- ALL & CLERICAL-	70.85	32,204.05
AUTO SERVICE/ REPAIR	237.21	8,502.15
BUILDING- NOC OPER BY	1,016.58	28,082.32
BUS COMPANY AND DRIVERS	152.66	2,765.61
CLERICAL OFFICE/ LIBRARY/	264.98	110,401.09
Electrician	59.11	1,882.40
FIREFIGHTERS & DRIVERS	3,959.17	112,476.26
GARBAGE/ ASH/ REFUSE	280.10	4,481.60
MUNICIPAL/ TOWN/	88.77	5,072.20
PARKS- NOC ALL EMPLOYEES	530.86	17,124.01
POLICE OFFICERS	4,813.40	109,894.90
RECREATION- ALL EMPLOYEES/	217.47	15,873.95
SEWAGE DISPOSAL/ PLANT	674.72	19,614.55
Street or Road Construction	1,910.74	23,794.37
WATERWORKS OPERATIONS	626.57	18,056.73
Total	$14,973.29	

Direct Deposits	Amount
1st Bank Yuma	27,622.56
ACADEMY BANK	2,073.45
Bank of America	1,903.07
BBVA COMPASS	916.30
Charles Sch	200.00
Chase Bank	165,680.66
CHASE BANK CA	947.12
chase centro	1,048.69
Federal Credit Union	38,605.81
FF CREDIT UNION	2,852.79
FIREFIGHTER FIRST CREDIT UNION	4,951.54
GREEN DOT BANK	361.04
National Bank	2,529.04
Navy Federal	17,509.41
NetSpend Corporation DD	120.00
NORTH ISLAND CREDIT UNION	650.84
Sunbank	1,300.73
USAA FEDERAL SAVING	3,015.04
WASHINGTON FEDERAL	930.95
Wells Fargo	71,958.10
WELLS FARGO BANK PP	865.41
Total	$346,042.55

Prepared by: Debora Luna

Date:

Approved by 06.09.2020

Schedule D

City of San Luis

Payment Register

From Payment Date: 6/8/2020 - To Payment Date: 6/11/2020

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source	Payee Name	Transaction Amount	Reconciled Amount	Difference
94298	06/11/2020	Open			Accounts Payable	SUPPORT PAYMENT CLEARINGHOUSE	$3,639.25		
94299	06/11/2020	Open			Accounts Payable	UNITED WAY OF YUMA COUNTY INC.	$14.00		
94300	06/11/2020	Open			Accounts Payable	UNITED YUMA FIRE FIGHTERS ASSOC	$92.50		
94301	06/11/2020	Open			Accounts Payable	UNITED YUMA FIRE FIGHTERS-IAFF	$1,000.00		
94302	06/11/2020	Open			Accounts Payable	INTERNAL REVENUE SERVICE	$221.11		
94303	06/11/2020	Open			Accounts Payable	INTERNAL REVENUE SERVICE	$100.00		
94304	06/11/2020	Open			Accounts Payable	DPE CONSTRUCTION, INC	$346,815.00		
Type Check Totals:					48 Transactions		$444,319.98		

1BYPAYABLE - 1st BY Accounts Payable Totals

Checks	Status	Count	Transaction Amount	Reconciled Amount
	Open	46	$443,428.70	$0.00
	Reconciled	0	$0.00	$0.00
	Voided	2	$891.28	$0.00
	Stopped	0	$0.00	$0.00
	Total	48	$444,319.98	$0.00

All	Status	Count	Transaction Amount	Reconciled Amount
	Open	46	$443,428.70	$0.00
	Reconciled	0	$0.00	$0.00
	Voided	2	$891.28	$0.00
	Stopped	0	$0.00	$0.00
	Total	48	$444,319.98	$0.00

Grand Totals:

Checks	Status	Count	Transaction Amount	Reconciled Amount
	Open	**46**	**$443,428.70**	**$0.00**
	Reconciled	**0**	**$0.00**	**$0.00**
	Voided	**2**	**$891.28**	**$0.00**
	Stopped	**0**	**$0.00**	**$0.00**
	Total	**48**	**$444,319.98**	**$0.00**

All	Status	Count	Transaction Amount	Reconciled Amount
	Open	**46**	**$443,428.70**	**$0.00**
	Reconciled	**0**	**$0.00**	**$0.00**
	Voided	**2**	**$891.28**	**$0.00**
	Stopped	**0**	**$0.00**	**$0.00**
	Total	**48**	**$444,319.98**	**$0.00**

Prepared By:
Angelica Velasco
06/11/2020
Miguel Ramirez
06/11/2020

City of San Luis

Payment Register

From Payment Date: 6/8/2020 - To Payment Date: 6/11/2020

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source	Payee Name	Transaction Amount	Reconciled Amount	Difference
1BYPAYABLE - 1st BY Accounts Payable									
Check									
94257	06/11/2020	Open			Accounts Payable	AFLAC	$4,067.90		
94258	06/11/2020	Open			Accounts Payable	ALLUVIAL MEDIA LLC	$1,000.00		
94259	06/11/2020	Open			Accounts Payable	ALSCO, INC	$2,459.71		
94260	06/11/2020	Open			Accounts Payable	AMBERLY'S PLACE	$3,484.00		
94261	06/11/2020	Open			Accounts Payable	AMERICAN BUSINESS FORMS INC.	$1,406.87		
94262	06/11/2020	Open			Accounts Payable	ARIZONA DEPARTMENT OF ENVIRONMENTAL QUALITY	$250.00		
94263	06/11/2020	Open			Accounts Payable	ARIZONA EMERGENCY PRODUCTS, INC.	$18,523.05		
94264	06/11/2020	Open			Accounts Payable	ARIZONA FURNISHINGS	$400.00		
94265	06/11/2020	Open			Accounts Payable	AYALA, MANUEL	$150.00		
94266	06/11/2020	Open			Accounts Payable	BIO PLANNER	$2,190.00		
94267	06/11/2020	Voided		06/11/2020	Accounts Payable	BLT READY MIX CONCRETE LLC	$570.17		
94268	06/11/2020	Open			Accounts Payable	CARDENAS GONZALEZ, JOANNA	$150.00		
94269	06/11/2020	Open			Accounts Payable	CORTEZ, GISSEL, JOANI	$150.00		
94270	06/11/2020	Open			Accounts Payable	DESERT VALLEY POWER SYSTEMS	$826.65		
94271	06/11/2020	Open			Accounts Payable	ENTERPRISE FM TRUST	$771.99		
94272	06/11/2020	Open			Accounts Payable	FILTRONICA, INC.	$1,125.00		
94273	06/11/2020	Open			Accounts Payable	GOMEZ-DOMINGUEZ, FRANCISCO	$1,977.99		
94274	06/11/2020	Open			Accounts Payable	LANTIS FIREWORKS AND LASERS	$10,200.00		
94275	06/11/2020	Open			Accounts Payable	LAWSON PRODUCTS INC.	$1,787.15		
94276	06/11/2020	Open			Accounts Payable	LITTLEWOOD, LIA, ESTELLE	$150.00		
94277	06/11/2020	Open			Accounts Payable	MAGANA LOPEZ, EVANGELINA	$50.00		
94278	06/11/2020	Open			Accounts Payable	MANHATTANLIFE ASSURANCE CO	$305.99		
94279	06/11/2020	Open			Accounts Payable	MASSMUTUAL FINANCIAL GROUP	$40.00		
94280	06/11/2020	Open			Accounts Payable	MENDEZ ROBLES, NAZZER, O	$4,191.67		
94281	06/11/2020	Open			Accounts Payable	NEW YORK LIFE INSURANCE CO.	$169.12		
94282	06/11/2020	Open			Accounts Payable	ROLLS AND BOWLS LLC	$230.00		
94283	06/11/2020	Open			Accounts Payable	SKAGGS COMPANIES, INC	$634.89		
94284	06/11/2020	Open			Accounts Payable	SMITH, RALPH E. SR.	$560.00		
94285	06/11/2020	Open			Accounts Payable	SPECTRUM BUSINESS	$4,008.13		
94286	06/11/2020	Open			Accounts Payable	STANDARD INSURANCE CO.	$1,809.05		
94287	06/11/2020	Open			Accounts Payable	TRANSWESTERN INSURANCE ADMIN	$193.00		
94288	06/11/2020	Open			Accounts Payable	TUMEX CORP.	$1,786.00		
94289	06/11/2020	Open			Accounts Payable	VERIZON WIRELESS MESSAGING SVC	$1,950.54		
94290	06/11/2020	Open			Accounts Payable	VISION SERVICE PLAN OF ARIZONA	$4,040.33		
94291	06/11/2020	Open			Accounts Payable	WAL-MART INC.C/O BANK OF AMERICA LOCK BOX	$19,100.21		
94292	06/11/2020	Open			Accounts Payable	YUMA WINLECTRIC CO.	$608.80		
94293	06/11/2020	Open			Accounts Payable	BALSINO, PETER, M	$6.85		
94294	06/11/2020	Open			Accounts Payable	CHARGO PA, GURSTEL	$26.95		
94295	06/11/2020	Open			Accounts Payable	FOP/ALC	$390.00		
94296	06/11/2020	Voided		06/11/2020	Accounts Payable	INTERNAL REVENUE SERVICE	$321.11		
94297	06/11/2020	Open			Accounts Payable	SAN LUIS POLICE OFFICERS ASSOC	$375.00		

Schedule E

Pay Day Register

Pay Date Range 06/15/20 - 06/15/20

Pay Batch 202006FH

Pay Batch 202006FH Total

Employees in Pay Batch 42

Female Employees in Pay Batch 2

Hours Description	Hours	Gross
704 - FIRE HOLIDAY EARNED	42.4000	.00
705 - FIRE HOLIDAY PAYOFF	4,603.2667	81,225.25
Total	4,645.6667	$81,225.25

Withholdings and Deductions		Gross Base
Gross	81,225.25	
Imputed Income		
FEDERAL TAX WITHHOLDING	5,692.48	73,749.36
SOCIAL SECURITY TAX	5,036.00	81,225.25
MEDICARE	1,177.81	81,225.25
STATE WITHHOLDING	2,284.55	73,749.36
PSPRS FIRE DB RATE - TIER 1a	2,984.98	39,019.47
PSPRS FIRE DB RATE - TIER 1b	1,765.91	15,157.98
PSPRS FIRE DB RATE - TIER 2	172.16	1,477.75
PSPRS FIRE DB RATE - TIER 3	2,347.09	23,612.34
PSPRS FIRE DC RATE - TIER 3	176.19	1,957.71
PSPRS FIRE DISABILITY RATE	29.56	1,957.71
Net	$59,558.52 ✓	

Benefits		Gross Base
PSPRS FIRE DB NORM - TIER 1	7,725.68	54,177.45
PSPRS FIRE DB NORM - TIER 2	210.73	1,477.75
PSPRS FIRE DB NORM - TIER 3	2,347.09	23,612.34
PSPRS FIRE DB UNFUND - TIER	1,695.74	54,177.45
PSPRS FIRE DB UNFUND - TIER	46.25	1,477.75
PSPRS FIRE DB UNFUND - TIER	800.37	25,570.05
PSPRS FIRE DCCN - TIER 3	176.19	1,957.71
PSPRS FIRE DISABILITY - TIER	29.56	1,957.71
Total	$13,031.61	

Workers' Comp		Gross Base
FIREFIGHTERS & DRIVERS	2,859.12	81,225.25
Total	$2,859.12	

Direct Deposits	Amount
Check	$59,558.52

Prepared by:
Debora Luna
Date:

C Cortes 06-16-2020
Approved by

AGENDA ITEM REVIEW FORM

Regular City Council Meeting **6. A.**

Meeting Date: 06/24/2020

Department Head: Jenny Torres, Economic Development Manager, Administration, Economic Development

Submitted By: Jenny Torres, Economic Development Manager, Administration, Economic Development

Action Requested: Motion

ITEM:

Discussion and possible action on any and all matters regarding a contract between the City of San Luis and Greater Yuma Port Authority in participating in the Economic Strength Program Grant (ESP) from the Arizona Department of Transportation (ADOT) and Arizona Commerce Authority (ACA) for the construction of infrastructure improvements to the Magrino Industrial Park. **(Jenny Torres, Economic Development Manager)**

SUMMARY:

On June 10, 2020, the City of San Luis worked with the Greater Yuma Port Authority (GYPA) to submit an application for a competitive Economic Strength Program grant to the Arizona Commerce Authority (ACA) and Arizona Department of Transportation (ADOT) for $500,000.00 in support of infrastructure improvements to the Magrino Industrial Park. The project is a public/private partnership between the City of San Luis and GYPA.

The total cost of the project including paving and underground work is estimated to cost approximately $1.3 million dollars. The ESP grant will provide $500,000.00 in grant funds and GYPA will provide the 10% match. The GYPA plans in reinvesting its land sales proceeds for the construction of the overall project. The grant funds will cover the paving of approximately 3320 LF of 57 feet wide dedicated public roadway in Magrino Industrial Park Unit No. 3. The project presents an opportunity to improve access to the industrial park and expand available industrial parcel options adjacent to the Commercial Port of Entry. The City of San Luis will be the applicant for the grant and will be responsible to administer the grant and oversee the construction of the project. GYPA will be the co-sponsor and agreed to pay for all funds require for the project including, but not limited to the cost of hiring a construction administration firm, and pay for all city fees and permits.

The project will support the creation of 111 jobs and estimated to have a total economic impact of $9 million dollars to the region. The staff recommends approval of the contract between the City of San Luis and Greater Yuma Port Authority.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVED CONTRACT BETWEEN THE CITY OF SAN LUIS AND GREATER YUMA PORT AUTHORITY.

N/A

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM:	Yes
CITY/STATE/FEDERAL FUNDS:	$500,000.00
TOTAL:	$500,000.00
BUDGETED AMOUNT:	$0
AVAILABLE AMOUNT TO TRANSFER:	$0
ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE:	TBD

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

If the City of San Luis is awarded the $500,000.00 ESP grant and the GYPA will provide the $50,000.00 match, the City will be resonsible to manage the grant funds and any other funds provided by the GYPA to oversee the entire project.

Attachments

Agreement
Grant Summary
Magrino Unit 3 Subdivision
ESP Request for Grant Applications

AGREEMENT

GYPA & San Luis for ACA Grant & Road Construction

This agreement ("Agreement") made this _____ day of June 2020 between the Greater Yuma Port Authority, an Arizona non-profit corporation whose members are public agencies, ("GYPA"), and the City of San Luis, Arizona, a municipal corporation and political subdivision of the State of Arizona ("City") and in consideration of the mutual covenants contained herein, hereby agree as follows:

1. GYPA and City agree to cooperate and participate in applying for and, in the event of an award, the administration of a proposed economic strength grant administered by the Arizona Commerce Authority ("ACA") for a road construction project to construct and pave roads within a platted subdivision within the area known as the Gary Magrino Industrial Park within the municipal limits of City (hereinafter the "grant project"), for the mutual benefit of GYPA and City.

2. GYPA responsibilities:

    a. GYPA shall develop the grant application for City review and submittal.

    b. If awarded, GYPA shall be responsible for assisting the City in submitting reports or any other reporting as may be required by the grant contract.

    c. GYPA shall be responsible for providing the City with the 10% grant match, as may be requested by the ACA.

    d. GYPA shall be responsible for providing the City with all funding related to the administration and completion of the grant project to include, but not limited to, the cost of hiring appropriate professionals for the construction administration of the grant project and all City fees as related to constructing the grant project.

    e. GYPA shall be responsible for any additional fees or costs that might arise from changes to or unforeseen costs related to the construction of the grant project. This responsibility includes, but is not limited to, the responsibility to pay for or reimburse the City during the City's fiscal year during which the funds are expended for any fees or costs in the construction of or management of constructing the construction and paving for improvements not covered by grant funds. The parties to this Agreement understand and agree that the roads are to be constructed and paved to the Public Works Standards of the City. City requirements may include underground utility construction such as water and wastewater utility improvement as part of the grant project. Such construction, while

part of the grant project, may not be within the scope of the grant, and therefore must be paid from sources other than grant funds.

3. City responsibilities:

    a. The City shall be responsible for reviewing and submitting the grant application to ACA.

    b. The City shall be responsible for adhering to the procurement process, for contracting with appropriate professionals for the construction administration of the grant project and contracting with a licensed contractor for the construction of the grant project. Any procurement process for appropriate professionals or licensed contractors shall be for the entire road construction of the grant project, which may include necessary improvements, not within the scope of the grant, as mentioned in Section 2.e above.

    c. The City shall be responsible for adhering to grant regulations and the conditions of any awarded grant.

    d. The City shall be responsible for administering the grant funds and all expenditures for the grant as may be required by the grant contract and the ACA. This administration shall include administration of the entire road construction for the grant project, including such improvements, which, while a necessary part of the road construction for the grant project, such as underground water and wastewater utility improvements, may not be within the scope of the grant.

    e. The City shall be responsible for submitting any reporting as required by the grant contract and the ACA.

4. 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.

5. This Agreement may not be amended, nor may any provision hereof be waived except by a written amendment executed by all parties.

6. This Agreement is entered into in Arizona and shall be construed and interpreted under the laws of Arizona. This Agreement is subject to A.R.S. § 38-511. The Parties agree that they are not currently engaged in and agree that for the duration of the Agreement, they shall not engage in a boycott of Israel, as that term is defined in A.R.S. §35-393.

7. There are no third-party beneficiaries to this Agreement, and no person or entity not a party shall have any right or cause of action under this Agreement.

8. No member, official or employee of the City shall be personally liable to GYPA, or any successor or assignee, (a) if any default occurs or breach by the City, (b) for any amount which may become due to GYPA or any successor or assign, or (c) under any obligation of the City under this Agreement; unless such personal liability arises out of the wrongful acts or gross negligence of said City member, official and or employee. Notwithstanding anything contained in this Agreement to the contrary, the liability of GYPA under this Agreement shall be limited solely to the assets of GYPA. The liability of GYPA shall not extend to or be enforceable against the individual assets of the individuals or entities who are shareholders, members, managers constituent partners, officers or directors of the general partners or members of GYPA.

9. It is not intended by this Agreement to, and nothing in this Agreement shall create any agency, partnership, joint venture, or other similar arrangement between the parties.

10. Time is of the essence in this Agreement.

[Intentionally left blank, signature page follows]

IN WITNESS WHEREOF, the Parties have executed this Agreement in Yuma County, Arizona, and it is effective as of the day and year set forth above.

ATTEST:

_____
Witness, if Contractor is an Individual

_____
(Authorized Signature)

By:_____
(Printed Name)

Title:_____

City of San Luis, Arizona

_____
Gerardo Sanchez, Mayor

ATTEST:

_____
Sonia Cornelio, City Clerk

APPROVED AS TO FORM:

_____
Kay Marion Macuil, City Attorney

GARY J. MAGRINO INDUSTRIAL PARK PHASE 3 PROJECT

The Greater Yuma Port Authority, Inc. (GYPA) is a nonprofit corporation established in 2000 to serve as a cooperative regional effort of government entities within the Yuma County region to develop the new port district in San Luis and to ensure the economic wellness of the Yuma County region. Current members of the Authority include representatives of the Yuma County Government, Cocopah Indian Tribe, City of San Luis, and City of Yuma. Development of the Gary J. Magrino Industrial Park has occurred gradually through carefully designed phases to ensure steady growth. More infrastructure is needed to secure subsequent development in the park to reach its fullest potential. GYPA and the City of San Luis are seeking FY 2020 Economic Strength Project funds for a rural road construction project to overcome infrastructure limitations, attract capital investment, and generate new jobs.

Located in the heart of a megaregion composed of four states and two nations, Yuma County is the 3rd largest metropolitan area in Arizona with a population of 212,128. The county is composed of the Cities of Yuma, San Luis, Somerton and the Town of Wellton. Yuma County is the Southwest's premier agricultural hub and Winter Lettuce Capital of the world thanks to its location, sunny weather, and senior Colorado River water rights. While agriculture accounts for $2.3 billion of Yuma's $7.8 billion GDP, the economy is also supported through military and government services ($1.7 billion), healthcare ($500 million), retail services ($700 million), professional services ($450 million), and manufacturing ($300 million). Yuma is home to two elite military installations: Marine Corps Air Station Yuma and Yuma Army Proving Ground that conduct extensive aviation and defense testing and attract talent from all over the world.

Yuma's unique location and assets allow for easy access to international markets and supply chains with the ability to deliver goods in a single day truck haul. The San Luis II Commercial Port of Entry is a unique, modern facility designed to use state of the art technology to facilitate commercial traffic and trade across the Arizona-Mexico border that is essential to the region's economy. Arizona is one of the top ten U.S. states to trade with Mexico. Manufacturing and agricultural goods account for most of the exports. In 2019, more than $1.3 billion in import and export commodities flowed through the San Luis area alone, as well as 36,885 trucks. It is estimated that number will exceed 50,000 trucks in 2020. The existing San Luis Port of Entry could only off load two tractor trailers to inspect before running out of dock space, while the new San Luis II can handle up to twenty-five trailers at a time reducing long wait times and allowing more goods to pass through. Taking into consideration the volumes of produce and perishable products that make their way across the border, the value of efficient operations that accommodate the critical element of time to market is an essential part of the Port's operations. The new USMCA trade agreement is poised to provide more opportunities to increase Arizona's foreign trade market with Mexico and benefit the border economy. Doug Ducey, Governor of Arizona, also recognized future potential and committed a directive to expand binational commerce through Arizona's ports of entry.

A binational community has grown alongside the bustling port. The City of San Luis is one of the fastest growing communities in Yuma County. According to the U.S. Census Bureau statistics, the population doubled from approximately 15,000 residents in 2010 to more than 30,000 in 2017. San Luis experienced a 24% increase compared to Yuma County's 4% change for that time period. The city's population is projected to continue to increase exponentially to more than 70,000 people by 2040 with the help of the ports and the Magrino Industrial Park to promote healthy binational relations. When the San Luis II port opened, CBP was able to open a SENTRI

lane to expedite border crossing also used by individuals who come to San Luis to work, shop, or visit with family. The City of San Luis's economy is supported by the many residents from the border community of San Luis Rio Colorado in Mexico who regularly cross through the port to purchase local American goods.

The Wilson Center of the Mexico Institute reported San Luis Rio Colorado is home to 63 industries that provide more than 20,000 jobs. The Maquiladora, or Twin Plants, industry is growing fast and impacts the local economy. These factories located primarily close to the border use raw materials imported from abroad to produce commodities for export developed in "twin plants" on the U.S. side of the border. This industry program began more than 60 years ago to serve as a lower cost manufacturing alternative to China for multinational organizations. Yuma County and the City of San Luis benefit from maquiladora businesses. Roughly each maquiladora job results in two ancillary jobs in Mexico. A single maquiladora job potentially supports about nine people (including dependents) in Mexico who are likely to cross the border to shop or dine.

Since incorporation in 2000, GYPA has worked diligently to make necessary improvements to the port district and continues to look for more opportunities. After taking ownership and responsibility for approximately 240 acres of land adjacent to the San Luis II Port of Entry to develop, GYPA gave life to the Magrino Industrial Park to support trade through the port of entry. Its location so close to Interstate 8, Highway 95, the Mexico border, and ports of entry make it the ideal place to manufacture goods for export. In 2014, the park was undeveloped and in need of an access road to attract occupants. The San Luis Commercial Operations Management, L.L.C. (SLCOM) committed to purchasing a lot in the park that would lead to an investment of $13 million dollars and 90 employees upon the completion of the construction.

GYPA flew into action to secure the necessary funding for the construction of the required infrastructure. GYPA committed matching funds to a Rural Economic Development Grant that were used to construct an interior roadway, County 25th Street, to secure the SLCOM development. The Yuma County Engineering Division went to bid and the project was completed within the designated eighteen month time frame in line with the City of San Luis' requirements. Not only did this project create jobs and develop much needed infrastructure, but also encouraged property owners surrounding the park to invest capital into their own land that helps attract more industries to the region.

More businesses followed SLCOM and purchased parcels in the Magrino Industrial Park. The Cocopah Tribe owns 26.7 acres. RL Jones Properties, a Customs Brokerage and International Logistics Company, currently owns 30.18 acres. Edy Lopez, Owner of Desert Runner Transportation purchased a 5.08-acre parcel as an expansion to his current operation that is currently based out of Nogales Arizona. San Luis Trading and Logistics purchased a 3.3737-acre parcel in September of 2019. At that time, they owned 10 acres but now own 13.54 acres and have begun construction on an expansion facility for Spindle Cooling & Warehousing who receive, ship, and streamline the movement of perishable goods. Cecilio Beltran of Chilos Trucking purchased 5.08 acres in January 2020. Franks Trucking owns 10.16 acres and currently operates out of the industrial park closer to San Luis I but hopes to expand to Magrino in the next few years.

GYPA still has 86.2893 acres to develop. The most recent unit of Magrino Industrial Park consists of 57.7465 acres currently zoned light industrial. The parcels sizes consist of 1-10.3327-acre parcels that is currently under option contract for purchase, 1- 5.6810-acre parcel that is already sold, 1-26.7-acre parcel that belongs to the Cocopah Tribe, 10-1.0028-acre

parcels. GYPA hopes to attract light and heavy industrial users to the unit. Commercial real estate agent Jerry Lococo of SVN Commercial Real Estate has been the listing agent since January of 2018 to attract investment activity in the park. The initial price point was at $45,000 an acre and has now increased to $50,000 an acre. There are currently more prospects in place than there are lots available with this new subdivision.

Originally, land use to the east side of Avenue D, the narrow portion of the property, was to accommodate a rail line. Upon further review and the current growth of the City of San Luis, GYPA realized a binational rail line would have to be located farther away from future residential districts. The smaller parcels were created to maximize the slender area to accommodate smaller enterprises that could support the service providers of its larger users such as: tire repair shops, mobile trucking service, mechanics, suppliers and/or the possibility of an overnight parking lot for trucks, contractors or any other type of micro enterprise. The goal is to encourage and provide businesses the opportunity to implement or expand that in turn leads to job creation and generating of revenue and consumerism. This goal falls directly into one of GYPA's main focus areas as expressed in their mission statement: to facilitate trade and enhance the economic development that will benefit the region.

San Luis's growing population provides access to a larger workforce in a centralized location also supplemented by Mexican Nationals who cross the border to work in Arizona. The Arizona Department of Administration reports San Luis has a labor force of 17,793 individuals, but 11,943 of those are currently unemployed. That means the area is experiencing a 67.1% unemployment rate and is in dire need of projects that lead to direct job growth. GYPA's proposed infrastructure construction project will not only benefit the park but provide the community with the creation of much needed jobs.

Project Description and Timeline – Improvements

This project consists of paving approximately 3320 LF of 57 feet wide dedicated public roadway in Magrino Industrial Park Unit No. 3. This roadway can be described as having a 54-foot-wide section of asphalt with ribbon curb at both edges. This newly platted subdivision will have 13 lots zoned "Heavy Industrial". Project work also includes construction of a box culvert over the 242 Irrigation/Drainage Lateral that will provide secondary access to the subdivision. The project will expand available industrial parcel options adjacent to the San Luis Commercial Port of Entry. One lot has already been sold and another lot is under option to purchase. After going to bid for a contractor, the construction project will take an estimated five months to complete.

Core Engineering Group calculated the total estimated cost for this construction project is $1.3 million dollars. As a non-profit organization with limited resources, GYPA is applying for ESP grant funds in the amount of $500,000 to fulfill Phase 3 of the Magrino Industrial Park development. GYPA has secured a 10% cash match in the amount of $50,000 committed to the cost of construction, available as needed and is not or will not be conditioned or encumbered in any way that would preclude its use consistent with the requirements of the investment opportunity, and plans to reinvest more than $300,000 in sales proceeds from the park towards making this project come to fruition. GYPA is also pursuing United States Economic Development Administration CARES Act grant funds to help offset costs since this project will help mitigate COVID-19 related economic injuries to the Yuma County population through millions of dollars in capital investment and job creation. GYPA has already taken several

essential steps to get the ball rolling on this project. Design of the construct is complete, a Bureau of Reclamation permit is in place, and the site is shovel ready with no expected delays. It is imperative GYPA secures this funding opportunity to begin construction as soon as possible to honor their commitment to have the project completed by March 2021 for the new users to begin development, otherwise the park will have to attract new investors.



Project Description and Timeline – Development Matters

The San Luis Trading and Logistics, L.L.C. has three projects contingent on the completion of construction that will lead to an estimated $10.7 million in total capital investment and 22 employees with average wages of $15-$16 dollars an hour. These projects are expected to be competed within a year. Labrie Properties, L.L.C. is a warehousing and light manufacturing company looking to develop a facility to support an existing facility in Mexico that has operated in San Luis Rio Colorado for over twenty years and employs 250 people. Labrie Properties plans to invest $4 million for the project that will 35 employees at $15 an hour. RL Jones is finalizing the engineering of a 42,000 square foot warehouse that will be completed within a year and will need to hire approximately 19 employees. At minimum, this project will lead to the creation of 111 jobs with an average wage of $15.00 an hour that will be 250% higher than the current per capita income of $12,913 in San Luis.

Economic Impact Summary						
Year	Total Capital Investment (Construction & Equipment)	Total New Jobs Created	Total New Payroll Supported	Square Footage of Construction	Land Cost	Total Value Economic Impact
2020	$31,500,000	111	$2,830,282	193,069	$221,612.72	$9,061,155

Source: *Applied Economics* (Attached)

This proposed project is more important than ever in lieu of the COVID-19 pandemic's effects on the local economy. The City of San Luis estimates a reduction of 30% of revenues for the last quarter of the fiscal year and the first quarter of the following fiscal year beginning in July of 2020. The City of San Luis does not have a property tax and depends on the Mexican shopper for sales tax revenue who accounts for 70% of sales tax revenue. Due to COVID-19, restriction of essential vs. non-essential travel and reduction of crossing lanes, people are waiting up to five hours in line to cross the border. CBP reported a reduction of 14% in crossings. This is a significant loss on top of impacts from the recent immigration crisis. US custom agents are being sent to Texas to assist border patrol reducing the already limited number of staff at the port of entry. Therefore, the immigration issue and the pandemic has negatively impacted the surrounding community. It is expected the percent will decrease, but the true long-lasting impact of COVID-19 is unknown. This project has the potential to offset some of the damage and introduce new capital investment to the region.

200' 0 200' 400' 600'
SCALE 1"=200'

INDEX OF DRAWINGS

1	COVER SHEET
2–5	ROADWAY PLAN
6–7	PAVING AND GRADING DETAILS
8–15	WATER AND SEWER PLAN AND PROFILES
16	STORM WATER POLLUTION PREVENTION PLAN

GENERAL NOTES

1. ROADWAY CONSTRUCTION AND OTHER CONSTRUCTION AS SHOWN WILL CONFORM TO CITY OF SAN LUIS STANDARDS (CITY OF YUMA STANDARD DETAILS, MAG SPECIFICATIONS AND CITY OF SAN LUIS SUPPLEMENT) OR AS MODIFIED ON THESE PLANS UNLESS OTHERWISE NOTED OR SPECIFICALLY ALTERED/MODIFIED BY CITY OF SAN LUIS ORDINANCE. ALL UNDERGROUND UTILITY CONSTRUCTION WILL CONFORM TO CITY OF YUMA STANDARDS AND SPECIFICATIONS. THESE SPECIFICATIONS ARE INCLUDED HERE BY REFERENCE.
2. IT IS THE RESPONSIBILITY OF THE CONTRACTOR TO CONSTRUCT THE WORK IN ACCORDANCE WITH THE APPROVED PLANS AND SPECIFICATIONS. ALL WORK SHALL BE COMPLETED IN A THOROUGH MANNER, FREE OF ANY WORKMANSHIP DEFECTS. THE CONTRACTOR SHALL INFORM THE ENGINEER OF ANY DISCREPANCIES OR CONDITIONS REQUIRING CHANGE TO THE PLANS AND REQUEST INSTRUCTIONS BEFORE PROCEEDING WITH THE WORK.
3. ANY DEFECTIVE MATERIAL OR WORKMANSHIP SHALL BE REPLACED AND/OR REPAIRED PRIOR TO FINAL ACCEPTANCE OF THE WORK.
4. PRIOR TO THE COMMENCEMENT OF ANY CONSTRUCTION, THE CONTRACTOR SHALL PROVIDE THE ENGINEER WITH ALL PROPOSED PROJECT MATERIAL DATA SHEETS AND ANY SHOP DRAWINGS. ANY MATERIAL SUPPLIED NOT IN CONFORMANCE WITH THE SPECIFICATIONS WILL BE REJECTED.
5. THE CONTRACTOR WILL BE RESPONSIBLE, IN ACCORDANCE WITH ARIZONA REVISED STATUTES, TO NOTIFY THE ARIZONA BLUE STAKE CENTER AT (800) 782–5348 AT LEAST FORTY–EIGHT (48) HOURS IN ADVANCE OF COMMENCING CONSTRUCTION ACTIVITIES. LOCATIONS OF EXISTING PUBLIC UTILITY LINES SHOWN ON THE PLANS ARE APPROXIMATE. THE CONTRACTOR MUST VERIFY THE LOCATIONS IN THE FIELD AND TAKE NECESSARY PRECAUTIONS. ANY DAMAGE TO A UTILITY SHALL BE REPAIRED AT THE EXPENSE OF THE CONTRACTOR.
6. THE CONTRACTOR SHALL MAINTAIN DUST ABATEMENT ACTIVITIES FOR THE DURATION OF THE PROJECT, INCLUDING WEEKENDS AND HOLIDAYS TO CONFORM WITH APPLICABLE ADEQ REGULATIONS. THE CONTRACTOR SHALL MAINTAIN ADEQUATE MOISTURE LEVELS IN THE SURFACE MATERIALS TO ELIMINATE BLOWING DUST FROM THESE MATERIALS. ALL HAUL TRUCKS, WHETHER INVOLVED IN DELIVERY OR REMOVAL ACTIVITIES, SHALL BE COVERED AND/OR TARPED IN ORDER TO NEGATE THE REMOVAL OF MATERIAL FROM TRUCKS BY WINDS, EITHER NATURAL OR CAUSED BY THE MOVEMENT OF THE TRUCK.
7. THE CONTRACTOR WILL BE RESPONSIBLE FOR PROVIDING AND MAINTAINING PROPER SIGNS, BARRICADES, AND WARNING LIGHTS TO CONTROL THE TRAFFIC AND TO ASSURE THE PUBLIC'S HEALTH, WELFARE, AND SAFETY. ALL TRAFFIC CONTROL DEVICES MUST CONFORM TO THE MANUAL OF UNIFORM TRAFFIC CONTROL DEVICES. THE CONTRACTOR SHALL BE RESPONSIBLE FOR THE INSPECTION OF ALL TRAFFIC CONTROL INSTALLATIONS USED IN CONJUNCTION WITH THIS PROJECT AND SHALL INSPECT, AT LEAST TWICE DAILY, TO ENSURE CONFORMANCE WITH THE APPROVED TRAFFIC CONTROL PLAN.
8. THE CONTRACTOR WILL BE RESPONSIBLE FOR THE PREPARATION AND FURNISHING OF "AS–BUILT" RECORD DRAWINGS. THE "AS–BUILT" INFORMATION SHALL BE RECORDED ON THE PLANS IN RED COLORED PENCIL. THIS INFORMATION SHALL INCLUDE ALL CASES WHERE ACTUAL FIELD CONSTRUCTION DIFFERS FROM THE DESIGNED INFORMATION, ALL CONCEALED WORK, ALL UTILITY LOCATIONS, ALL WATER VALVES AND MANHOLES. DIMENSIONS SHALL BE SHOWN FROM KNOWN REFERENCE POINTS.
9. OCCUPATIONAL SAFETY AND HEALTH ACT (OSHA) STANDARD FOR CONSTRUCTION (TITLE 29, CODE OF FEDERAL REGULATIONS, PART 1926 AS AMENDED) AND CITY OF SAN LUIS SAFETY REGULATIONS ARE APPLICABLE FOR THE COMPLETION OF THE WORK ON THIS PROJECT.
10. THE CONTRACTOR SHALL OBTAIN ENCROACHMENT PERMITS FROM THE CITY OF SAN LUIS PRIOR TO THE COMMENCEMENT OF ANY WORK IN PUBLIC RIGHT–OF–WAY.
11. THE CONTRACTOR SHALL GUARANTEE THE WORK COMPLETED AGAINST DEFECTIVE MATERIAL AND/OR WORKMANSHIP FOR A PERIOD OF ONE (1) YEAR FROM THE DATE OF FINAL ACCEPTANCE GRANTED BY YUMA COUNTY.
12. GYPA WILL BE CONTRACTING WITH AN INDEPENDENT TESTING LABORATORY. REQUIREMENTS PER SECTION 106.2 OF COUNTY SPECIFICATIONS. THE CONTRACTOR IS TO PROVIDE THE CITY OF SAN LUIS WITH ALL CERTIFIED COPIES OF FIELD DENSITY, CONCRETE COMPRESSION BREAKS AND LABORATORY TESTS.
13. ANY SURVEY MONUMENT DISTURBED DURING CONSTRUCTION ACTIVITIES SHALL BE REPLACED IN ACCORDANCE WITH CITY OF SAN LUIS STANDARD DETAILS BY THE CONTRACTOR AT NO EXTRA COST TO THE OWNER. CONTRACTOR SHALL UTILIZE A REGISTERED LAND SURVEYOR TO ASSURE PROPER PLACEMENT OF SAID MONUMENT.
14. AZPDES PERMIT SHALL BE OBTAINED PRIOR TO THE START OF GRADING ACTIVITIES.
15. GRADING SPOILS TO BE SPREAD ON ADJACENT LOTS.
16. STOCKPILED EXISTING ABC FOUND IN THIS PROJECT MAY ONLY BE REUSED ON THIS PROJECT IF IT IS TESTED AND MEETS REQUIRED PROJECT SPECIFICATIONS.

UTILITY COMPANIES

WATER – CITY OF SAN LUIS
1090 E. UNION STREET
P.O. BOX 3750
SAN LUIS, AZ 85349
(928) 341–8577 (ANTONIO SANDOVAL)

SEWER – CITY OF SAN LUIS
1090 E. UNION STREET
P.O. BOX 3750
SAN LUIS, AZ 85349
(928) 341–8577 (GILBERTO TORRES)

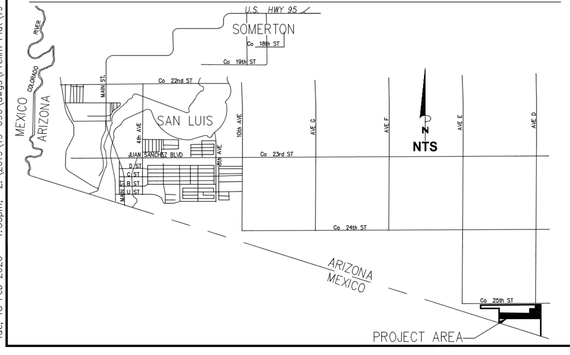
ELECTRIC – APS COMPANY
MAIL STATION 4853
6700 E. 30TH STREET
YUMA, ARIZONA 85364
(928) 336–9838 (ANNE CAMACHO)

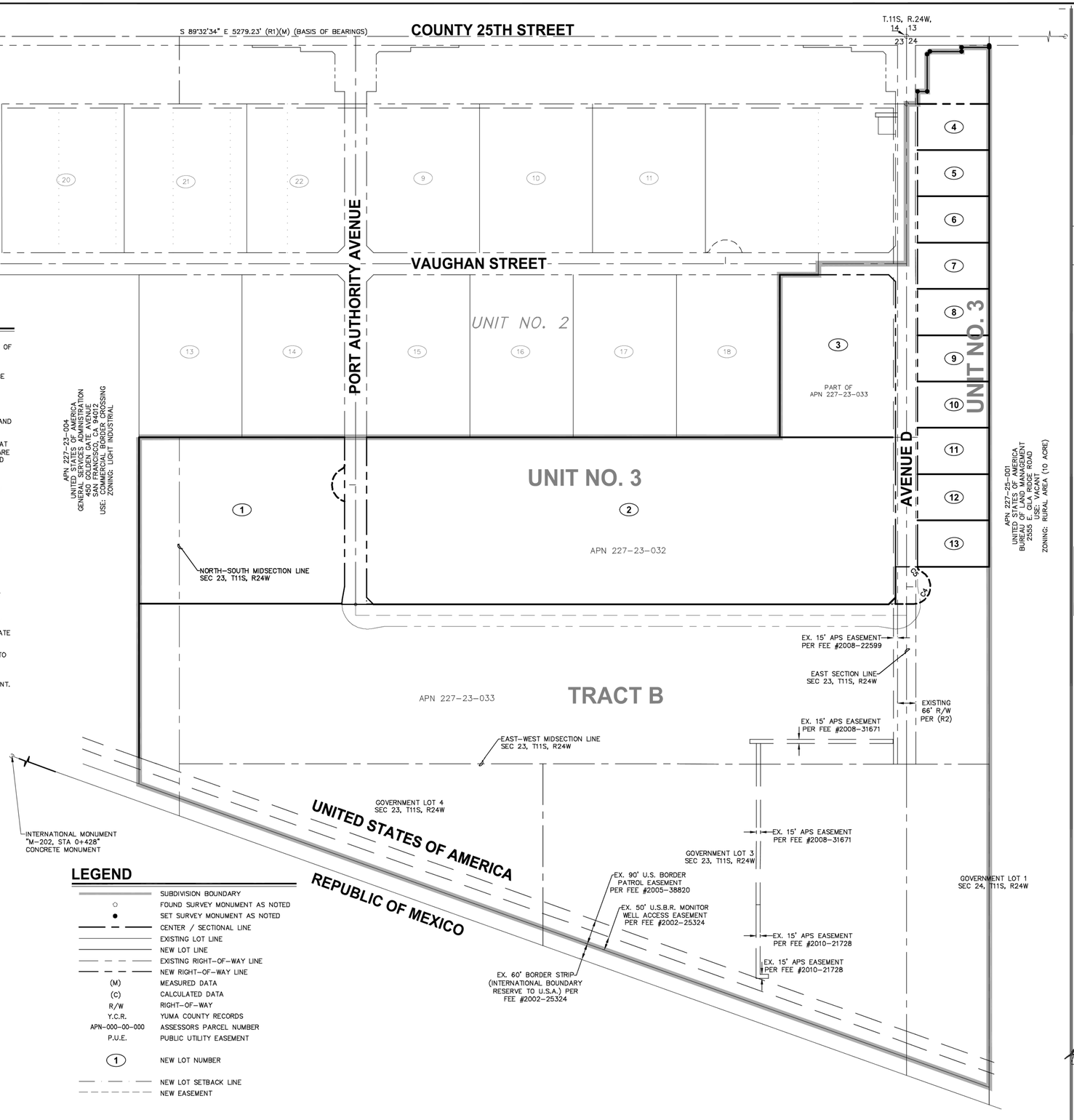
FIRE PROTECTION – SAN LUIS FIRE DEPARTMENT
1165 N. McCAIN AVENUE
P.O. BOX 445
SAN LUIS, AZ 85349
(928) 341–8550 (ANGEL RAMIEREZ)

CABLE TELEVISION – TIME WARNER
1289 SOUTH 2ND AVENUE
YUMA, ARIZONA 85364
(760) 250–2469 (PLACIDO LOPEZ)

TELEPHONE – CENTURYLINK
1850 EAST 20TH STREET
YUMA, ARIZONA 85365
(928) 343–8943 (ED ALUPAY)

VICINITY MAP





LEGEND

	SUBDIVISION BOUNDARY
○	FOUND SURVEY MONUMENT AS NOTED
●	SET SURVEY MONUMENT AS NOTED
	CENTER / SECTIONAL LINE
	EXISTING LOT LINE
	NEW LOT LINE
	EXISTING RIGHT–OF–WAY LINE
	NEW RIGHT–OF–WAY LINE
(M)	MEASURED DATA
(C)	CALCULATED DATA
R/W	RIGHT–OF–WAY
Y.C.R.	YUMA COUNTY RECORDS
APN–000–00–000	ASSESSORS PARCEL NUMBER
P.U.E.	PUBLIC UTILITY EASEMENT
(1)	NEW LOT NUMBER
	NEW LOT SETBACK LINE
	NEW EASEMENT

DRAWING RECORD:

No.	DATE:
.	.

CORE ENGINEERING GROUP, PLLC
200 East 16th Street, Suite 150
Yuma, AZ 85364
V - 928.344.5931 F - 928.344.5932
www.CoreEngineeringGroup.com
Core@core-e-g.com

MAGRINO INDUSTRIAL PARK
UNIT NO. 3
CITY OF SAN LUIS
YUMA COUNTY, ARIZONA
COVER SHEET

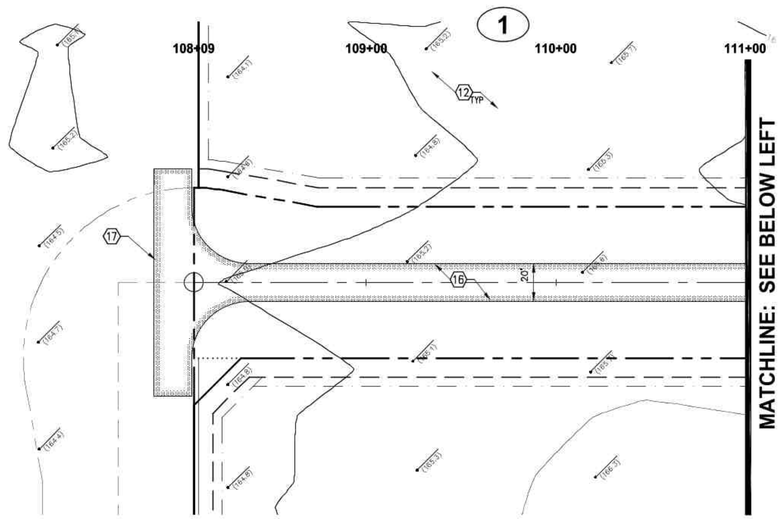
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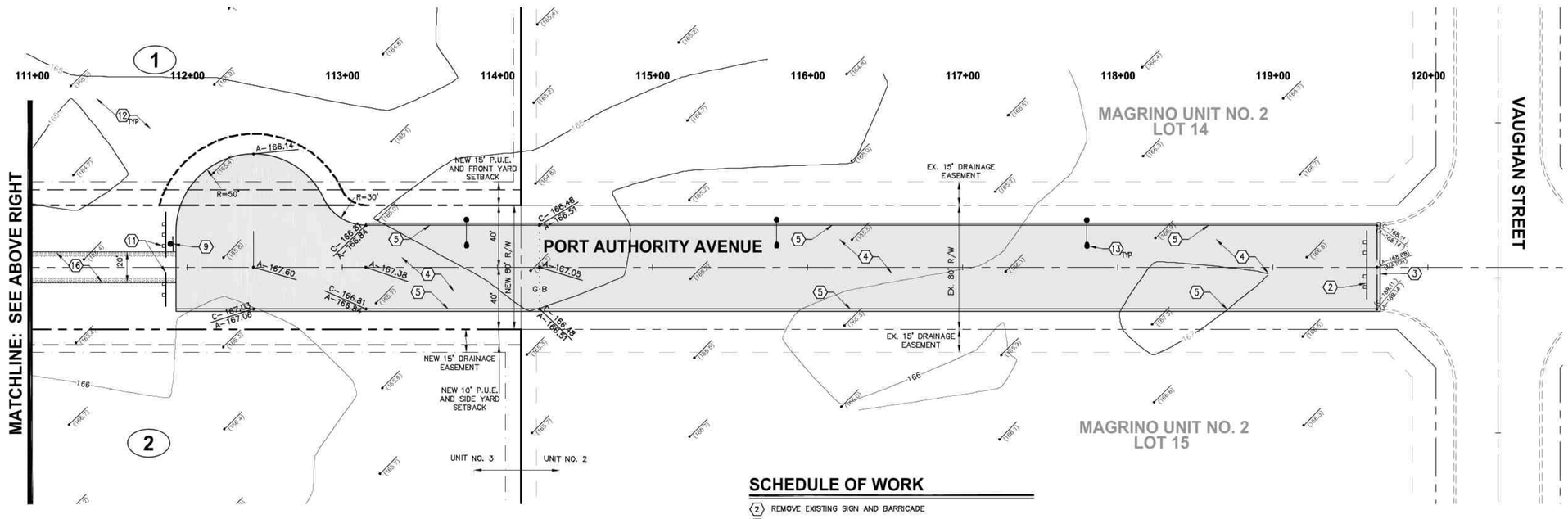
Registered Professional Engineer (Civil)
CERTIFICATE NO.
32329
DOUGLAS J.
NICHOLLS
Date Signed 12/18/19
ARIZONA, U.S.A.

Date: DEC. 2019
Designed: K.L.B.
Drawn: J.M.G.
Checked: D.J.N.
Proj. No.: 19–096

SHEET 1

Tue, 18 Feb 2020 - 1:53pm, Z:\2019\19–096\dwgs\Prelim Plat\19–096 Cover.dwg, " Core Engineering Group, PLLC"





SCHEDULE OF WORK

(2)	REMOVE EXISTING SIGN AND BARRICADE	
(3)	SAWCUT AND MATCH EXISTING	
(4)	INDUSTRIAL STREET SECTION	–SEE DETAIL A/6
(5)	PAVEMENT BORDER CURB	–SEE DETAIL C/6
(7)	STREET NAME SIGN WITH 30"X30" R1–1 "STOP" SIGN.	–SEE DETAIL D/6
(8)	30" X 30" R1–1 "STOP" SIGN	–SEE DETAIL D/6
(9)	30" X 30" R5–1 "DO NOT ENTER" SIGN	–SEE DETAIL D/6 (SIM)
(10)	24" SOLID WHITE THERMOPLASTIC STRIPE	
(11)	TYPE III BARRICADE	–SEE DETAILS A/7
(12)	ON–SITE LOT GRADING AND RETENTION BY FUTURE LOT DEVELOPER	–SEE DETAIL B/7
(13)	STREET LIGHT	–BY APS
(14)	REMOVE EXISTING PAVEMENT	
(16)	20' WIDE ABC ACCESS ROAD	–SEE DETAIL E&F/8
(17)	HAMMERHEAD TURN AROUND	–COY STD NO. 3–210

Call at least two full working days before you begin excavation.
ARIZONA 811
Arizona Blue Stake, Inc.
Dial 8-1-1 or 1-800-STAKE-IT (782-5348)
In Maricopa County: (602) 263-1100

UTILITY DISCLAIMER

THE UNDERGROUND UTILITIES SHOWN HAVE BEEN LOCATED FROM THE FIELD SURVEY INFORMATION AND EXISTING DRAWINGS. THE SURVEYOR MAKES NO GUARANTEE THAT THE UNDERGROUND UTILITIES SHOWN COMPRISE ALL SUCH UTILITIES IN THE AREA, EITHER IN SERVICE OR ABANDONED. THE SURVEYOR FURTHER DOES NOT WARRANT THAT THE UNDERGROUND UTILITIES SHOWN ARE IN THE EXACT LOCATION INDICATED ALTHOUGH HE DOES CERTIFY THAT THEY ARE LOCATED AS ACCURATELY AS POSSIBLE FROM INFORMATION AVAILABLE. THE SURVEYOR HAS NOT PHYSICALLY LOCATED THE UNDERGROUND UTILITIES.

40' 0 40' 80' 120'
SCALE: 1" = 40'

DRAWING RECORD:

No.	DATE:
.	.
.	.

CORE ENGINEERING GROUP, PLLC
200 East 16th Street, Suite 150
Yuma, AZ 85364
V - 928.344.5931 F - 928.344.5932
www.CoreEngineeringGroup.com
Core@core-e-g.com

MAGRINO INDUSTRIAL PARK UNIT NO. 3

CITY OF SAN LUIS
YUMA COUNTY, ARIZONA

ROADWAY PLAN

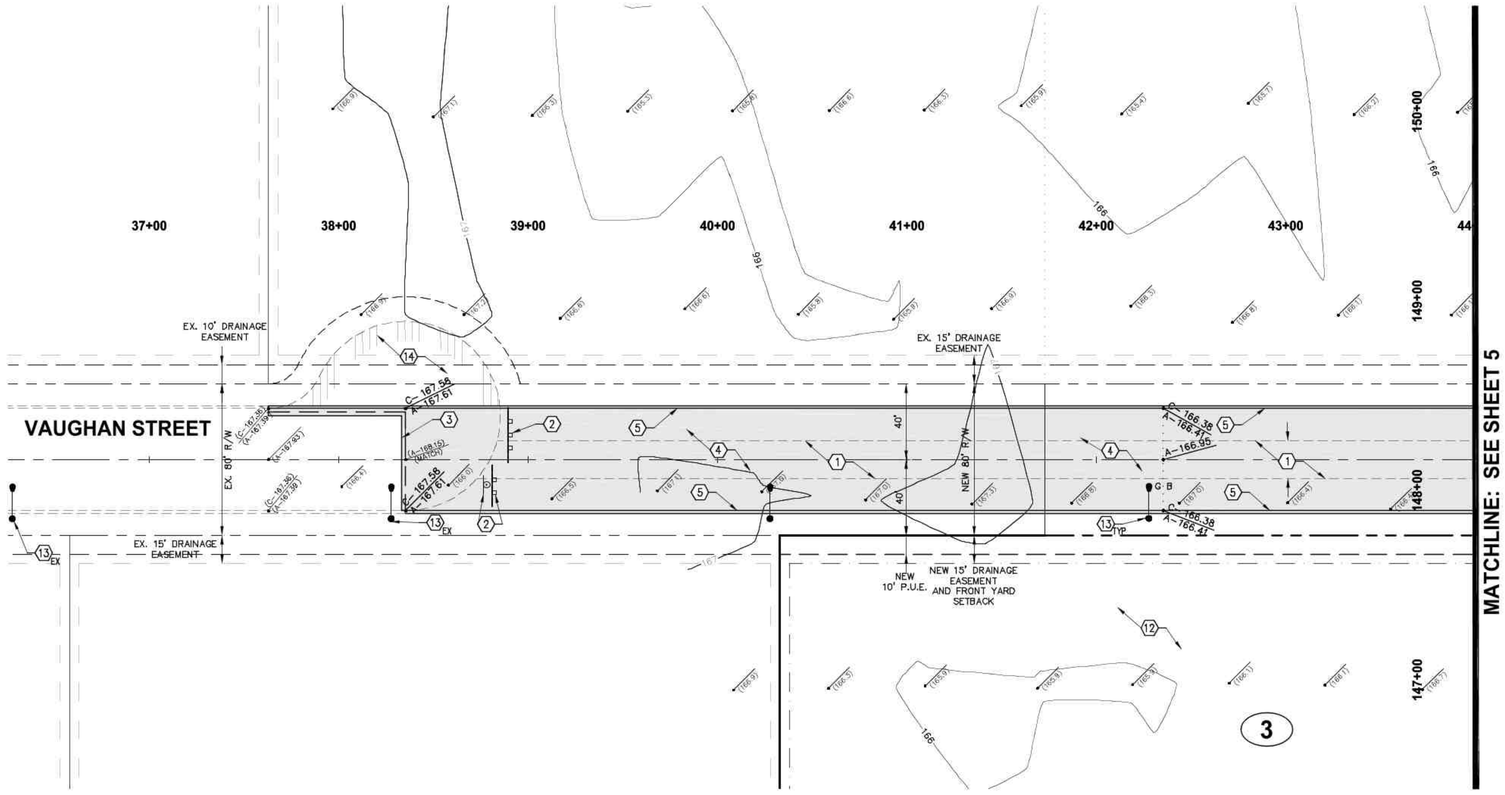
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Proj. No.: 19–096

SHEET 2

Tue, 18 Feb 2020 – 3:34pm, Z:\2019\19-096\dwgs\Prelim Plat\19-096 Prelim Plat Grading Plan.dwg, " Core Engineering Group, PLLC"



SCHEDULE OF WORK

(1)	REMOVE EXISTING ABC AND STOCKPILE FOR REUSE (GEN. NOTE 16, SHT 1)	
(2)	REMOVE EXISTING SIGN AND BARRICADE	
(3)	SAWCUT AND MATCH EXISTING	
(4)	INDUSTRIAL STREET SECTION	-SEE DETAIL A/6
(5)	PAVEMENT BORDER CURB	-SEE DETAIL C/6
(7)	STREET NAME SIGN WITH 30"X30" R1-1 "STOP" SIGN.	-SEE DETAIL D/6
(8)	30" X 30" R1-1 "STOP" SIGN	-SEE DETAIL D/6
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(11)	TYPE III BARRICADE	-SEE DETAILS A/7
(12)	ON-SITE LOT GRADING AND RETENTION BY FUTURE LOT DEVELOPER	-SEE DETAIL B/7
(13)	STREET LIGHT	-BY APS
(14)	REMOVE EXISTING PAVEMENT	
(15)	PROVIDE COLD JOINT FOR FUTURE REMOVAL	

SCALE: 1" = 40'

LEGEND

	FOUND SURVEY MONUMENT AS NOTED
	CENTER / SECTIONAL LINE
	EXISTING EASEMENT (AS NOTED)
	EXISTING LOT LINE
	EXISTING RIGHT-OF-WAY LINE
	EXISTING SUBDIVISION BOUNDARY
	EXISTING GROUND LINE
EX 12"-W	EXISTING WATER LINE
EX 8" S	EXISTING SEWER LINE
EX E-(OH)	EXISTING OVERHEAD ELECTRIC
EX T-(OH)	EXISTING OVERHEAD TELEPHONE
EX E-(UG)	EXISTING UNDERGROUND ELECTRIC LINE
EX T-(UG)	EXISTING UNDERGROUND TELEPHONE LINE
EX G	EXISTING GAS LINE
	NEW BORDER CURB
	EXISTING ASPHALT
	EXISTING CONCRETE
	EXISTING ABC CANAL ROAD
	NEW ASPHALT
	NEW ABC PAVEMENT FOR ACCESS ROAD
	EXISTING CHAIN LINK FENCE
	EXISTING BARBED WIRE FENCE
PP	EXISTING POWER POLE
	EXISTING GUY WIRE ANCHOR
WM	EXISTING WATER METER
BO	EXISTING BLOW OFF
	EXISTING SEWER MANHOLE
	EXISTING ELECTRICAL TRANSFORMER
T-PED	EXISTING TELEPHONE PEDESTAL
EJ-BOX	EXISTING ELECTRICAL JUNCTION BOX
	EXISTING SIGN
	NEW SIGN
	NEW STREET NAME AND STOP SIGN
	NEW LIGHT POLE
	NEW BARRICADE
	EXISTING BARRICADE
	EXISTING FIRE HYDRANT
	EXISTING VALVE
GM	EXISTING GAS METER
	EXISTING SLOPE
	NEW SLOPE
R/W	RIGHT-OF-WAY
FFE	FINISHED FLOOR ELEVATION
(100.9)	EXISTING GROUND ELEVATION
(C=100.50) (G=100.00)	EXISTING CURB ELEVATION
	EXISTING GUTTER ELEVATION
(CONC=100.00)	EXISTING CONCRETE ELEVATION
(SW=100.00)	EXISTING SIDEWALK ELEVATION
(A=100.00)	EXISTING ASPHALT ELEVATION
(GR=100.00)	EXISTING GRATE ELEVATION
(INV=100.00)	EXISTING INVERT ELEVATION
C=100.00	NEW CURB ELEVATION
G=100.00	NEW GUTTER ELEVATION
A=100.00	NEW ASPHALT ELEVATION
FL=100.00	NEW FLOW WAY ELEVATION
G.B.	NEW GRADE BREAK
(100)	NEW LOT NUMBER
(M)	MEASURED DATA
(R1)	RECORDED DATA PER BOOK 23 OF PLATS PAGES 57&58, Y.C.R.
(R2)	RECORDED DATA PER COUNTY ROAD MAP #3856
(C)	CALCULATED DATA

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No.	DATE:

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Yuma, AZ 85364
V - 928.344.5931 F - 928.344.5932
www.CoreEngineeringGroup.com
Core@core-e-g.com

MAGRINO INDUSTRIAL PARK UNIT NO. 3

CITY OF SAN LUIS
YUMA COUNTY, ARIZONA

ROADWAY PLAN

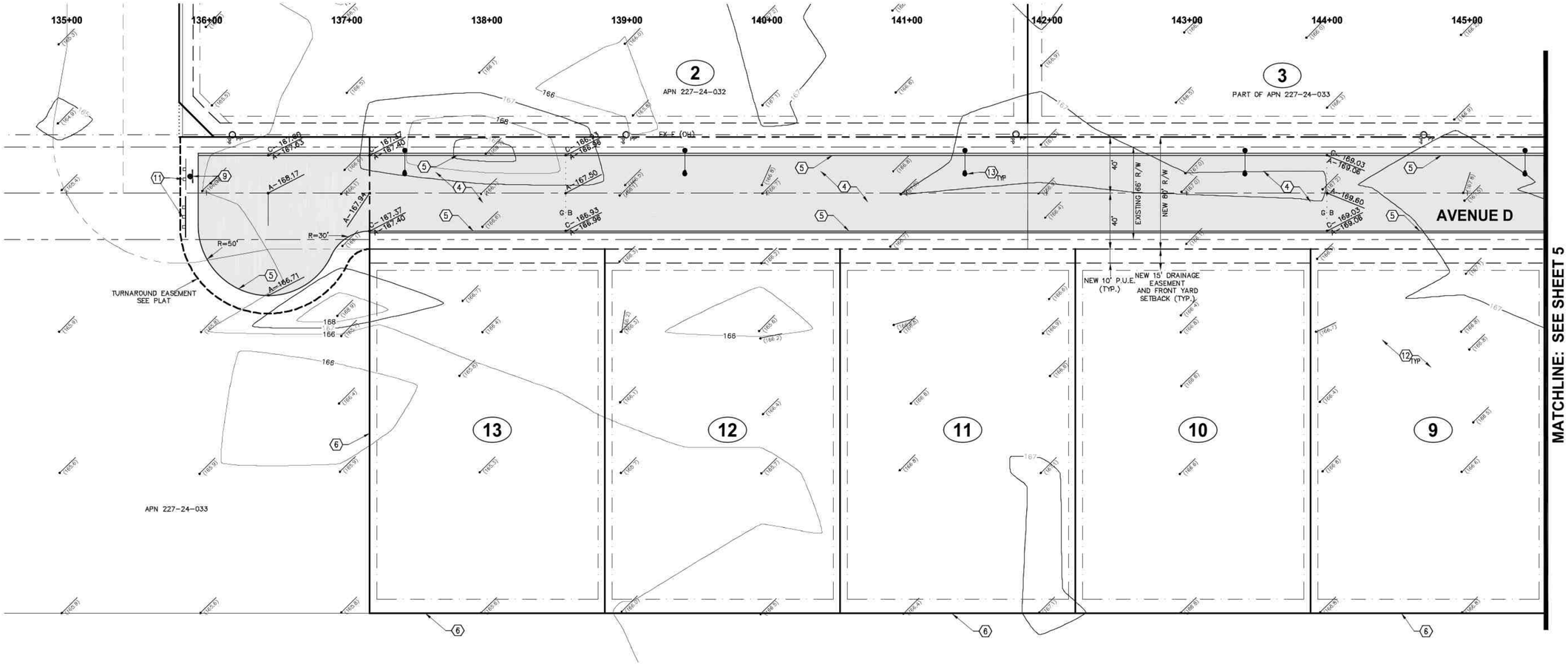
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Registered Professional Engineer (Civil)
CERTIFICATE NO.
32329
DOUGLAS J. NICHOLLS
Date Signed 12/31/19
ARIZONA U.S.A.

Date: DEC. 2019
Designed: K.L.B.
Drawn: J.M.G.
Checked: D.J.N.
Proj. No.: 19-096

SHEET 3

Tue, 18 Feb 2020 - 3:34pm, Z:\2019\19-096\dwgs\Prelim Plat\19-096 Prelim Plat Grading Plan.dwg, " Core Engineering Group, PLLC"



SCHEDULE OF WORK

1	REMOVE EXISTING ABC AND STOCKPILE FOR REUSE (GEN. NOTE 16, SHEET 1)	
2	REMOVE EXISTING SIGN AND BARRICADE	
3	SAWCUT AND MATCH EXISTING	
4	INDUSTRIAL STREET SECTION	-SEE DETAIL A/6
5	PAVEMENT BORDER CURB	-SEE DETAIL C/6
6	6' SCREEN WALL BY FUTURE LOT DEVELOPERS OR GYPA	
7	STREET NAME SIGN WITH 30"X30" R1-1 "STOP" SIGN.	-SEE DETAIL D/6
8	30" X 30" R1-1 "STOP" SIGN	-SEE DETAIL D/6
9	30" X 30" R5-1 "DO NOT ENTER" SIGN	-SEE DETAIL D/6 (SIM)
10	24" SOLID WHITE THERMOPLASTIC STRIPE	
11	TYPE III BARRICADE	-SEE DETAILS A/7
12	ON-SITE LOT GRADING AND RETENTION BY FUTURE LOT DEVELOPER	-SEE DETAIL B/7
13	STREET LIGHT	-BY APS
14	REMOVE EXISTING PAVEMENT	

40' 0 40' 80' 120'

SCALE: 1" = 40'

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Core@core-e-g.com

MAGRINO INDUSTRIAL PARK UNIT NO. 3

CITY OF SAN LUIS
YUMA COUNTY, ARIZONA

ROADWAY PLAN

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Date Signed
ARIZONA, U.S.A.

Date: DEC. 2019
Designed: K.L.B.
Drawn: J.M.G.
Checked: D.J.N.
Proj. No.: 19-096

SHEET 4

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UNIT NO. 3

WORK PERMITTED WITH UNIT NO. 2 BUT NOT CONSTRUCTED - SEE PREVIOUS DESIGN

40' 0 40' 80' 120'
SCALE: 1" = 40'

MATCHLINE: SEE SHEET 3

MATCHLINE: SEE SHEET 4

AVENUE D

EX E (GH)

EX 8" S T&E

EX 15" S

EX E (UG)

EX 8" W

EXISTING 66' R/W

NEW 80' R/W

40'

40'

NEW 10' P.U.E. (TYP.)

NEW 15' DRAINAGE EASEMENT AND FRONT YARD SETBACK (TYP.)

FOUND ½" REBAR WITH CAP "LS 16810" NE COR, SEC 23, T11S, R24W

COUNTY 25TH STREET

TRACT A

8 7 6 5 4

APN 227-25-001
UNITED STATES OF AMERICA
BUREAU OF LAND MANAGEMENT
2555 E. GILA RIDGE ROAD
USE: VACANT
ZONING: RURAL AREA (10 ACRE)

SCHEDULE OF WORK

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3	SAWCUT AND MATCH EXISTING	
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5	PAVEMENT BORDER CURB	-SEE DETAIL C/6
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MAGRINO INDUSTRIAL PARK UNIT NO. 3
CITY OF SAN LUIS YUMA COUNTY, ARIZONA
ROADWAY PLAN

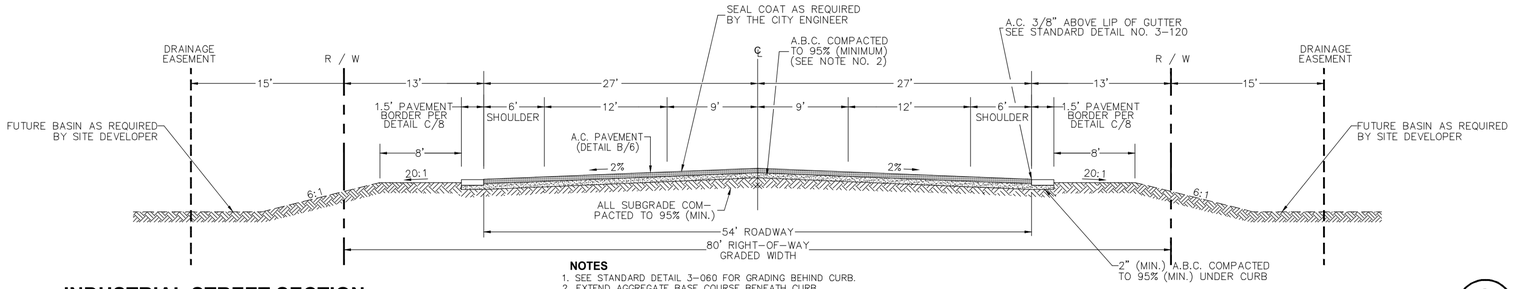
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CERTIFICATE NO.
32329
DOUGLAS J. NICHOLLS
Date Signed: 01-07-20
ARIZONA, U.S.A.

Date: DEC. 2019
Designed: K.L.B.
Drawn: J.M.G.
Checked: D.J.N.
Proj. No.: 19-096

SHEET 5

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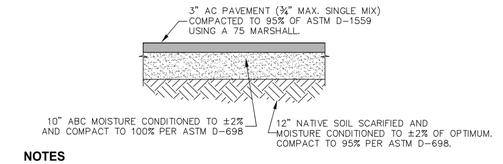


NOTES
1. SEE STANDARD DETAIL 3-060 FOR GRADING BEHIND CURB.
2. EXTEND AGGREGATE BASE COURSE BENEATH CURB.

INDUSTRIAL STREET SECTION

YUMA COUNTY CONSTRUCTION STANDARD DETAIL DRAWINGS STD. NO. 2-070 (MODIFIED, NTS)

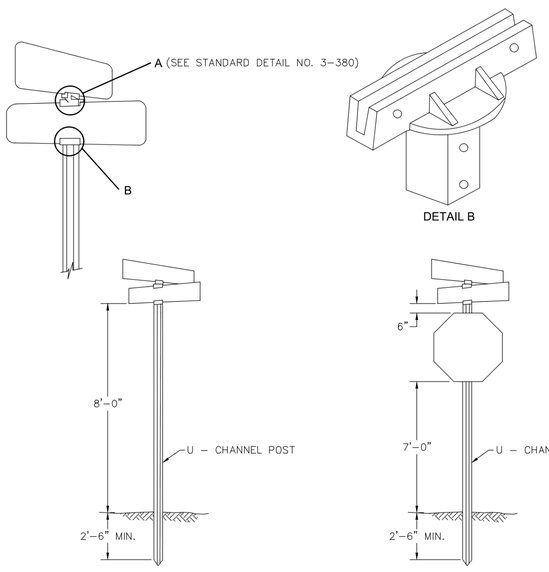
NTS — A / 6



NOTES
1. ASPHALT SHALL MEET CURRENT YUMA COUNTY STANDARD SPEC. 321 FOR ¾ INCH MAXIMUM SINGLE COARSE.
2. AGGREGATE BASE SHALL YUMA COUNTY SPECIFICATION SECTION 310.

PAVEMENT STRUCTURAL SECTION

NTS — B / 6



INDEPENDENT INSTALLATION
SEE STD. NO. 23 FOR LOCATION

REGULATORY SIGN INSTALLATION
SEE NOTES FOR LOCATION

NOTES
U-CHANNEL POSTS SHALL BE FLANGED GALVANIZED AND A MINIMUM OF 2 LB. PER FOOT IN WEIGHT.

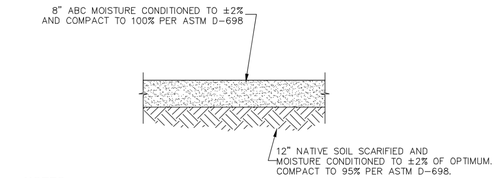
WHEN STREET NAME SIGNS ARE MOUNTED WITH A REGULATORY SIGN, THE LOCATION WILL BE AS PER THE M.U.T.C.D.

SEE GENERAL NOTES ON STD. DETAIL NO. 3-380.

DOUBLE FACED STREET SIGN - STOP SIGN

YUMA COUNTY CONSTRUCTION STANDARD DETAIL NO. 3-390

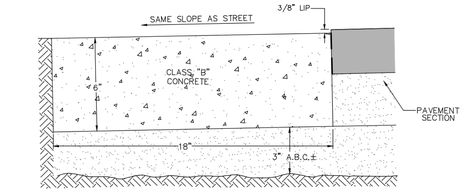
NTS — D / 6



NOTES
1. ASPHALT SHALL MEET CURRENT YUMA COUNTY STANDARD SPEC. 321 FOR ¾ INCH MAXIMUM SINGLE COARSE.
2. AGGREGATE BASE SHALL YUMA COUNTY SPECIFICATION SECTION 310.

ABC STRUCTURAL SECTION

NTS — E / 6

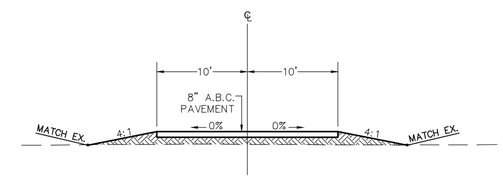


NOTES
1. IN GROUP A SOIL CONDITIONS: 8" OF CONCRETE MAY BE SUBSTITUTED FOR 6" OF CONCRETE AND 3" A.B.C. WITH THE APPROVAL OF THE CITY ENGINEER.
2. BROOM FINISH EXPOSED SURFACE
3. CONTRACTION JOINT SPACING AS PER SECTION 3.3.8 OF PUBLIC WORKS STANDARD
4. EXPANSION JOINT SPACING 50' MAX AS PER SECTION 3.3.8 OF PUBLIC WORKS STANDARDS.

PAVEMENT BORDER

YUMA COUNTY CONSTRUCTION STANDARD DETAIL NO. 3-160 (MODIFIED)

NTS — C / 6



NOTE
1. AGGREGATE BASE SHALL MEET YUMA COUNTY SPECIFICATION SECTION 310.

20' ABC ACCESS ROADWAY

NTS — F / 6

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PAVING DETAILS

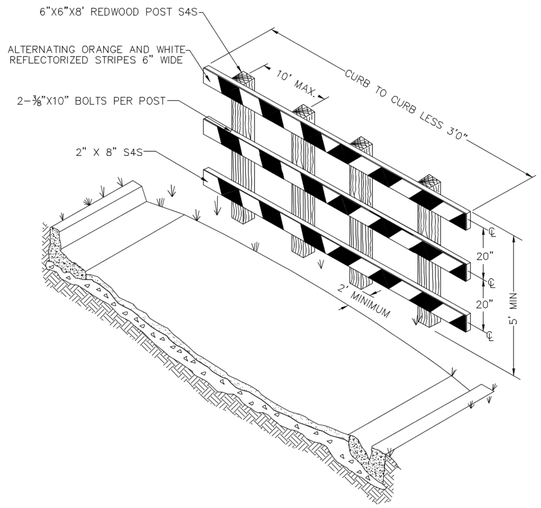
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Registered Professional Engineer (Civil) CERTIFICATE NO. 32329 DOUGLAS J. NICHOLLS Date Signed 02/19/20 ARIZONA U.S.A.

Date: DEC. 2019
Designed: K.L.B.
Drawn: J.M.G.
Checked: D.J.N.
Proj. No.: 19-096

SHEET 6

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NOTES

BARRICADE MARKINGS SHALL BE 3M ENGINEER GRADE REFLECTIVE SHEETING ON .080" THICK ALUMINUM SHEET OR EQUAL AS DIRECTED BY PUBLIC WORKS.

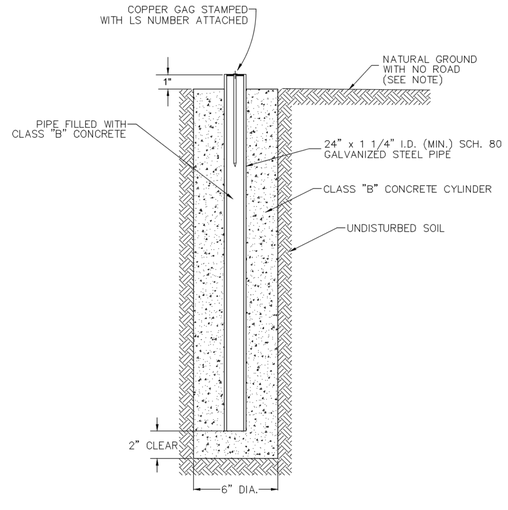
RAIL TIMBER TO BE NO. 1 D.F. S4S AND TO RECEIVE 2 COATS OF OUTSIDE WHITE PAINT ON NON-REFLECTIVE SURFACES. STRIPES SHALL SLOPE TOWARD THE CENTER OF THE PAVEMENT FROM BOTH SIDES, UNLESS OTHERWISE INSTRUCTED BY THE ENGINEER.

STREET WIDTH	NO. OF POSTS
26' - 32'	4
38' - 44'	5
48'	6
68' - 72'	8

TYPE III BARRICADE

YUMA COUNTY CONSTRUCTION STANDARD DETAIL NO. 3-360

NTS — A/7



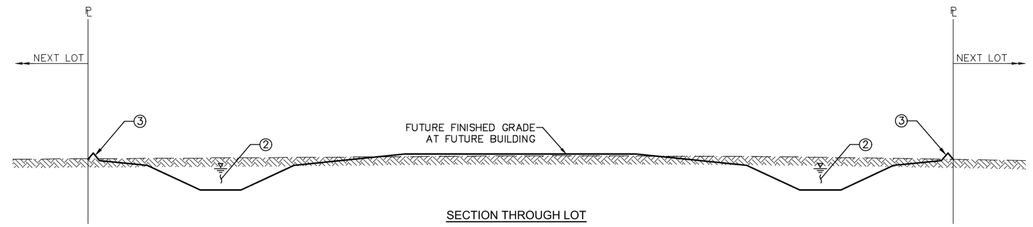
NOTE

IF SUBDIVISION BOUNDARY MONUMENT IS LOCATED WITHIN THE ROADWAY, INSTALL STANDARD NO. 4-080.

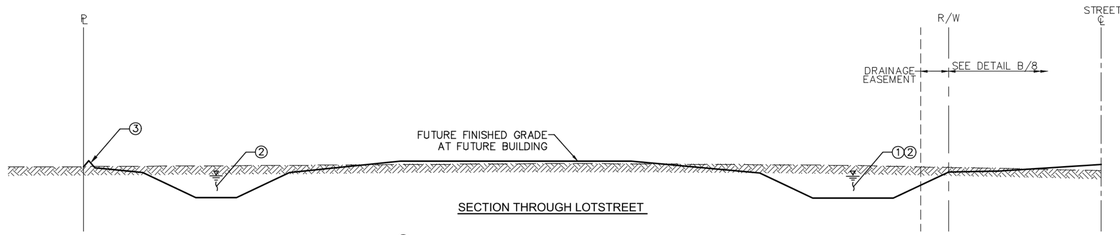
BOUNDARY MONUMENT

YUMA COUNTY CONSTRUCTION STANDARD DETAIL DRAWING NO. 4-030

NTS — C/7



SECTION THROUGH LOT



SECTION THROUGH LOTSTREET

① ROADWAY RETENTION BASIN —SEE DETAILS B&C/8

② POSSIBLE ON SITE RETENTION BY LOT DEVELOPER

③ BERM AS REQUIRED TO PREVENT CROSS PROPERTY DRAINAGE —BY LOT DEVELOPER

NOTE

THE INTENT OF THIS DETAIL IS TO SHOW THE LOT DRAINAGE/GRADING FUTURE CONCEPT. THIS DETAIL IS FOR REFERENCE ONLY SINCE THE LOT GRADING AND ROADSIDE DRAINAGE WILL BE BY INDIVIDUAL LOT DEVELOPER AT THE TIME OF LOT DEVELOPMENT. A STANDARD GRADING PERMIT IS STILL REQUIRED FOR THE LOT DEVELOPMENT.

CONCEPTUAL ON-SITE RETENTION AND LOT GRADING DETAIL (BY OTHERS)

NTS — B/7

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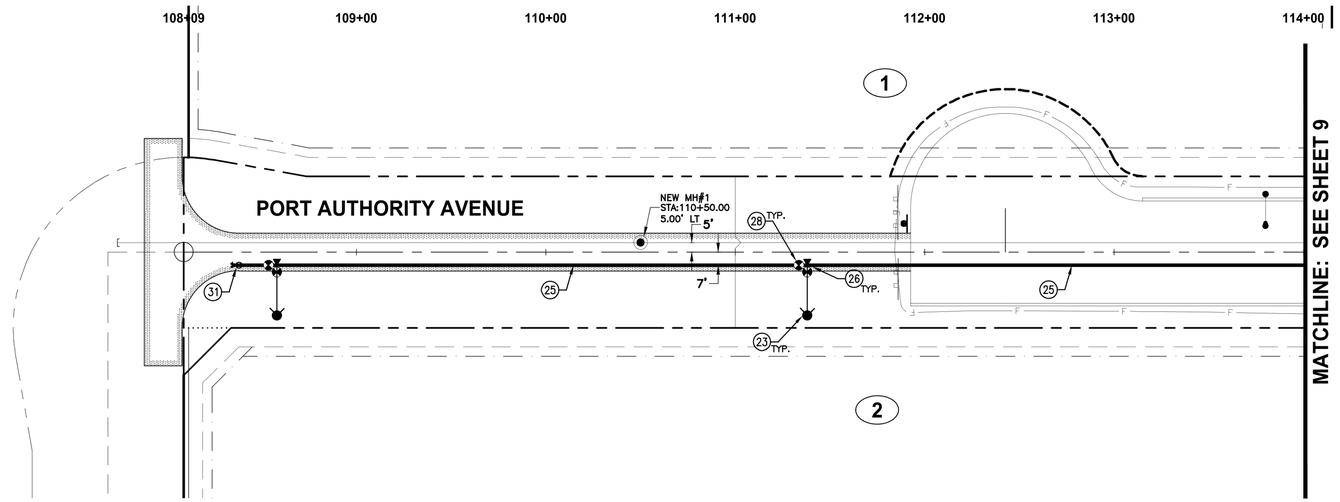
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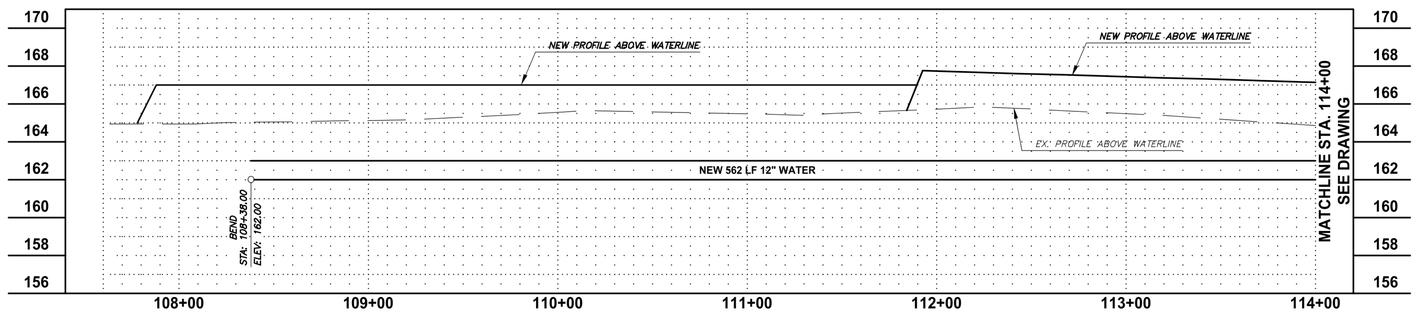
Registered Professional Engineer(Civil) CERTIFICATE NO. 32329 DOUGLAS J. NICHOLLS Date Signed 12/18/20 ARIZONA U.S.A.

Date:	DEC. 2019
Designed:	K.L.B.
Drawn:	J.M.G.
Checked:	D.J.N.
Proj. No.:	19-096

SHEET 7

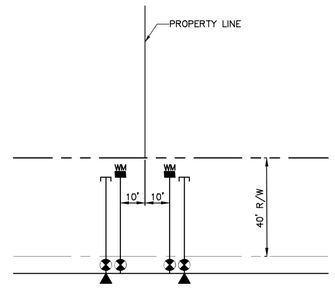
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WATER SCHEDULE OF WORK

20	12" 45° BEND AND THRUST BLOCK (COST INCLUDED IN WATERLINE)	–COY STD NO. 5–020 –COY STD NO. 5–025
21	1" SINGLE WATER SERVICE (COST INCLUDED IN ITEM 22)	–COY STD NO. 5–035 –COY STD NO. 5–015 –SEE DETAIL A/8
22	1" SERVICE METER BOX	–COY STD NO. 5–055
23	6" FIRE HYDRANT ASSEMBLY AND STREET MARKER	–COY STD NO. 5–155 –COY STD NO. 5–160
24	6" CLASS 150 C900 PVC WATERLINE	–COY STD NO. 5–010
25	12" CLASS 150 C900 PVC WATERLINE	–COY STD NO. 5–010
26	12" X 12" X 6" TEE AND THRUST BLOCK (COST INCLUDED IN WATERLINE)	–COY STD NO. 5–020 –COY STD NO. 5–025
27	6" GATE VALVE WITH ANCHOR, VALVE BOX, FRAME AND COVER	–COY STD NO. 5–065 –COY STD NO. 5–075
28	12" GATE VALVE WITH ANCHOR, VALVE BOX, AND COVER	–COY STD NO. 5–065 –COY STD NO. 5–075
29	CONNECT NEW 12" WATERLINE TO EXISTING	
30	12" 90° BEND AND THRUST BLOCK (COST INCLUDED IN WATERLINE)	–COY STD NO. 5–020 –COY STD NO. 5–025
31	WATERMAIN BLOWOFF	–COY STD NO. 5–085



TYPICAL WATER SERVICE SPACING FROM PROPERTY LINE NTS — A/8

UTILITY DISCLAIMER

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Dial 8-1-1 or 1-800-STAKE-IT (782-5348)
In Maricopa County: (602) 263-1100

40' 0 40' 80' 120'

DRAWING RECORD:

No.	DATE:
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CORE ENGINEERING GROUP, PLLC
200 East 16th Street, Suite 150
Yuma, AZ 85364
V - 928.344.5931 F - 928.344.5932
www.CoreEngineeringGroup.com
Core@core-e-g.com

MAGRINO INDUSTRIAL PARK UNIT NO. 3

CITY OF SAN LUIS
YUMA COUNTY, ARIZONA

PORT AUTHORITY - WATER PLAN & PROFILE

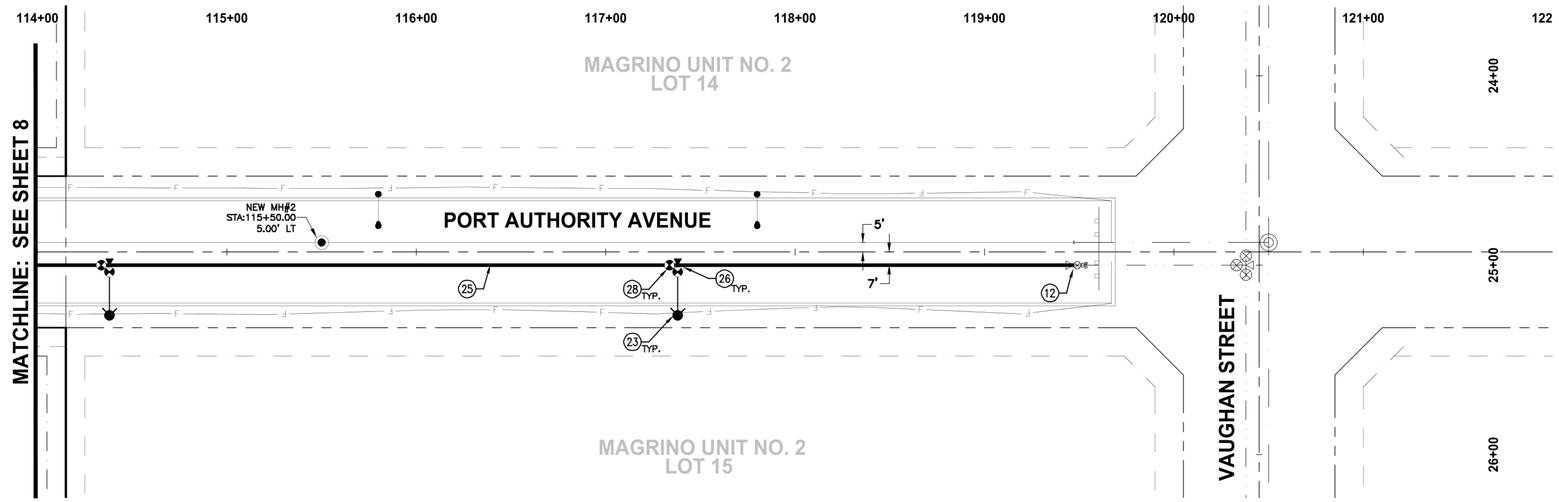
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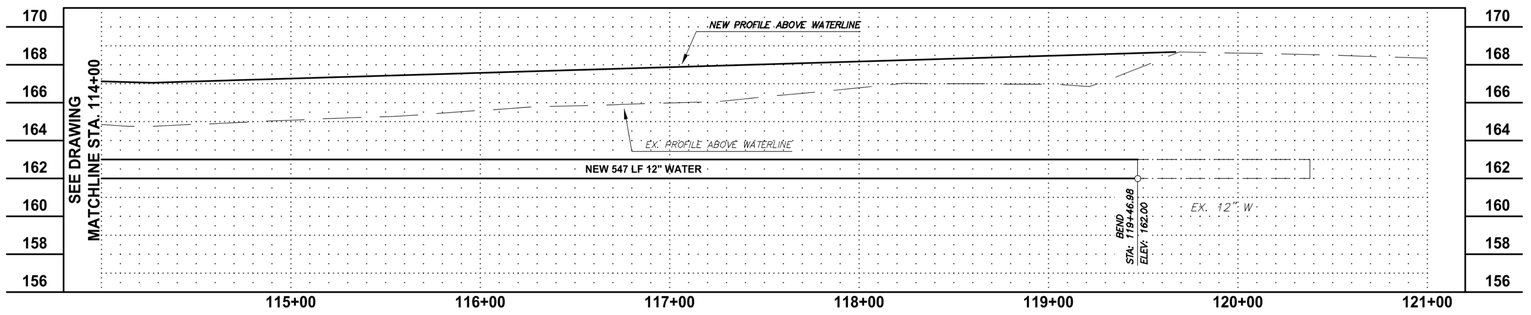
Registered Professional Engineer (Retired)
CERTIFICATE NO.
32329
DOUGLAS J. NICHOLLS
Date Signed 02/18/20
ARIZONA U.S.A.

Date: DEC. 2019
Designed: K.L.B.
Drawn: J.M.G.
Checked: D.J.N.
Proj. No.: 19–096

SHEET 8

Tue, 18 Feb 2020 – 3:37pm, Z:\2019\19-096\dwgs\Prelim Plat\19-096 Prelim Plat Watsew.dwg, " Core Engineering Group, PLLC"





WATER SCHEDULE OF WORK

(20)	12" 45° BEND AND THRUST BLOCK (COST INCLUDED IN WATERLINE)	–COY STD NO. 5–020 –COY STD NO. 5–025
(21)	1" SINGLE WATER SERVICE (COST INCLUDED IN ITEM 22)	–COY STD NO. 5–035 –COY STD NO. 5–015 –SEE DETAIL A/8
(22)	1" SERVICE METER BOX	–COY STD NO. 5–055
(23)	6" FIRE HYDRANT ASSEMBLY AND STREET MARKER	–COY STD NO. 5–155 –COY STD NO. 5–160
(24)	6" CLASS 150 C900 PVC WATERLINE	–COY STD NO. 5–010
(25)	12" CLASS 150 C900 PVC WATERLINE	–COY STD NO. 5–010
(26)	12" X 12" X 6" TEE AND THRUST BLOCK (COST INCLUDED IN WATERLINE)	–COY STD NO. 5–020 –COY STD NO. 5–025
(27)	6" GATE VALVE WITH ANCHOR, VALVE BOX, FRAME AND COVER	–COY STD NO. 5–065 –COY STD NO. 5–075
(28)	12" GATE VALVE WITH ANCHOR, VALVE BOX, AND COVER	–COY STD NO. 5–065 –COY STD NO. 5–075
(29)	CONNECT NEW 12" WATERLINE TO EXISTING	
(30)	12" 90° BEND AND THRUST BLOCK (COST INCLUDED IN WATERLINE)	–COY STD NO. 5–020 –COY STD NO. 5–025
(31)	WATERMAIN BLOWOFF	–COY STD NO. 5–085

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MAGRINO INDUSTRIAL PARK UNIT NO. 3

CITY OF SAN LUIS
YUMA COUNTY, ARIZONA
PORT AUTHORITY - WATER PLAN & PROFILE

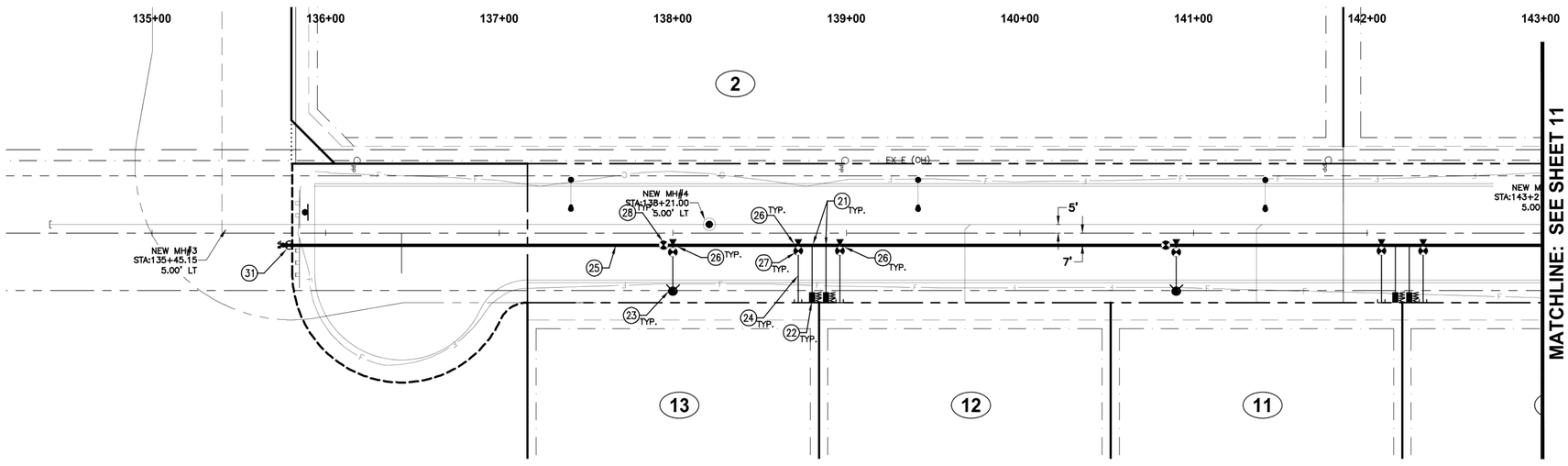
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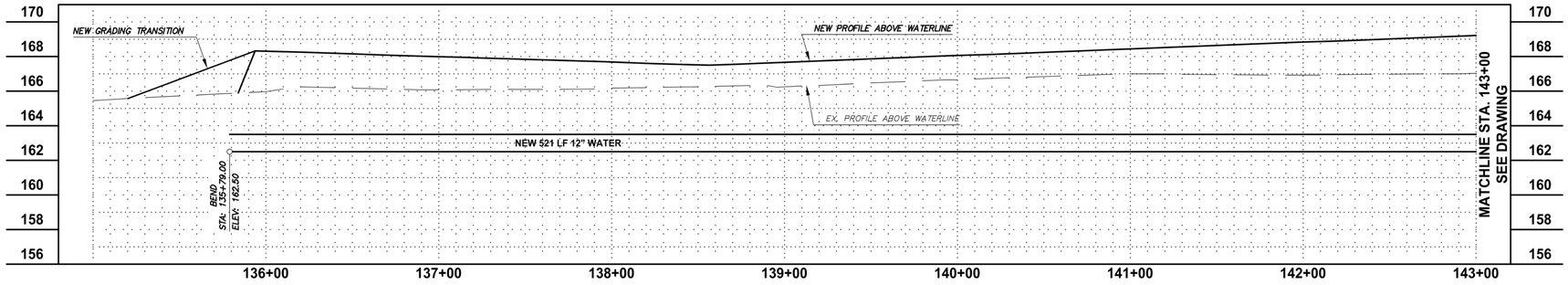
Registered Professional Engineer (Civil)
CERTIFICATE NO.
32329
DOUGLAS J. NICHOLLS
Date Signed 02/18/20
ARIZONA, USA

Date: DEC. 2019
Designed: K.L.B.
Drawn: J.M.G.
Checked: D.J.N.
Proj. No.: 19–096

SHEET 9

Tue, 18 Feb 2020 – 3:37pm, Z:\2019\19–096\dwgs\Prelim Plat\19–096 Prelim Plat Watsew.dwg, " Core Engineering Group, PLLC"





WATER SCHEDULE OF WORK

20	12" 45° BEND AND THRUST BLOCK (COST INCLUDED IN WATERLINE)	-COY STD NO. 5-020 -COY STD NO. 5-025
21	1" SINGLE WATER SERVICE (COST INCLUDED IN ITEM 22)	-COY STD NO. 5-035 -COY STD NO. 5-015 -SEE DETAIL A/8
22	1" SERVICE METER BOX	-COY STD NO. 5-055
23	6" FIRE HYDRANT ASSEMBLY AND STREET MARKER	-COY STD NO. 5-155 -COY STD NO. 5-160
24	6" CLASS 150 C900 PVC WATERLINE	-COY STD NO. 5-010
25	12" CLASS 150 C900 PVC WATERLINE	-COY STD NO. 5-010
26	12" X 12" X 6" TEE AND THRUST BLOCK (COST INCLUDED IN WATERLINE)	-COY STD NO. 5-020 -COY STD NO. 5-025
27	6" GATE VALVE WITH ANCHOR, VALVE BOX, FRAME AND COVER	-COY STD NO. 5-065 -COY STD NO. 5-075
28	12" GATE VALVE WITH ANCHOR, VALVE BOX, AND COVER	-COY STD NO. 5-065 -COY STD NO. 5-075
29	CONNECT NEW 12" WATERLINE TO EXISTING	
30	12" 90° BEND AND THRUST BLOCK (COST INCLUDED IN WATERLINE)	-COY STD NO. 5-020 -COY STD NO. 5-025
31	WATERMAIN BLOWOFF	-COY STD NO. 5-085

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40' 0 40' 80' 120'

DRAWING RECORD:

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Core@core-e-g.com

MAGRINO INDUSTRIAL PARK
UNIT NO. 3
CITY OF SAN LUIS
YUMA COUNTY, ARIZONA
AVE D - WATER PLAN & PROFILE

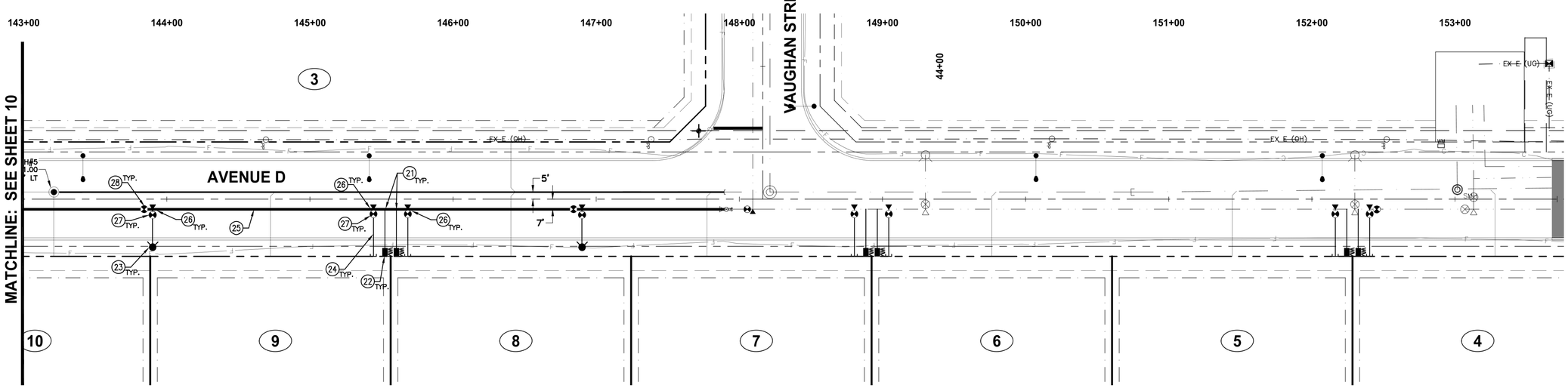
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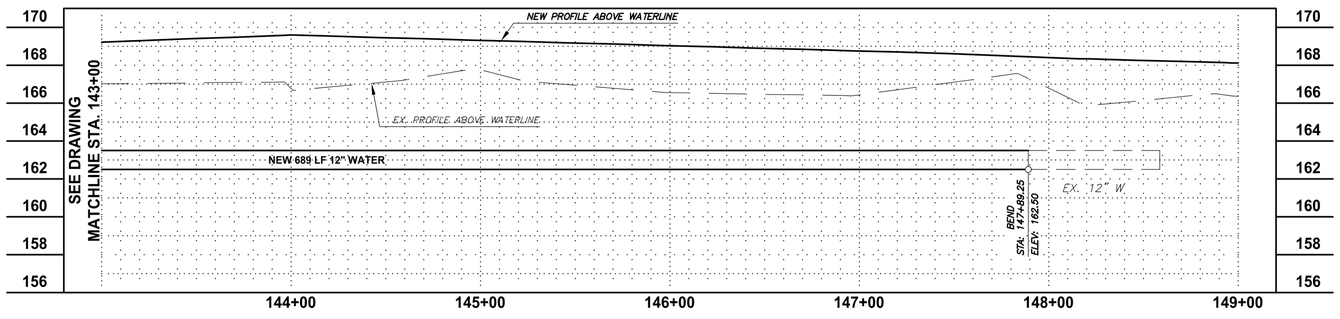
Registered Professional Engineer (Civil)
CERTIFICATE NO.
32329
DOUGLAS J.
NICHOLLS
Date Signed 02/18/20
ARIZONA U.S.A.

Date: DEC. 2019
Designed: K.L.B.
Drawn: J.M.G.
Checked: D.J.N.
Proj. No.: 19-096

SHEET 10

Tue, 18 Feb 2020 - 3:38pm, Z:\2019\19-096\dwgs\Prelim Plat\19-096 Prelim Plat Watsew.dwg, " Core Engineering Group, PLLC"





WATER SCHEDULE OF WORK

(20)	12" 45° BEND AND THRUST BLOCK (COST INCLUDED IN WATERLINE)	–COY STD NO. 5–020 –COY STD NO. 5–025
(21)	1" SINGLE WATER SERVICE (COST INCLUDED IN ITEM 22)	–COY STD NO. 5–035 –COY STD NO. 5–015 –SEE DETAIL A/8
(22)	1" SERVICE METER BOX	–COY STD NO. 5–055
(23)	6" FIRE HYDRANT ASSEMBLY AND STREET MARKER	–COY STD NO. 5–155 –COY STD NO. 5–160
(24)	6" CLASS 150 C900 PVC WATERLINE	–COY STD NO. 5–010
(25)	12" CLASS 150 C900 PVC WATERLINE	–COY STD NO. 5–010
(26)	12" X 12" X 6" TEE AND THRUST BLOCK (COST INCLUDED IN WATERLINE)	–COY STD NO. 5–020 –COY STD NO. 5–025
(27)	6" GATE VALVE WITH ANCHOR, VALVE BOX, FRAME AND COVER	–COY STD NO. 5–065 –COY STD NO. 5–075
(28)	12" GATE VALVE WITH ANCHOR, VALVE BOX, AND COVER	–COY STD NO. 5–065 –COY STD NO. 5–075
(29)	CONNECT NEW 12" WATERLINE TO EXISTING	
(30)	12" 90° BEND AND THRUST BLOCK (COST INCLUDED IN WATERLINE)	–COY STD NO. 5–020 –COY STD NO. 5–025
(31)	WATERMAIN BLOWOFF	–COY STD NO. 5–085

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CORE
40' 0 40' 80' 120'

DRAWING RECORD:
No. DATE:

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Yuma, AZ 85364
V - 928.344.5931 F - 928.344.5932
www.CoreEngineeringGroup.com
Core@core-e-g.com

MAGRINO INDUSTRIAL PARK
UNIT NO. 3
CITY OF SAN LUIS
YUMA COUNTY, ARIZONA
AVE D - WATER PLAN & PROFILE

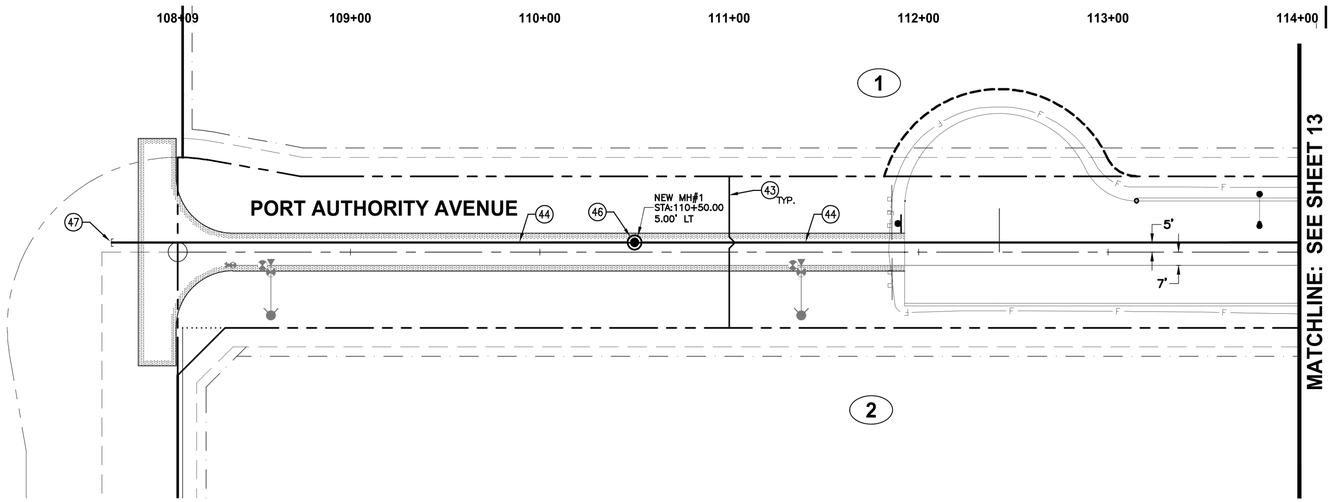
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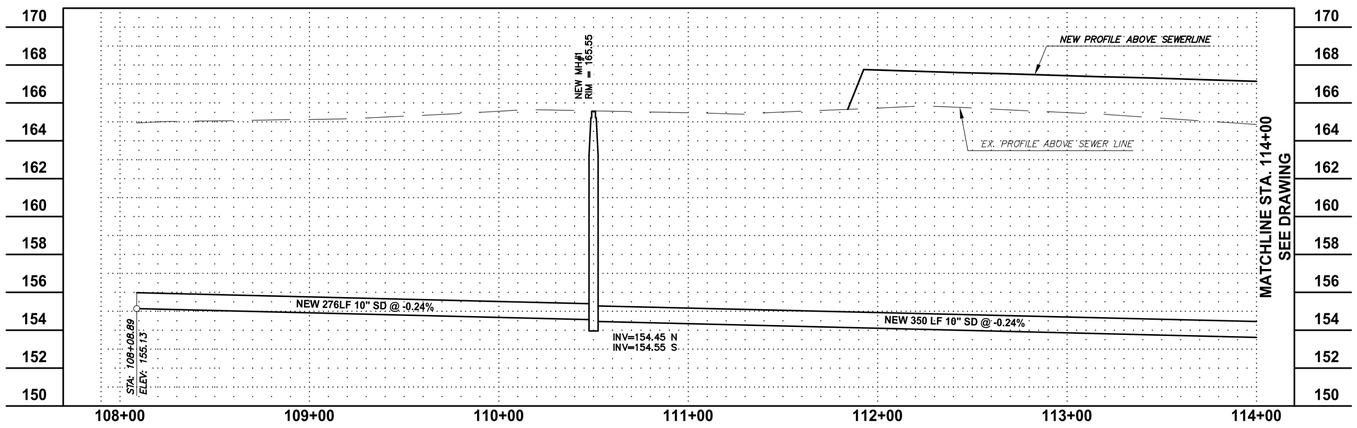
Registered Professional Engineer (Civil)
CERTIFICATE NO.
32329
DOUGLAS J. NICHOLLS
Date Signed 02/18/20
ARIZONA U.S.A.

Date: DEC. 2019
Designed: K.L.B.
Drawn: J.M.G.
Checked: D.J.N.
Proj. No.: 19–096

SHEET 11

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SEWER SCHEDULE OF WORK

41	8" SDR 35 PVC SEWER LINE	-COY STD NO. 5-010
42	60" POLYMER MANHOLE	-COY STD NO. 6-080 -COY STD NO. 6-090
43	6" SEWER SERVICE (TYP. ALL LOTS)	-COY STD NO. 6-015 -COY STD NO. 5-015
44	10" SDR 35 PVC SEWER LINE	-COY STD NO. 5-010
45	8" WATER & SEWER CROSSING	-COY STD NO. 5-005
46	48" POLYMER MANHOLE	-COY STD NO. 6-080 (SIM.) -COY STD NO. 6-090
47	WATERTIGHT CAP	
48	ADJUST POLYMER MANHOLE TO FINAL GRADE	-COY STD NO. 6-080

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CORE

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MAGRINO INDUSTRIAL PARK
UNIT NO. 3
CITY OF SAN LUIS
YUMA COUNTY, ARIZONA
PORT AUTHORITY - SEWER PLAN & PROFILE

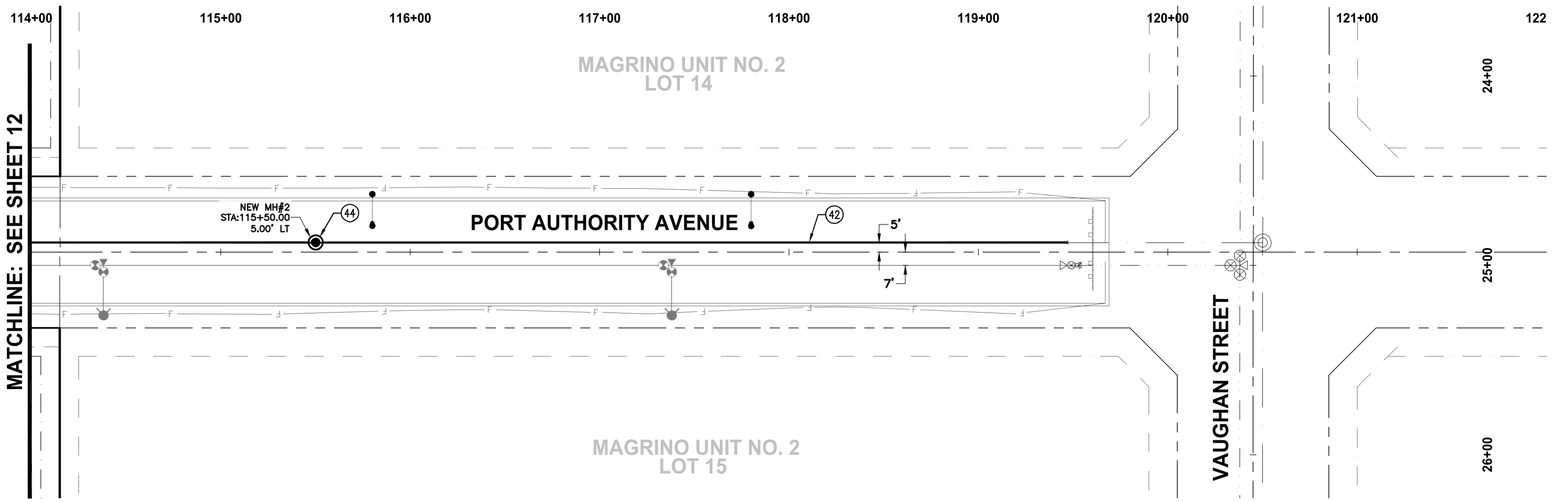
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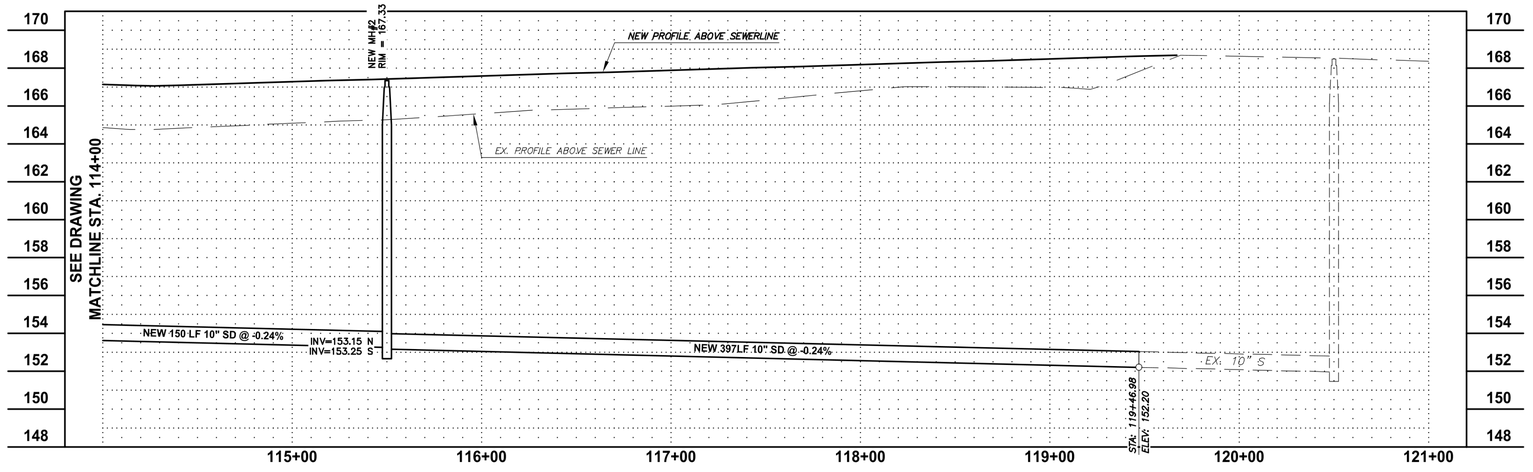
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SHEET 12

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SEWER SCHEDULE OF WORK

41	8" SDR 35 PVC SEWER LINE	–COY STD NO. 5–010
42	60" POLYMER MANHOLE	–COY STD NO. 6–080 –COY STD NO. 6–090
43	6" SEWER SERVICE (TYP. ALL LOTS)	–COY STD NO. 6–015 –COY STD NO. 5–015
44	10" SDR 35 PVC SEWER LINE	–COY STD NO. 5–010
45	8" WATER & SEWER CROSSING	–COY STD NO. 5–005
46	48" POLYMER MANHOLE	–COY STD NO. 6–080 (SIM.) –COY STD NO. 6–090
47	WATERTIGHT CAP	
48	ADJUST POLYMER MANHOLE TO FINAL GRADE	–COY STD NO. 6–080

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40' 0 40' 80' 120'

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No. DATE:

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CORE

MAGRINO INDUSTRIAL PARK UNIT NO. 3

CITY OF SAN LUIS
YUMA COUNTY, ARIZONA

PORT AUTHORITY - SEWER PLAN & PROFILE

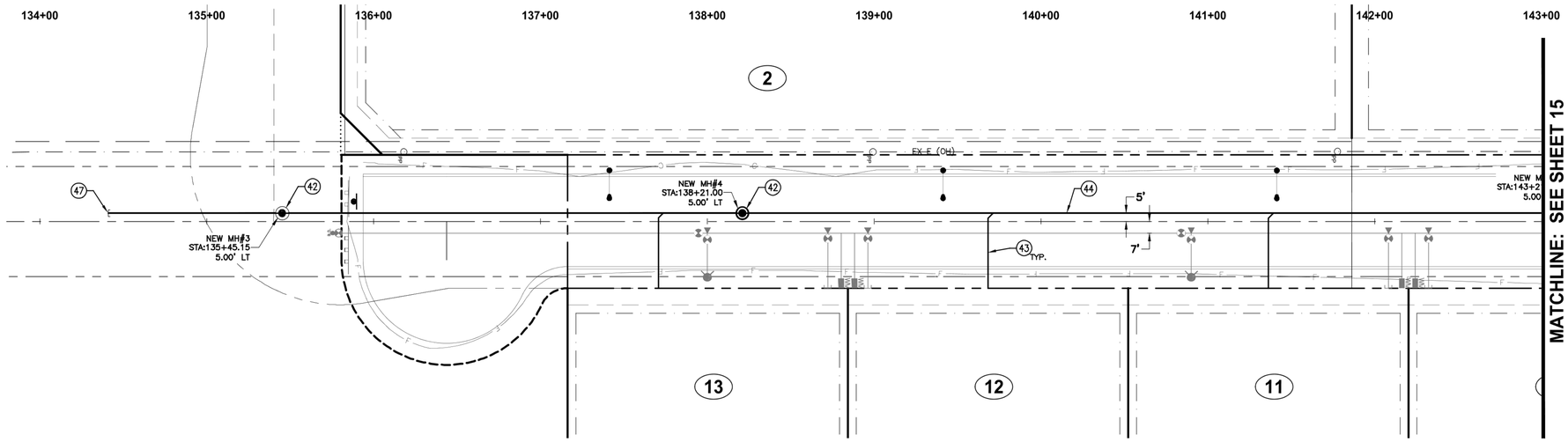
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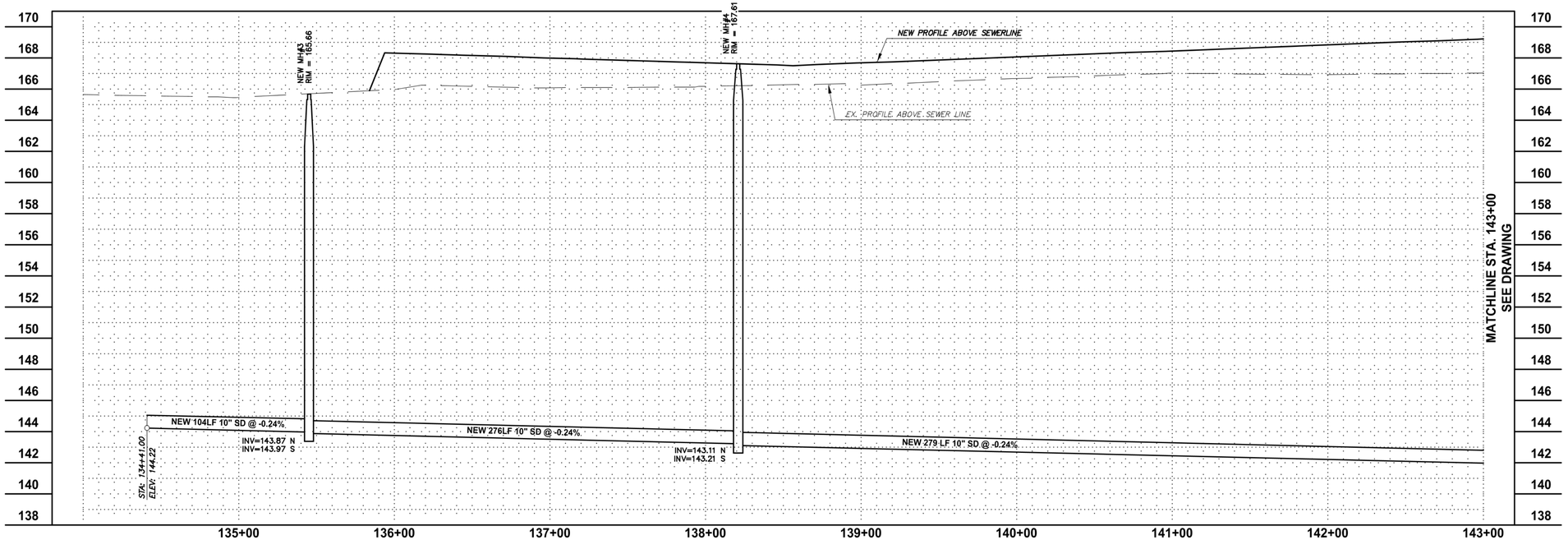
Registered Professional Engineer (Retired)
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SEWER SCHEDULE OF WORK

41	8" SDR 35 PVC SEWER LINE	–COY STD NO. 5–010
42	60" POLYMER MANHOLE	–COY STD NO. 6–080 –COY STD NO. 6–090
43	6" SEWER SERVICE (TYP. ALL LOTS)	–COY STD NO. 6–015 –COY STD NO. 5–015
44	10" SDR 35 PVC SEWER LINE	–COY STD NO. 5–010
45	8" WATER & SEWER CROSSING	–COY STD NO. 5–005
46	48" POLYMER MANHOLE	–COY STD NO. 6–080 (SIM.) –COY STD NO. 6–090
47	WATERTIGHT CAP	
48	ADJUST POLYMER MANHOLE TO FINAL GRADE	–COY STD NO. 6–080

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In Maricopa County: (602) 263-1100

CORE ENGINEERING GROUP, PLLC
200 East 16th Street, Suite 150
Yuma, AZ 85364
V - 928.344.5931 F - 928.344.5932
www.CoreEngineeringGroup.com
Core@core-e-g.com

DRAWING RECORD:

No.	DATE:	

MAGRINO INDUSTRIAL PARK
UNIT NO. 3
CITY OF SAN LUIS
YUMA COUNTY, ARIZONA
AVE D - SEWER PLAN & PROFILE

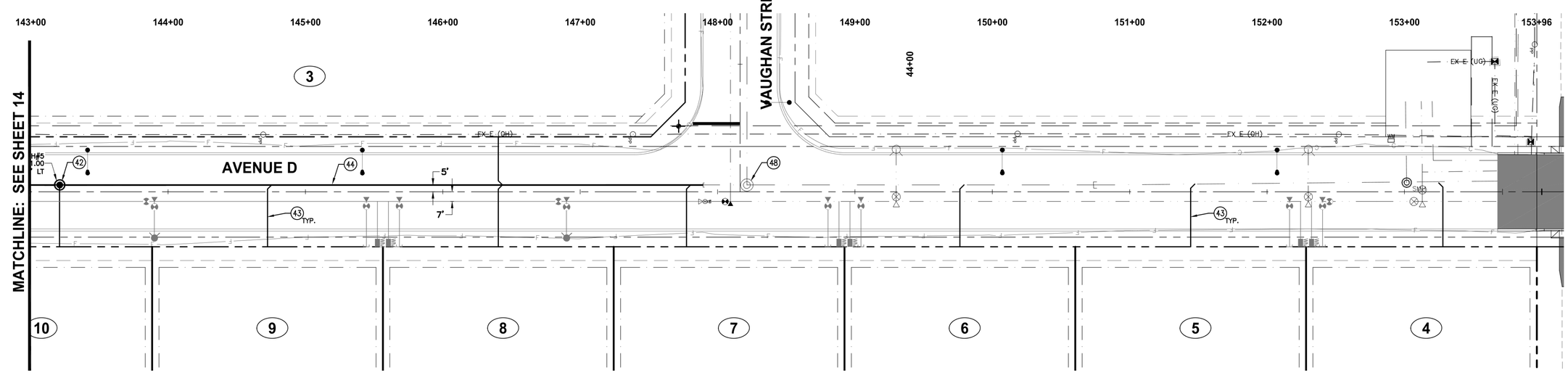
Registered Professional Engineer (Civil)
CERTIFICATE NO.
32329
DOUGLAS J. NICHOLLS
Date Signed 02/18/20
ARIZONA U.S.A.

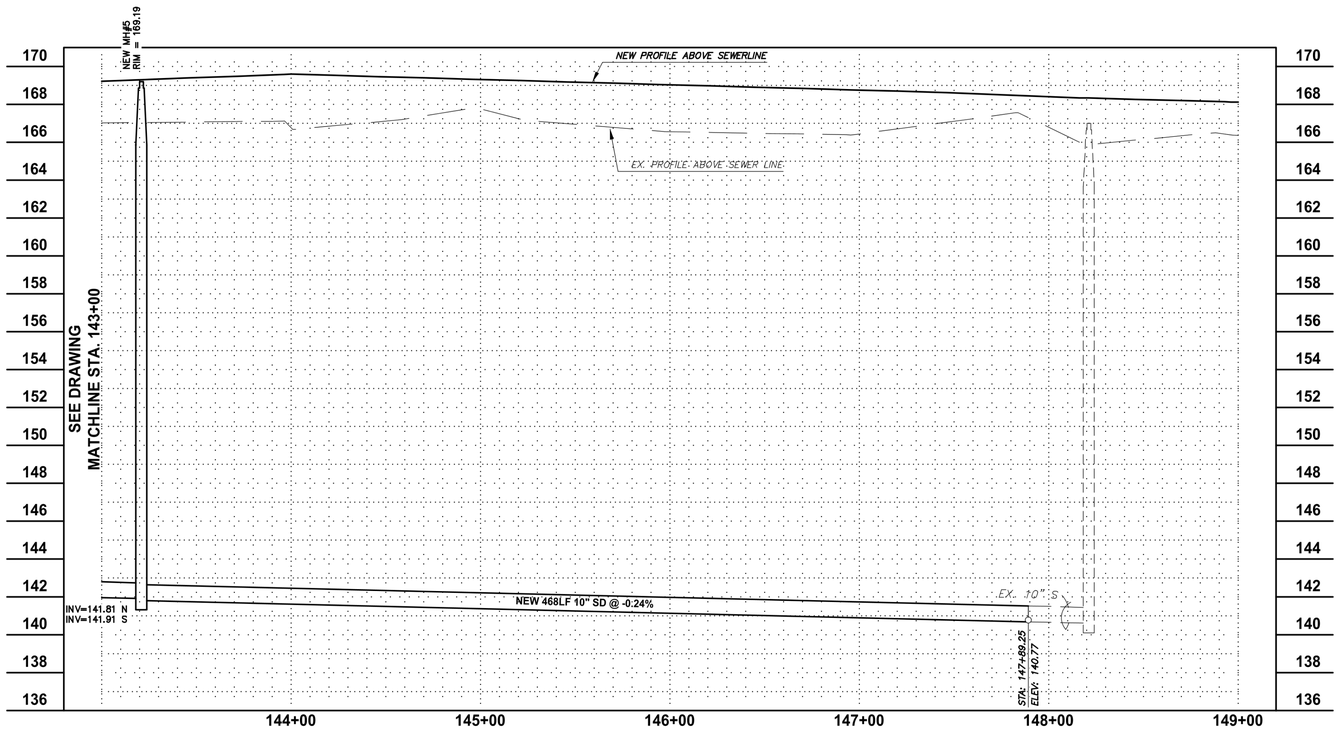
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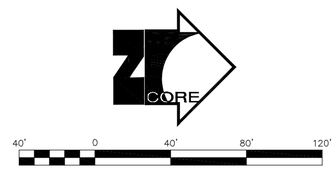
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SEWER SCHEDULE OF WORK

(41)	8" SDR 35 PVC SEWER LINE	-COY STD NO. 5-010
(42)	60" POLYMER MANHOLE	-COY STD NO. 6-080 -COY STD NO. 6-090
(43)	6" SEWER SERVICE (TYP. ALL LOTS)	-COY STD NO. 6-015 -COY STD NO. 5-015
(44)	10" SDR 35 PVC SEWER LINE	-COY STD NO. 5-010
(45)	8" WATER & SEWER CROSSING	-COY STD NO. 5-005
(46)	48" POLYMER MANHOLE	-COY STD NO. 6-080 (SIM.) -COY STD NO. 6-090
(47)	WATERTIGHT CAP	
(48)	ADJUST POLYMER MANHOLE TO FINAL GRADE	-COY STD NO. 6-080

Call at least two full working days before you begin excavation.
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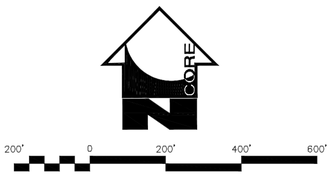
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SHEET 15

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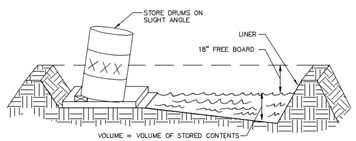


LEGEND

- W/A — DESIGNATED WASHOUT AREA
- SCE — STABILIZED CONSTRUCTION ENTRANCE
- PSA — PROTECTED STORAGE AREA
- SILT FENCE
- PROJECT INFORMATION SIGN WITH AZCON AUTHORIZATION NUMBER

STORMWATER MANAGEMENT PLAN NOTES:

1. AFTER PERMITS HAVE BEEN OBTAINED & EROSION CONTROL MEASURES INSTALLED, THE CONTRACTOR SHALL ROUGH GRADE SITE.
2. CONTRACTOR SHALL PREVENT ANY SILTATION FROM ENTERING ANY STORM SEWER SYSTEM. ALL INLETS & INLET OPENINGS SHALL BE FULLY ENCIRCLED WITH INLET PROTECTION DURING AND AFTER CONSTRUCTION OF INLET.
3. NO LAND CLEARING OR GRADING SHALL BEGIN UNTIL ALL EROSION CONTROL MEASURES HAVE BEEN INSTALLED.
4. ALL EXPOSED AREAS SHALL BE SEEDED AS SPECIFIED, WITHIN 7 DAYS OF FINAL GRADING.
5. SHOULD CONSTRUCTION STOP FOR LONGER THAN 14 DAYS, THE SITE SHALL BE SEEDED AS SPECIFIED.
6. MAINTAIN EROSION CONTROL MEASURES AT ALL TIMES ESPECIALLY BEFORE ANY PREDICTABLE RAIN.
7. THIS PLAN SHALL NOT BE CONSIDERED ALL INCLUSIVE; AS THE CONTRACTOR SHALL TAKE ALL NECESSARY PRECAUTIONS TO PREVENT SOIL SEDIMENT FROM LEAVING THE SITE. THIS PLAN IS INTENDED TO BE UPDATED BY A QUALIFIED PERSON AS CONSTRUCTION ACTIVITIES PROCEED. METHODS OF EROSION CONTROL SHALL BE TAKEN FROM "DRAINAGE DESIGN FOR MARICOPA COUNTY, ARIZONA, VOLUME III EROSION CONTROL".
8. CONTRACTOR SHALL COMPLY WITH ALL STATE AND LOCAL ORDINANCES THAT APPLY.
9. ADDITIONAL EROSION AND SEDIMENT CONTROL MEASURES WILL BE INSTALLED IF DEEMED NECESSARY BY ON SITE INSPECTION.
10. LAND DISTURBING ACTIVITIES SHALL NOT COMMENCE UNTIL APPROVAL TO DO SO HAS BEEN RECEIVED BY GOVERNING AUTHORITIES.
11. ALL EXISTING STRUCTURES, FENCING, TREES, AND ETC., WITHIN CONSTRUCTION AREA SHALL BE REMOVED AND DISPOSED OF OFF SITE. ANY BURNING ON SITE SHALL BE SUBJECT TO LOCAL ORDINANCES.
12. CONTRACTOR SHALL BE RESPONSIBLE TO TAKE WHATEVER MEANS NECESSARY TO ESTABLISH PERMANENT SOIL STABILIZATION.
13. CONTRACTOR TO IDENTIFY, ON PLAN, AREAS THAT HAVE REACHED FINAL STABILIZATION.
14. THE CONTRACTOR SHALL ADHERE TO THE SEQUENCE OF OPERATIONS FOR EROSION CONTROL IMPLEMENTATION HEREON. ANY DEVIATION FROM THIS SEQUENCE DEEMED NECESSARY BY THE CONTRACTOR SHALL BE APPROVED BY A QUALIFIED PERSONAL PERFORMING THE SITE SWPPP INSPECTIONS OR AS DESIGNATED IN SWPPP REPORT.
15. THE GENERAL CONTRACTOR AND ALL SUBCONTRACTORS INVOLVED WITH CONSTRUCTION ACTIVITIES RELATED TO EROSION CONTROL AS SHOWN OR NOTED HEREON, SHALL OBTAIN A COPY OF THE STORM WATER POLLUTION PREVENTION PLAN IN THE SITE WORK SPECIFICATIONS, AS WELL AS THE ARIZONA POLLUTANT DISCHARGE ELIMINATION SYSTEM (AZPDES) PERMIT FOR THIS SITE, AND BECOME FAMILIAR WITH THEIR CONTENTS.
16. ALL WASH WATER SHALL BE DISPOSED OF IN A MANNER THAT PREVENTS CONTACT BETWEEN WASH WATER POLLUTANTS AND STORM RUNOFF DISCHARGED FROM THIS SITE.
17. OIL AND GREASE ABSORBING MATERIALS SHALL BE READILY AVAILABLE ONSITE AND SHALL BE PROMPTLY USED TO CONTAIN AND/OR CLEAN UP ALL FUEL OR CHEMICAL SPILLS OR LEAKS.
18. DUST CONTROL SHALL BE ACCOMPLISHED BY WATERING DRY, EXPOSED AREAS ON A REGULAR BASIS. SPRAYING OF PETROLEUM BASED OR TOXIC LIQUIDS FOR THIS IS PROHIBITED.
19. DISTURBED AREAS OF THE SITE WHERE CONSTRUCTION ACTIVITIES HAVE CEASED FOR AT LEAST TWENTY-ONE DAYS SHALL BE TEMPORARILY SEEDED AND WATERED.
20. DISTURBED AREAS OF THE SITE WHERE CONSTRUCTION ACTIVITIES HAVE PERMANENTLY CEASED SHALL BE PERMANENTLY SEEDED WITHIN FOURTEEN DAY PER LANDSCAPING SPECIFICATIONS.
21. ALL VEHICLES SHALL BE CLEANED AT THE CONSTRUCTION EXIT POINTS ACCORDING TO NOTES SHOWN ON THE DETAIL THEREOF.
22. ALL MATERIALS SPILLED, DROPPED, WASHED OR TRACKED ONTO ADJACENT ROADWAYS BY VEHICLES EXITING THE SITE SHALL BE CLEANED OR REMOVED IMMEDIATELY.
23. THE CONTRACTOR SHALL BE RESPONSIBLE FOR PROMPT REMOVAL OF ALL ACCUMULATED SILT ALONG SITE PERIMETER.
24. SILT FENCES SHALL BE PLACED AROUND ANY STOCKPILES USED ON THIS SITE.
25. ANY ADDITIONAL EROSION CONTROL MEASURES REQUIRED TO ENSURE COMPLIANCE WITH THE ARIZONA POLLUTANT DISCHARGE ELIMINATION SYSTEM CONSTRICTION GENERAL PERMIT REGULATIONS SHALL BE IMPLEMENTED BY THE CONTRACTOR, AT NO ADDITIONAL EXPENSE TO THE OWNER.
26. ALL TEMPORARY EROSION CONTROL MEASURES SHALL BE REMOVED AND PROPERLY DISPOSED OF OFF-SITE WITHIN THIRTY DAYS AFTER STABILIZATION OF ALL SURFACES.
27. THE CONTRACTOR SHALL ASSUME LIABILITY FOR DAMAGE TO ADJACENT PROPERTIES AND/OR PUBLIC RIGHT-OF-WAY RESULTING FROM FAILURE TO FULLY IMPLEMENT AND EXECUTE ALL EROSION CONTROL PROCEDURES SHOWN AND NOTED IN THESE PLANS.
28. WHENEVER DIRT, ROCK, OR OTHER MATERIALS ARE EXPORTED FOR USE OFF OF THE PRIMARY CONSTRUCTION SITE, THE CONTRACTOR IS RESPONSIBLE FOR DETERMINING THAT STORM WATER PERMITTING REQUIREMENTS ARE MET. PRIOR TO ANY EXPORT OF MATERIALS, THE CONTRACTOR SHALL FURNISH THE ENGINEER WITH A WRITTEN AGREEMENT WITH ANY LANDOWNER WHO WILL RECEIVE EXPORTED MATERIALS, STATING THAT THE SITE WILL BE PROPERLY PERMITTED WHEN REQUIRED AND DESCRIBE THE EROSION CONTROL MEASURES WHICH WILL BE USED. AT A MINIMUM, EROSION CONTROL MEASURES MUST CONSIST OF PERIMETER CONTROLS (HAY BALES OR SILT FENCES) ON ALL DOWNSLOPES AND SIDESLOPE BOUNDARIES OF ANY DISTURBED AREA, PLUS PROVISIONS FOR REVEGETATION AFTER THE FILL MATERIALS ARE IN PLACE. SEE DRAINAGE DESIGN MANUAL FOR MARICOPA COUNTY, ARIZONA VOLUME III, EROSION CONTROL FOR METHODS OF STORM WATER CONTROL.
29. GRADED AREAS AROUND THE PERIMETER MUST DRAIN AWAY FROM THE FACE OF SLOPE AT THE CONCLUSION OF EACH WORKING DAY SO THAT STORM WATER WILL REMAIN ONSITE.
30. THE CONTRACTOR SHALL BE RESPONSIBLE AND SHALL TAKE NECESSARY PRECAUTIONS TO PREVENT PUBLIC TRESPASS ONTO AREAS WHERE IMPOUNDED WATER CREATES A HAZARDOUS CONDITION.



PROTECTED STORAGE AREA FOR CHEMICALS

PSA

NTS

SILT FENCE

SF

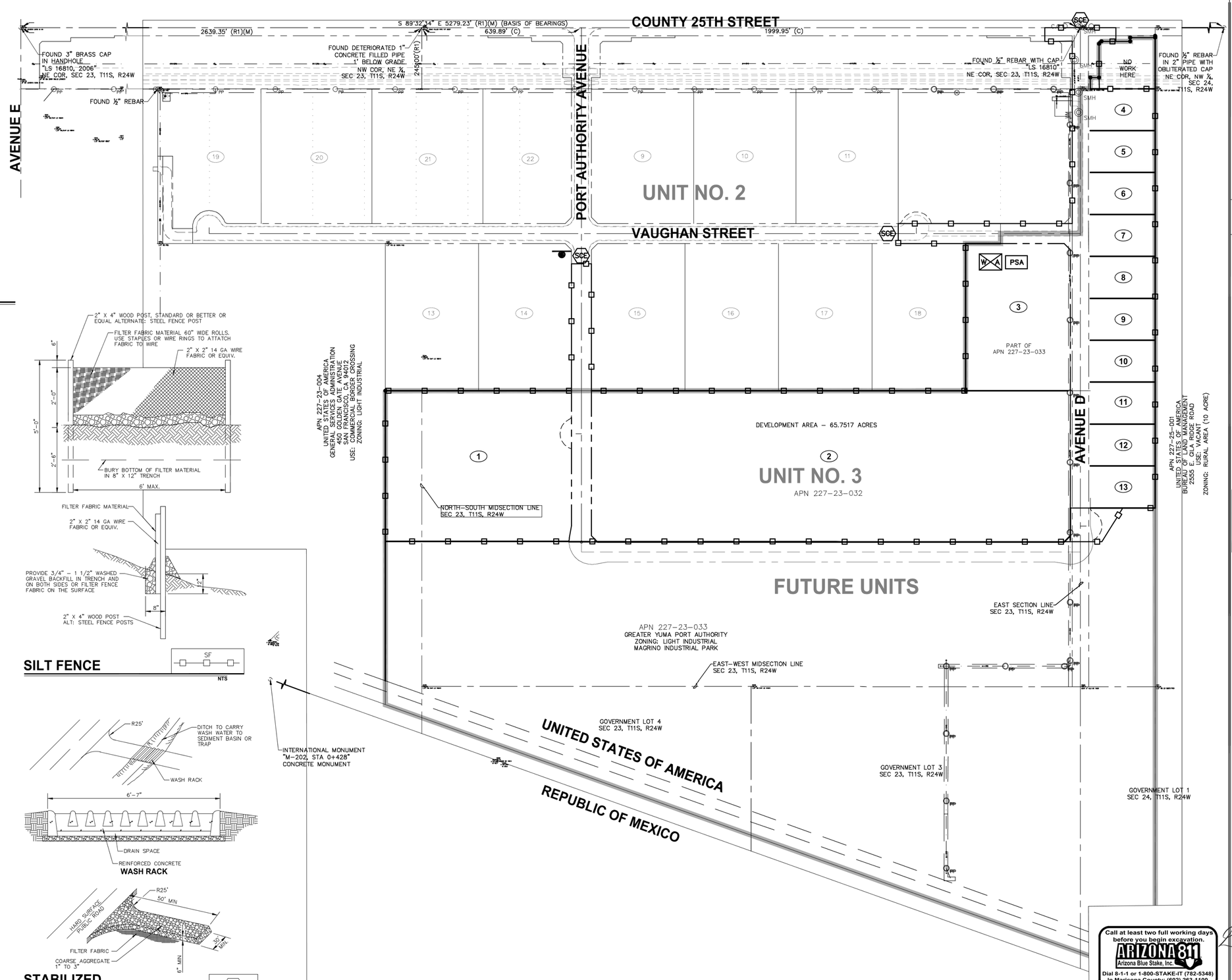
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WASH RACK

STABILIZED CONSTRUCTION ENTRANCE

SCE

NTS



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MAGRINO INDUSTRIAL PARK UNIT NO. 3

CITY OF SAN LUIS
YUMA COUNTY, ARIZONA

STORMWATER POLLUTION PREVENTION PLAN

Registered Professional Engineer (Civil)
CERTIFICATE NO.
32329
DOUGLAS J. NICHOLLS
Date Signed 12/17/19
ARIZONA U.S.A.

Date:	DEC. 2019
Designed:	K.L.B.
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Checked:	D.J.N.
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SHEET 16

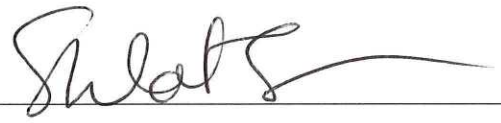
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ARIZONA COMMERCE AUTHORITY	**Request for Grant Applications** **ACA Solicitation Number: 2020-21**	Arizona Commerce Authority 100 N. 7th Avenue Suite 400 Phoenix, AZ 85007 602-845-1200

NOTICE OF REQUEST FOR GRANT APPLICATIONS

Solicitation Number:	2020-21
Solicitation Type:	Request for Grant Applications (RGA)
Solicitation Title:	FY2020 Economic Strength Projects Grant ("ESP")
Solicitation Release Date:	March 16, 2020
Questions Due Date:	April 6, 2020 by 5:00 PM MST
Questions & Answers Release Date:	April 13, 2020 (tentative)
Submission Due Date and Time:	May 11, 2020 by 4:30 PM MST
Pending Award Notification Date[1]:	June 30, 2020 (tentative)
Contract Term:	Projects must be completed within 18-months from the effective date of the governing grant agreement.
Total Funding Amount:	$1,000,000
Solicitation Point of Contact:	Teri Orman Grants and Procurement Manager (602) 845-1245 terio@azcommerce.com
ACA Authorized Representative:	Sandra Watson President and CEO

Signature: 

[1] Reference Section 4.1, Notice of Award, for further information.

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1. FY2020 ECONOMIC STRENGTH PROJECTS GRANT PROGRAM

Pursuant to ARS §§ 28-7281 et seq. and 41-1505(E), the Arizona Commerce Authority, an agency of the State of Arizona (the "ACA"), and the Arizona Department of Transportation ("ADOT") hereby establish the Fiscal Year 2020 ("FY20") Economic Strength Projects Grant Program (the "ESP").

1.1. Grant Nature and Intent

The ESP is a competitive grant program designed to enhance the economic strength and competitiveness of Arizona rural communities by providing funding for highway projects that foster job growth. The ESP will reimburse specified costs of qualifying rural road and/or highway projects that are projected to accomplish one or more of the following: (i) significantly increase the number of new jobs, (ii) foster significant private capital investment and (iii) otherwise make a significant contribution to the regional economy, particularly in base industries[2].

Administration of the ESP is shared between the ACA and ADOT. After initial screening by the ACA of eligible Projects and a recommended priority ranking of eligible Projects by the ACA's Rural Business Development Advisory Council ("RBDAC"), ADOT is charged with the final selection of approved Projects and with the contractual and financial administration of the Program[3]. Further, see RFP Sections 3.1 and 4.1 and ARS §§ 41-1505(E) and 28-7286(A).

1.2. Available Funding – Funding Schedule

Funding for the Program is allocated to ADOT though the Highway User Revenue Fund.

The total amount available for grants pursuant to the ESP is $1,000,000. The ACA and ADOT reserve the right to award less than $1,000,000 in ESP grants depending on, among other considerations, the number and quality of Project proposals ("Proposals") received. Unallocated Program funds may be available for use in future Economic Strength Grant Project funding rounds.

A single ESP grant award cannot exceed $500,000. There is no prescribed minimum ESP grant award. The ACA and ADOT may choose to make one or more ESP grant awards.

1.3. Eligible Applicants

Applicants eligible for the ESP are as follows:

- Arizona incorporated cities and towns with populations of less than 150,000 (based on U.S. Census Bureau 2010 population data) not contiguous with or situated within a Metro Area[4],
- Arizona counties with populations of less than 750,000 (based on U.S. Census Bureau 2010 population data)
- Federally recognized Indian tribes situated in Arizona.
- Incorporated cities and towns situated in Metro Areas, unincorporated communities (irrespective of location) and all other persons and entities not specifically identified herein as eligible Applicants are not eligible to apply for or receive grants under the Program.
- A private, non-profit economic development organization may be identified as a "co-sponsor" on, and serve as a point of contact for, a Proposal submitted by an eligible Applicant. However, in any such case, only the eligible Applicant may receive an ESP award and enter into a grant agreement with ADOT (the "Agreement"). Documentation of support must be submitted with a co-sponsored Proposal. Private for-profit firms are not eligible Applicants.
- An Applicant may seek funding for only one Project during the term of the Program. For this purpose, an otherwise eligible county Applicant is not precluded from seeking funding for a Project because one or more incorporated cities and towns (or Indian tribes) within such county is/are also seeking funding for a Project. Similarly, an otherwise eligible city, town or Indian tribe is not precluded from seeking funding for a Project because the county in which the city, town or Indian tribe is situated is also seeking funding for a Project.

An Applicant in receipt of an outstanding Economic Strength Project grant may not apply for ESP grant funding in FY19.

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[2] The term "base industry" refers to businesses that bring net new wealth into the Arizona community in which they operate by exporting products or services out of the State and, therefore, excludes retail, tourism, hospitality and entertainment-oriented businesses.

[3] In compliance with Title VI and according to the Civil Rights Act 1964, the ACA and ADOT assure through their respective policies, assurances and procedures that no person shall on the grounds of race, color, national origin, age, sex, or disability or limited English proficiency be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any of their administrated, funded, or sponsored programs or activities.

[4] For this purpose, the term "Metro Area" refers to a city and its contiguous and surrounding communities with a population of 750,000 or more.

1.4. Eligible Projects

Projects that meet all of the following criteria are eligible for consideration of ESP grant funding:

A. Highway and Rural Road Projects

ESP grant funds are available for public highway or rural road projects in Arizona that are available for use by the public at all times.

A local jurisdiction is required to construct and maintain a Project if the Project is not part of the State highway system.

B. Demonstrated Private Investment

Projects must directly benefit a planned (i.e., non-speculative) private investment in the relevant community. Applicants must demonstrate that the planned private investment will occur directly because of the ESP grant award. Private investment entities must be established enterprises with operating histories of at least two (2) years.

Evidence of private investment can take the form of an executed letter of intent, lease agreement, or development agreement between the Applicant and the private investor/developer. Further, see RFP Section 2.4(E)

C. Demonstrated Economic Impact

Applicants must demonstrate how the Project will affect and advance the community's overall economic strategic course and general plan. Eligible Projects must directly assist a private business to (i) retain a significant number of jobs (ii) significant increase the number of jobs (iii) lead to significant capital investment and/or (iv) otherwise make a significant contribution to the local economy.

Evidence thereof must take the form of completion of a Proposal and all required documentation, including jobs, wage and capital investment projections.

Please note that after submittal of a Proposal, business substitutions are impermissible, and any such substitution will cause the Proposal to be rejected. Please further note that if the business creating or retaining the jobs significantly changes or cancels its development plans after a grant is awarded, the grant is subject to revocation by either the ACA or ADOT.

1.5. Required Match Funding

Every Proposal requires evidence of a committed match of at least ten percent (10%) of the total reimbursement-eligible Project costs, as determined under RFP Section 1.6. Documentation of the committed source(s) and amount of the match, including, if applicable, both public sector funds and/or private sector funds, must be provided. If match funding requires obtaining a public entity's official approval or vote after the notice of grant award, the grantee must provide documentation of such approval within 90 days of the notice of award.

Grant funds obtained or available from other State-funded programs, including the ACA's Rural Economic Development Grant ("REDG"), cannot be used as matching funds.

1.6. Eligible Project Costs

A. Costs eligible for reimbursement include, but are not limited to, costs for construction or reconstruction of the following:

- Public highways
- Rural roadways
- Turn lanes
- Acceleration/deceleration lanes
- Utility placement within the public right of way that is component of the overall public highway or rural roadway construction Project
- Curb and gutter and/or other drainage construction associated with the overall public highway or rural roadway construction Project

B. Costs ineligible for reimbursement or use as a match include but are not limited to:

- Costs incurred prior to the 18-month project period such as proposal preparation
- Routine maintenance and rehabilitation
- Landscaping
- Beautification
- Construction of areas not designated for vehicular traffic such as sidewalks
- Work performed on private property
- Signage for private companies

- Contingency fees
- Property purchases or easements
- Design and engineering
- Work done prior to the effective date of the executed Agreement
- Grant administration

1.7. Timeline

Applicants must be capable of executing the Agreement (the "Agreement") with ADOT within ninety (90) days of being approved by the State Transportation Board. Further, see RFP Section 4.2.

Costs incurred prior to the effective date of the executed Agreement cannot be reimbursed. Accordingly, Applicants should plan Project construction timelines carefully and be sure to include the amount of time needed for agreement review and governing body approval that is customary in the relevant jurisdiction.

Further, the first request for reimbursement of eligible Project costs must be submitted no later than eight (8) months after the effective date of the executed Agreement.

1.8. Other Eligibility Criteria

The Project must be administered by and through an eligible Applicant

- Upon completion of the Project, the grantee must, as applicable, approve and accept the Project and provide maintenance thereto
- Construction of the ESP portion of the Project must be accomplished according to the procurement laws, rules and regulations set forth by ADOT in the Agreement.
- An otherwise eligible Applicant with an outstanding REDG grant is eligible for an ESP grant provided that the REDG grant funds (i) are committed to improvements separate and distinct from those contemplated for the ESP grant as described in the Applicant's Proposal and (ii) are not utilized as matching funds for the ESP grant.

1.9. Other Terms and Conditions of General Applicability

A. Changes to the Program

The ACA and ADOT reserve the right to terminate or modify the contents of the Program at their collective discretion.

B. Public Records

Because both the ACA and ADOT are subject to Arizona's public records laws (ARS §§ 39-101 et seq.), information submitted to either agency may be subject to disclosure in response to public records requests. However, the public records laws provide exceptions for business information that, if released, would undermine the Applicant's competitive position and for proprietary or trademark (or copyright) protected information. The public records laws also permit the agencies to redact (block out) personal information before documents are released. The agencies will attempt to preserve the confidentiality of information to the extent permitted by law but cannot guarantee that such information will not be disclosed and is not responsible for the consequences of any such disclosure. Additionally, the agencies specifically hereby reserve the right to use the following information in their respective marketing materials, including without limitation in press releases: (i) the name and type of a project, (ii) the name of a grantee, (iii) the projected economic impact of a Project including without limitation the number of jobs to be created and the extent of capital investment contemplated, (iv) the uses of an ESP award, and (v) the amount or other terms of an ESP award.

2. SPECIAL INSTRUCTIONS FOR PREPARING AND SUBMITTING GRANT APPLICATION

Grant Application must be prepared according to the following instructions. Applicants are strongly encouraged to carefully read the entire RGA. In the event of any conflict between ACA's Uniform Instructions for Solicitations and this Special Instructions for Preparing and Submitting Responses Section or the Evaluation and Acceptance Section, those Sections shall prevail. ACA's Uniform Instructions for Solicitations can be found at: http://www.azcommerce.com/about-us/aca-policies.

2.1. Grant Application Submission

All Responses must be submitted by email (or online file share with email notification) to Teri Orman, terio@azcommerce.com, by the Submission Due Date/Time listed on the Notice of Request for Grant Application on the first page hereof.

Late submissions will not be considered.

2.2. Applicant Questions

In the event of questions regarding this RFA, the only person to contact directly is Teri Orman, via email only, at terio@azcommerce.com. The ACA cannot respond to inquiries regarding the evaluation status of a response submission or the pendency of awards.

ACA answers to questions will be responded to the requesting individual as they are received. Questions must be submitted in writing by the Questions Due Date listed in the Notice of Request for Grant Application. All Applicant questions will be collected, and answers will be released in writing to all Applicants that requested the RGA. The ACA reserves the right to modify any answers supplied before the final response is released. Questions must include the following information:

- RFA 2020-21
- Applicant's name
- Applicant's detailed question
- Reference to the section or page number related to the question (if applicable)

The ACA cannot respond to inquiries regarding the evaluation status of a response submission or the pendency of grant awards.

2.3. Format

Grant Application must be prepared in the following format:

- MS Word or Adobe PDF file (if multiple files are submitted, they should be assigned a numerical order by file name)
- Conventional, non-cursive font, 10-12 pt.
- Single-spaced
- Letter-sized (8.5" x 11")
- One (1) inch margins
- Clearly marked sections (header or cover page)

Where page limits are specified, any information provided in excess of limit will not be considered as part of the Grant Application and will not be considered during evaluation.

2.4. Grant Application Contents and Organization

Grant Application must include the documents and sections described below. No other documents or sections will be considered. Failure to provide all the required documents and sections may result in rejection of Grant Application. The documents and sections must be provided in the order listed below.

A. Cover Letter (optional)

The cover letter is limited to one (1) single-sided page and must conform to the RGA format requirements specified in Section 2.3.

B. Grant Application Form

The Application Form provided in Section 6 must be completed and included within the Grant Application.

C. Project Narrative

The Project Narrative section of Grant Application must not exceed eight (8) pages (single-spaced) and must include the sections described below in the order indicated. Applicants are strongly encouraged in their Grant Applications to be clear, concise and to the point.

The Project Narrative section of a Proposal must not exceed eight (8) pages (single-spaced) and must include the sections described below in the order indicated. Applicants are strongly encouraged in their Proposals to be clear, concise and to the point.

1. Project Description and Timeline Improvements

   Project Narratives must include a "Project Description and Timeline – Improvements" section which provides a detailed description of the Project including the following:

   - The nature of the highway or roadway improvements
   - The anticipated economic development benefit achieved by construction of such improvements
   - The party or parties that will perform the construction or reconstruction (if known)
   - The intended uses of the ESP funds in respect to the construction or reconstruction
   - The specific information required under Section 1.4 (to the extent relevant)
   - A timeline for completion of the improvements

   The Project description should also describe the amount of the cash "match" contribution to be provided including the following:

   - The timing of such match
   - The intended use(s) of the match
   - The identity of any sources other than the Applicant responsible for such match or portions thereof
   - The nature of the commitment by the Applicant or other parties to deliver the match including whether such commitment is in writing and binding in all circumstances.

   If a description of at least a ten percent (10%) cash match contribution is not reflected, the Proposal will be deemed incomplete and excluded from consideration.

   NOTE: The cash match percentage is determined by the ratio of the actual cash match contribution to the total reimbursement-eligible costs.

   This section must also explain the circumstances as to why, in the absence of ESP funding, the proposed Project would not proceed within the same time frame or would not otherwise be as effective in advancing the objectives of the Program, including a description of the efforts to obtain funding for the Project from other sources and the status thereof.

2. Project Description and Timeline – Development Matters (required)

   Project Narratives must include a "Project Description and Timeline –Development Matters" section which must contain a detailed description of any and all development that is intended to be benefited by the proposed highway or roadway improvements, including, as applicable, a timeline for the Project.

   This section should also identify, to the extent known:

   - The business(es) or types of business(es) located, or that will locate, at or near the development(s) and will directly or indirectly benefit from the improvements
   - Whether such business(es) exports or will export goods and hence whether any such business constitutes a base industry
   - The extent of the capital investment anticipated to be expended by each such business within one (1) year and within three (3) years of the completion of the improvements or the commencement of the business (as the case may be) which, if possible, should be certified by the owner of such business
   - The number of jobs anticipated for retention or creation by each such business within one (1) year and within three (3) years of the completion of the improvements or the commencement of the business (as the case may be) including the estimated wages payable and the benefits to be provided which, if possible, should be certified by the owner of such business.

The Proposal must set forth anticipated capital investment and jobs creation (or retention) information in this section even if the Applicant is unable to identify specific businesses that will incur the investment and create the jobs. If the capital investment and job information are not supported by certifications by businesses intending to locate at the development(s) benefited by the improvements, the Applicant must indicate the basis for the investment and job investment projections.

In addressing the foregoing matters, Applicants should note the following general considerations: (i) an Applicant must furnish at least some information regarding the private sector job creation and capital investment that is projected to occur as a result of the improvements in order that that the Project can be evaluated and compared with other Proposals and the basis used to arrive at those projections; (ii) an Applicant is not required to obtain certifications from businesses regarding the amount of job creation and capital investment that each business projects, but such certifications can be helpful and (iii) as a general matter, the more information and the more detailed the information that is furnished by an Applicant regarding the private sector job creation and capital investment and that is projected to occur as a result of the improvements, the better.

Applicants seeking funding for Projects in which job retention is the principal motivation must provide written documentation demonstrating the potential loss of existing jobs as a result of the relevant employer's bona fide threat to leave the State.

3. Other Project Outcomes (optional)

Project Narratives must also include an "Other Project Outcomes" section which includes a description of any intended Project outcomes not described in other sections. The outcomes should be described in terms of how the Project will support or enhance private sector job creation (or retention) and capital investment.

D. Project Budget

The Project Budget section must include a line-item budget for the Project and the proposed uses of both (i) the funds sought and (ii) the cash match committed to the Project by the Applicant or other parties. This section should identify all line items for which reimbursement is sought and also identify the source of funding for all pending Project costs that are ineligible for funding by the ESP and the nature of the commitments therefor.

A sample Project Budget is provided in RFP Section 5.

E. Documentation of Commitments

In this section, Applicants should submit documentation reflecting statements of commitments for any of the following: (i) cash match funds, (ii) capital investment, (iii) job creation/retention and (iv) resolutions to approve and maintain the Project. For example: (a) if a private company is providing matching funds, the Applicant must provide a Letter of Commitment/Intent from the company attesting to its commitment and (b) if a government entity has passed a resolution to approve, accept, and maintain the Project, the Applicant should provide a copy of the resolution. This section should also include any evidence of private investment as referenced in RFP Section 1.4(B).

F. Aerial Image or Map of Site and Surrounding Area

Proposals must include an aerial image or map of the site and surrounding area. Affected businesses and infrastructure must be clearly marked.

G. Letters of Support

Letters of support of the proposal may be submitted, up to a maximum of six (6) letters, each no longer than two (2) pages (single-spaced). The letters may be written by members of local business, community, and elected leadership, and attest to the merits of, and anticipated benefits provided by, the Project.

3. EVALUATION OF GRANT APPLICATIONS

3.1. Grant Application Review Process

A. Initial Review & Evaluation

The ACA will conduct an initial eligibility screening of all submitted Proposals after which a list of eligible Proposals will be provided to an evaluation committee comprised of, but not limited to, ACA-personnel, ADOT-personnel, and RBDAC members (the "Evaluation Committee") for review and initial evaluation.

The ACA may, at its discretion, waive informalities and minor irregularities in Grant Applications. However, Grant Applications that have material omissions, in the ACA's judgment, with respect to Grant Application requirements set forth herein will be precluded from consideration for funding.

At any point during the review process, ACA staff may, at its discretion, communicate with an Applicant about the Applicant's Grant Application. Such communications may include, but are not limited to, requests for clarification of information or additional information, or negotiations relating to any prospective terms of an ESP award.

B. Grantee Recommendations

The recommendations of the Evaluation Committee will be reviewed by the RBDAC during a public meeting[5] (held in accordance with ARS § 38-431.09), during which it will determine, a recommended priority ranking based on applicable evaluation criteria[6].

C. Award Determination

RBDAC's recommended priority ranking will then be transmitted to ADOT which will be responsible for the final selection of ESP grantees in accordance with ARS § 28-7286(A). Reference Section 4.1, Notice of Award, herein.

There is no guarantee of funding for Proposals that satisfy all eligibility standards.

3.2. Evaluation Criteria

Final recommendation and ranking of proposals for funding will be based on the following evaluation criteria:

- The cost of the Project;
- The number of jobs that the Project will cause to be created;
- The nature and amount of capital investment or other contribution to the economy of the State as a result of the Project;
- The likelihood that benefits resulting from the Project will exceed the costs of the Project;
- The amount and percentage of funding for the Project that will come from a source other than the Program;
- The amount of expenditures required for the Project;
- The magnitude of the Project and its relative value to the State as compared to other proposed Projects;
- The extent to which the Project would contribute to achieving an equitable distribution of monies and Projects among the various regions of the State and throughout the State as a whole; and
- The schedule for completion of the Project.

[5] The RBDAC meeting notice and agenda will be made available on the Public Notices page of the ACA website, www.azcommerce.com.

[6] Pursuant to Title VI of the Civil Rights Act of 1964, and the Americans with Disabilities Act ("ADA"), the ACA and RBDAC do not discriminate on the basis of race, color, national origin, age, sex or disability. Persons that plan to attend the RBDAC's public meeting that require a reasonable accommodation based on language or disability should contact the ACA's office at 602-845-1200. Requests should be made as early as possible to ensure the ACA has an opportunity to address the accommodation.

4. AWARD ADMINISTRATION INFORMATION

4.1. Notice of Award

As noted, ADOT is responsible for the final decision regarding Projects selected for Program grants after receipt of the recommended priority ranking from the ACA. See RFP Sections 1.1 and 3.1 and A.R.S §§ 41-1505(E) and 28-7286(A). ADOT will formally communicate its decision regarding Projects selected for Program grants by transmitting to each relevant Project Proposal Applicant with a "Notice of Award" upon approval by the Arizona State Transportation Board.

4.2. Grant Agreement

The Agreement will be executed between ADOT and each recipient of a Notice of Award within 90-days of receipt of award notice from ADOT. An extension may be granted by ADOT for extenuating circumstances.

ADOT will draft and send the Agreement to the selected Applicant(s). The Agreement will specify the responsibilities of each party and the scope of work and the grant recipient must submit the Agreement to its jurisdiction's attorney for review prior to presentation to the governing body (such as the relevant City Council or Board of Supervisors). The governing body must take appropriate action to approve the Agreement. Evidence of approval, such as an ordinance or a resolution, as well as attorney review documentation must be returned to ADOT with the signed Agreement. ADOT will sign the Agreement at which time the Agreement will become effective.

The Agreement will include the following state contact information:

	Agreement Contact	Reimbursement Contact	ADOT Project Manager	ACA Project Manager
Name	Sally J. Palmer	Angela Ringor	Ungyo (Lynn) Sugiyama	Jamie Kerr
Title	Contracts Program Manager	Senior Accountant	Transportation Planner 4	VP, Rural Economic Development
Email	SPalmer@azdot.gov	ARingor@azdot.gov	LUngyoSugiyama@azdot.gov	JamieK@azcommerce.com
Phone	602-712-6732	602-712-8316	602-712-6883	602-845-1255
Invoice Submissions	MPDInvoice@azdot.gov			
Mailing Address	Arizona Department of Transportation Multimodal Planning Division Mail Drop 310B 206 S. 17th Avenue Phoenix, AZ 85007			

Consistent with Section 1.6(B), ESP funds may be used only for reimbursement of costs for highway or roadway construction or reconstruction occurring after the Agreement is effective. Therefore, Applicants are encouraged not to procure, contract for, or otherwise incur costs prior to entering into the Agreement unless such costs will be paid independent of ESP funds.

Eligible costs must be incurred during the eighteen (18) month period following the effective date of the Agreement.

4.3. Progress/Annual Reports

For a period of eighteen (18) months from the effective date of the executed Agreement, each grantee of ESP funding (a "Grantee") is required to provide a quarterly activity report to ADOT that sets forth updates on performance measures outlined in the Grantee's Proposal. These reports are due to ADOT not later than twenty (20) calendar days after the close of each calendar quarter. The Grantee is required to use the forms provided by ADOT to submit these quarterly activity reports. The reports must contain all information as deemed necessary by ADOT. ADOT will track project outcomes relative to goals based on these activity reports.

The quarterly statements will contain, but are not limited to, the following items:

- An overall description of the status of the Project
- The construction progress made up to and including the current quarter, including costs expended to date on the Project
- A current timeline addressing the work remaining to complete the Project
- The name of the construction contractor and a copy of the pricing and signature pages of the contract, if not provided in previous statements
- A breakdown reflecting private sector development generated by the project to date, including information relating to job creation (including wage levels and healthcare benefits) and capital investment
- Any other benefits resulting from the project to date

For a period of 36-months after Project completion, an annual outcome report will also be required. This report will include but, not be limited to, information similar to that provided in the quarterly progress reports exclusive of construction matters and shall be reported to both ACA and ADOT.

4.4. Site Visits

ADOT may conduct one or more site visits during or after Project construction. Grantees must provide site access to ADOT in any such case.

4.5. Financial Reimbursement

Grantees will be paid on a cost-reimbursement basis; i.e., ADOT will reimburse the Grantee for Project costs previously paid by the Grantee.

Reimbursement requests must be submitted by the Grantee to ADOT no more frequently than monthly and no less frequently than quarterly. Reimbursement requests are encouraged to be made in conjunction with quarterly reporting as described in Section 4.3. Requests must be made on forms provided by ADOT and must include all information and attachments required by such forms, including but not limited to copies of invoices paid and evidence of payment. Subcontractor invoices to the general contractor managing the Project may be required to demonstrate that reimbursement is being requested only for qualifying Project costs, as determined under Section 1.5.

As noted, the first request for reimbursement of eligible project costs must be submitted to ADOT no later than eight (8) months after the effective date of the Agreement.

4.6. Fiscal Responsibility

It is understood and agreed that the total amount of ESP funds identified in the Agreement will be used for the Project as outlined in the Grantee's Proposal. Therefore, should the Project not be completed, be only partially completed or be completed at a cost lower than the original Project Budget, the amount reimbursed to the Grantee will be only for the amount of approved funds actually spent by the Grantee. For any funds received under the executed Agreement for which expenditure is disallowed by an audit exception by the State, the Grantee is required to reimburse said funds to ADOT within (fifteen) 15 business days.

4.7. Grantee Compliance with Administration Requirements

Notwithstanding any other provision described herein, a Grantee's failure to (i) submit required reports when due, (ii) to provide access to ADOT for inspection of a Project site, or (iii) to perform any other material ESP obligation will result in withholding of payment under the Agreement or other sanction (including liability for repayment of ESP funds and/or restrictions on eligibility for future ESP funding) unless such failure is demonstrated to have arisen due to causes beyond the control and without the fault or negligence of the Grantee.

5. SAMPLE BUDGET FOR GRANT APPLICATIONS

Applicants are not required to submit their budget in this format. However, Applicant budgets must include each of the elements of this sample.

ESP Sample Budget

Applicant:

Costs	Budget
Eligible ESP Project Costs	
[list line items]	$[TBD]
Total Eligible ESP Project Costs	*$[TBD]*
Other Costs Ineligible for ESP Reimbursement	
[list line items]	$[TBD]
Total costs ineligible for ESP reimbursement	*$[TBD]*
Total Project Costs	**$[TBD]**

Funding	Budget
ESP Funds Requested for Cost Reimbursements	**$[TBD]**
Match Contributions	
[list cash match sources]	$[TBD]
Total Match Contributions	*$[TBD]*
Match Percent of Total Eligible ESP Project Costs	*[TBD]%*
Other Funding for Costs Ineligible for ESP Reimbursement	
[list other funding sources]	$[TBD]
	$[TBD]
Total funding for ineligible costs	*$[TBD]*
Total Project Funding	**$[TBD]**

6. APPLICATION FORM

The Application Form is provided in electronic format on the following page. Applicants are required to complete all fields, print, sign in ink, and include the original signed form with their Grant Application submission.

FY2020 Rural Economic Development Grant (ESP) Application Form			
APPLICANT INFORMATION			
Entity Name		FEIN	
Entity Type	☐ Arizona incorporated city or town with a population less than 150,000 and not contiguous with or situated within a Metro Area		
	☐ Arizona county with a population less than 750,000		
	☐ Federally recognized Indian tribe situated in Arizona not contiguous to an urban area		
Mailing Address		Website	
Application Contact: The contact person for clarifications and communications regarding the Grant Application.			
Name		Title	
Phone Number		Email	
AWARD CONTACT INFORMATION[7]			
Project Manager: Reviews Agreement content and starts signature process; responsible for managing project and tracking project.			
Name		Title	
Phone Number		Email	
Authorized Signatory: The contact person authorized to execute the Agreement, if awarded.			
Name		Title	
Phone Number		Email	
Alternate Signatory: The alternate person authorized to sign on behalf of the Applicant in the absence of the principal authorized signatory named above.			
Name		Title	
Phone Number		Email	
Legal: The person responsible for legal review of the Agreement. If unknown, this must be determined prior to Agreement execution.			
Name		Title	
Phone Number		Email	
Records: Receives executed Agreement for official agency records and is the primary contact for the project.			
Name		Title	
Phone Number		Email	
Accounting: Receives executed Agreement for funding and billing records; point of contact for questions on billing.			
Name		Title	
Phone Number		Email	

[7] If unavailable at time of Grant Application, the information requested must be provided prior to a Grantee receiving the Agreement.

PROJECT INFORMATION	
Project Name	
Brief Project Description	
Name(s) and NAICS Code(s) of Direct Private Beneficiary(ies)	
Name(s) and NAICS Code(s) of Indirect Private Beneficiary(ies)	

PROJECT BUDGET SUMMARY[8]			
Total Eligible Project Costs		Total Match for Eligible Costs[9]	
Total Ineligible Project Costs		Match % of Total Eligible Costs[10]	
Total Project Costs		Total Other Funding for Ineligible Costs	
ESP Grant Funds Requested[11]		Total Project Funding	

PROJECTED PROJECT OUTCOMES (36 months after project completion)	
Number of New Jobs	
Average Wage	
New Payroll	
% of Employer-Provided Healthcare Costs	
Capital Investment	

AFFIRMATION

As the authorized representative of the Applicant, I certify under penalty of perjury that the information contained herein and attached hereto is true and correct according to the best of my knowledge and belief after a reasonable investigation of the facts.

Authorized Representative			
Signature		Date	
Printed Name		Title	
Co-sponsor (if applicable)			
Signature		Date	
Printed Name		Title	

[8] See Section 5 herein for additional budgetary requirements within Grant Application.
[9] Match contributions must be at least 10% of total eligible project costs.
[10] Enter ratio of match contributions to total eligible project costs as a percentage.
[11] Grant funds requested cannot exceed 90% of the total eligible project costs.

AGENDA ITEM REVIEW FORM

Regular City Council Meeting **6. B.**

Meeting Date: 06/24/2020

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

Submitted By: Jose L. Cisneros, Executive Assistant, Administration

Action Requested: Motion

ITEM:

Discussion and possible action on any and all matters regarding authorization for employee vacation accrual payout. **(Tadeo A. De La Hoya, City Manager)**

SUMMARY:

As COVID-19 cases continue to increase, vacation hours have not been used by city staff. Employees were encouraged to stay home, to limit travel outside Yuma County, and were recommended to avoid travel outside of the United States. Therefore, they were unable to take vacations as a safety measure to protect themselves and others. Currently, there are employees, mostly from public safety, who have already maxed out their vacation hours and are losing accruals, and yet are unable to take time off. Employee Vacation Buyback is a benefit that is utilized by employees to supplement their family's finances and is a good incentive for employees who do not use their vacation hours, as it is their prerogative. The Employee Buyback benefit is done twice a year, limited to twenty (20) hours.

At this moment, there are about sixty (60) employees who are already losing or will begin losing vacation hours starting June 30, 2020. Unfortunately, 35% are currently losing vacation hours, and 65% of these employees will start losing accrued hours shortly after. About 56% of these employees are part of our Police and Fire Departments. Our public safety departments have, for some time, been short-staffed. Once this pandemic subsides, and these employees decide to take time off, we could be faced with a loss of our Police force of about 39% and 22% in our Fire Department.

City of San Luis employees have begun to contract COVID-19, with public safety departments being the most affected as they are constantly exposed to this disease. Unfortunately, the number of confirmed cases keeps rising, and now more than ever, these essential employees are needed to serve the community.

The other portion of employees losing hours are part of essential departments, including Public Works, Finance, and other equally essential departments. Employees who are loosing or will begin losing accrual time have served and been loyal to our community for over ten (10) years, some having been working for the city for over twenty (20) years. These employees make up more than 50% of those who may be affected by losing accrual time.

City employees cannot be forced to go out and travel, nor can they be punished because they are unable to take vacations. We also do not want to encourage travel, as cases keep rising all around the region. The State of California has over 160,000 cases, with Los Angeles County with over 70,000 cases. Other close destinations include the State of Sonora, which currently has more than 5,000 cases and Baja California, with approximately 7,000 confirmed cases.

The San Luis Employee Vacation Buyback Program has served as a benefit for our employees. It has

helped retain employees and bring in necessary talent with the skills, knowledge, and experience to our organization. It also serves as an incentive to retain employees who might be lured by higher salaries in other organizations.

Overall, it is critical to ensure that employees are available to serve our residents when needed, so we can continue to provide the best customer service. We must be conscious of how the decisions made will be viewed by employees. In these times of crisis, employee morale and job satisfaction are more important than ever. Any action perceived by employees as overly harsh during this challenging time could cause significant morale issues in the workplace.

For these reasons, the city administration wants to make sure that the City of San Luis employees are able to sell back (as per policy already allows) for some of their vacation accruals. City Administration is seeking approval from the Mayor and City Council to transfer up to $80,946.00 from City Council Contingencies GL account #100-110-81000 to the accounts of the affected departments to cover for Employee Vacation Buyback payments of the affected sixty (60) employees.

City Administration acknowledges that during these uncertain times, this action might not be able to be taken in the future and that a permanent solution needs to be sought as recommended by the Finance Department. However, for the time being, it is requested that this payout be done during this fiscal year as the bottom line of the budget totals allows to and that vacation accrual caps be increased. The City of San Luis should acknowledge those employees with good attendance and not force them to forfeit or let go of their accruals when staffing needs are crucial. It is also a prerogative for city administration to understand that vacation is not mandatory, and to understand that some of these sixty (60+) employees have been unable to take time off due to this pandemic.

RECOMMENDATION / SUGGESTED MOTION:

1. I MOVE TO APPROVE A ONE-TIME, 40-HOUR CAP ON THE VACATION BUY-BACK PROGRAM IN A TOTAL AMOUNT NOT TO EXCEED $80,000.00 WITHIN THE 2019-2020 FISCAL YEAR AND TO USE CONTINGENCY FUNDS ONLY IF DEPARTMENTS HAVE INSUFFICIENT FUNDS.

2. I MOVE TO DIRECT STAFF TO WORK ON A PERMANENT SOLUTION.

N/A

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM:	Yes
CITY/STATE/FEDERAL FUNDS:	City
TOTAL:	$80,946.00
BUDGETED AMOUNT:	$0
AVAILABLE AMOUNT TO TRANSFER:	$80,946.00
ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE:	100-110-81000 Contingencies/$257,100.00

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

N/A

AGENDA ITEM REVIEW FORM

Regular City Council Meeting **6. C.**

Meeting Date: 06/24/2020

Department Head: Maria Munoz, HR Technician, Human Resources Department

Submitted By: Maria Munoz, HR Technician, Human Resources Department

Action Requested: Motion
Order

ITEM:

Discussion and possible action on any and all matters regarding Order No. 2020-13. 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 2020-2021 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, Acting Director of Human Resources)**

SUMMARY:

The PowerPoint presentation from the Budget Meeting on April 17, 2019 (2020 Renewal Presentation), the Benefit Plan Documents and the 2020 amendments are attached

Background
Consultant and Benefits Broker Susan Posada negotiated the Employee Benefits Plans for the 2020 - 2021 Fiscal Year.

At the April 17, 2020, Budget Meeting of the City Council, Ms. Posada 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 $2,683,400.00

Recommendation of the Trust and Staff
The final plan went to the San Luis Employees Benefits Trust on March 11, 2020, and the Trustees approved plan changes that were presented to City Council on April 17, 2020, at the budget meeting. The benefit plans and the amendments for the 2020 - 2021 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 2020 - 2021 and to make it effective on July 1, 2020.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE ORDER NO. 2020-13

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 allocation of 2,683,400.00 to the Trust Fund was passed as part of the final budget for Fiscal Year 2020-2021.

Attachments

Order No. 2020-13
Susan Posada's budget retreat presentation
Plan document USMEX medical
US/MEX Medical plan Amendment # 1
USMEX plan amendment #2
US/MEX Medical plan amendment #3
USMEX dental plan document
USMEX dental plan amendment #1
USMEX dental plan Amendment #2
MEXICO ONLY Medical document plan
MEXICO ONLY Medical amendment #1
MEXICO ONLY medical amendment #2
MEXICO ONLY medical amendment #3
MEXICO ONLY Dental plan document
MEXICO ONLY dental amendment #1
MEXICO ONLY dental amendment #2

OFFICE OF THE
MAYOR
CITY OF SAN LUIS

Order

No. 2020-13

AN ORDER OF THE MAYOR AND CITY COUNCIL OF THE CITY OF SAN LUIS, ARIZONA DECLARING THE EMPLOYEE BENEFIT PLANS A PUBLIC RECORD; APPROVING THE EMPLOYEE BENEFITS PLANS FOR THE FISCAL YEAR 2020-2021 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 24, 2020, 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 $2,683,400.00 to the San Luis Employee Benefit Trust to implement said employee benefits plans for the fiscal year 2020-2021.

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 titles:

1. "2020 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); Amendment #2 (Effective March 1, 2020); Amendment #3 (Effective July 1, 2020);

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); Amendment #3 (Effective July 1, 2020);

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" and

7. "Master Plan Document Amendment #1" (Mexico Coverage, Effective July 1, 2019); Amendment #2 (Effective March 1, 2020) Amendment #3 (Effective July 1, 2020);

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), Amendment #3 (Effective July 1, 2020),

Note: Amendments #2 will only be added to medical plans.

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 2020-2021, 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, 2020.

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, 2020.

PASSED, ADOPTED and APPROVED by the Mayor and City Council of the City of San Luis, Yuma County, Arizona this ____day of June 2020

Gerardo Sanchez, Mayor

ATTEST:

Sonia Cornelio, City Clerk

APPROVED AS TO FORM:

Kay Marion Macuil, City Attorney

CITY OF San Luis Arizona

Gateway to the Sea of Cortez

Management Meeting

Renewal Presentation

For July 1, 2020 to June 30, 2021

Presented by Susan Posada

SUSAN POSADA
AGENCY

City of San Luis Recommended Plan Changes for plan year 2020-2021

			Recommended
Changes require Trust approval for Medical, Dental and Heaqlthiest You Plan Changes		Current Plan 2019-2020	Renewal Plan 2020-2021
US Medical Plan Recommended Changes - from Win-Win to Esurgeries			
		Win-Win Present Plan	**Esurgeries**
	Change - Replace Win-Win with Esurgeries		
X-ray's and Lab's			
	At Primary Care Provider	$15 Copay	$0 Copay
	At Secondary Care Provider	$25 Copay	$0 Copay
	At Stand-alone Provider	$15 Copay	$0 Copay
	At aa Hosital - X-ray and Lab's	20% + deductible	20% + deductible
Complex Imaging - MRI, CT Pet Scan etc.			
	At Contracted Provider i.e. Sonora Quest and Lab Corp	$25 Copay	$0 Copay
	At a hospital - Complex, MRI, CT and Pet Scan	20% + deductible	20% + deductible
Hospital and Out-patient Surgery With Esurgeries			
	Hospitalization	20% + deductible	$0 deductible Waived
			$0 Coinsurance
	Out-Patient Surgery	20% + deductible	$0 deductible Waived
			$0 Coinsurance
Precertification			
	CT Scans, PetScans & MRI's	None	Required
	Special Services such as acupuncture, podiatry & TMJ	Required	Required
	Out-patient surgeries	Required	Required
Reimbursements for travel for Lodging			
	In-Patient - Lodging Reimbursement	Up to $125 per night up to 4 nights	None
	Out-Patient - Lodging Reimbursement	Up to $125 per night up to 4 nights	None
	Maximum Out-of-Pocket (In Network)	$5,500 plus lodging reimbursement	None
	Hospital and Outpatie4nt Surgery	0% + deductible	None
US Medical Plan Recommended Changes			
Out of Network Out of Pocket			
	Out-pocket for Out of Network Only (Individual/Family)	$5,500/$11,000	$4,500/$9,000
	Out-pocket for Out of Network Only	40%	50% Coinsurance
	The change is to mirror the Mexico Plan which is 50%		
Specialty Medications			
	Allow for Out of Country Specaility Medications	N/A	Allow

	Current Plan 2019-2020	Renewal Plan 2020-2021
US Dental		
Dental Carry-over - In-Network Only		
Calendar Year Benefits	$2,000 per calendar year	$2,000 +$250 per calendar year
Does not apply to Orttho Max of $2,000		
The carry over is allowed if the member does not exceed 75% of the benefit in the calendar year		
Does not apply to Orttho Max of $2,000		
Mexico Medical Plan		
Mexico In Network Out of Pocket		
Out of Pocket In Network Only (Individual/Family)	$6,250/$12,500	$4,500/$9,000
Mexico Out of Network	Covered	Change to Emergency Services Only
Out of Network - Emergency Services	$150 Copay	$150 Copay
Out of Network - Allow other services	50%	None
Pharmacy - RX copay's	$3/$6	$2/$5
Mexico Dental		
Mexico Dental Plan		
5	$1,000 per calendar year	$1,000 + $125 per calendar year
Preventative Copay	$10 Copay	$0 Copay
Basic Services Copay	$20 Copay	$5 Copay
Major Services Copay	$20 Copay	$10 Copay
The carry over is allowed if the member does not exceed 75% of the benefit in the calendar year		
Does not apply to Orttho Max of $1000		
Siarmed Agreemnt renewal for 7/1/2020 to 7/1/2023		
	N/A	No Change
Wellness and Biometrics		
Wellness and Biometrics add to Budget	N/A	No Change
Welnness $10,000 and Biometrics	N/A	$18,000
Vision Plan - Frame Only	$130 Allowance	$150 Allowance

Vision Renewal Rates		Vision Service Plan Current		Vision Service Plan Renewal	
		In Network	Out of Network	In Network	Out of Network
Exam Copay		$10	N/A	$10	N/A
Frame Copay		$25	N/A	$25	N/A
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
Frame Allowance		$130	Up to $70	$150	Up to $70
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 $105	$130	Up to $130
LASIK Benefit		Up to 15% Discount	N/A	Up to 15% Discount	N/A
Coverage for Dependents		Up to 26		Up to 26	
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		7/1/2023		7/1/2023	
RATES:		**Two Tier**		**Two Tier**	
Employee Only	149	$10.91		$11.29	
Family	103	$23.46		$24.26	
Total Monthly Premium	**252**	**$4,041.97**		**$4,180.99**	
Annual Premium		**$48,503.64**		**$50,171.88**	
Percentage Change				**3.44%**	

Savings
$1,667..36

***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**

Renews 7/1/2023

Contribution Comparison 2019-2020 - 2020 - 2021

Contribution Changes Employee Benefits - Employer (ER), Employee (EE)

	Current Plan			Renewal Option				
	2019-2020 Total Premium	2019-2020 ER Contribution	2019-2020 EE Contribution	2020-2021 Total Premium	2020-2021 ER Contribution	2020-20210 EE Contribution	ER Difference Contribution	% Change
Medical (US & Mex)	$ 2,715,633.72	$ 2,344,840.19	$ 370,793.53	$ 2,579,858.88	$ 2,227,604.80	$ 352,254.08	$(117,235.38)	-5.00%
Dental (US & Mex)	$ 148,723.68	$ 100,432.22	$ 48,291.46	$ 144,255.12	$ 97,414.40	$ 46,840.72	$ (3,017.82)	-3.00%
Vision	$ 47,559.60	$ 22,124.73	$ 25,434.87	$ 50,171.88	$ 23,339.96	$ 26,831.92	$ 1,215.23	5.49%
Short Term Disability	$ 81,114.62	$ 81,114.62	$ -	$ 81,114.62	$ 81,114.62	$ -	$ -	0.00%
Long Term Disability	$ 6,430.00	$ 6,430.00	$ -	$ 6,430.00	$ 6,430.00	$ -	$ -	0.00%
Basic Life	$ 19,004.76	$ 19,004.76	$ -	$ 19,004.76	$ 19,004.76	$ -	$ -	0.00%
Healthiestyou	$ 24,576.00	$ 24,576.00		$ 24,576.00	$ -			0.00%
EAP Preferred	$ 7,004.16	$7,004.16		$ 7,004.16				
Total Budget Requirements	$ 3,050,046.54	$ 2,605,526.67	$ 444,519.87	$ 2,905,411.26	$ 2,454,908.54	$ 425,926.72	$(119,037.97)	-6.14%

Premium Increases	**$**	**%**
Medical Premium (US & Mexico)	-$135,774.84	-5.00%
Dental Premium	-$4,468.56	-3.00%
Life, STD, LTD Premium	$0.00	0.00%

Summary

Medical	Increase in Total Premium	-$135,774.84
	Employer Portion	-$117,235.38
	Employee Portion	-$18,539.46
Dental	Increase in Total Premium	-$4,468.56
	Employer Portion	-$3,017.82
	Employee Portion	-$1,450.74
Total Changes:	All Benefits	**-$144,635.28**
	ER	**-$150,618.13**
	EE	**-$18,593.15**

Employer & Employee Contribution Calculations - Renewal Plan Medical, dental and vision

Proposed rates for 7/1/2020 - 6/30/2021

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	$ 604.84	$ 84,677.60	$ 84,677.60	$ -	$ 36.47	$ 5,069.33	$ 5,069.33	$ -	$ 11.29	$ 1,682.21	$ 1,682.21	$ -
Medical, Dental & Vision	US & Mexico-Spouse Cost	$ 1,255.16	$ 8,786.12	$ 6,793.43	$ 1,992.69	$ 72.93	$218.79	$ 95.65	$ 123.14				
Medical, Dental & Vision	US & Mexico-Child(ren) Cost	$ 1,255.16	$ 52,716.72	$ 40,760.57	$ 11,956.15	$ 72.93	$ 2,260.83	$ 988.43	$ 1,272.40				
Medical, Dental & Vision	Us & Mexico-Spouse & Child(ren) Cost	$ 1,920.04	$ 44,160.92	$ 34,145.22	$ 10,015.70	$ 91.03	$ 2,275.75	$ 994.73	$ 1,281.02	$ 24.26	$ 2,498.78	$ 1,162.43	$ 1,336.35
Medical, Dental & Vision	Mexico-Employee	$ 220.40	$ 881.60	$ 881.60	$ -	$ 16.28	$ 16.28	$ 16.28	$ -				
Medical, Dental & Vision	Mexico-Employee & Spouse	$ 457.32	$ 2,743.92	$ 2,121.60	$ 622.32	$ 32.54	$ 390.48	$ 170.76	$ 219.72				
Medical, Dental & Vision	Mexico-Employee & Children	$ 457.32	$ 3,658.56	$ 2,828.80	$ 829.76	$ 32.54	$ 488.10	$ 213.45	$ 274.65				
Medical, Dental & Vision	Mexico-Emp, Spouse & Child(ren) Cost	$ 667.80	$ 17,362.80	$ 13,424.92	$ 3,937.88	$ 43.39	$ 1,301.70	$ 569.23	$ 732.47				
	Monthly Premium Totals		**$ 214,988.24**	**$ 185,633.73**	**$ 29,354.51**		**$ 12,021.26**	**$ 8,117.87**	**$ 3,903.39**		**$ 4,180.99**	**$ 1,945.00**	**$ 2,235.99**
	Annual Premium Totals		**$ 2,579,858.88**	**$ 2,227,604.80**	**$ 352,254.08**		**$ 144,255.12**	**$ 97,414.40**	**$ 46,840.72**		**$ 50,171.88**	**$ 23,339.96**	**$ 26,831.92**

Combined Monthly Total	**$ 231,190.49**	
Employer Contribution Monthly	**$ 195,696.60**	
Other Expenses	**$ 138,129.54**	
Annual Total	**$ 2,912,415.42**	
	Changes from Current:	
	Dollar Change	**($185,190.72)**
	Percent Change	**-5.98%**

Enrollment Counts	Medical	Dental		Healthiest You	Vision
US-Single	140	139		256	149
US-Employee + Spouse	7	3			
US-Employee + Child(ren)	42	31			
US-Family	23	25			103
MX-Single	4	1			
MX-Employee + Spouse	6	12			
MX-Employee + Child(ren)	8	15			
MX-Family	26	30			
	256	**256**		**256**	**252**

EAP	$	7,004.16
Healthiest You $8.00 PEPM (256EE's)	$	24,576.00
Short Term Disability	$	81,114.62
Long Term Disability	$	6,430.00
Basic Life Insurance	$	19,004.76
	Total	**$138,129.54**

2020-2021 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				
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 07-01-2019 to 6-30-2020

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	$ 89,133.80	$ 89,133.80	$ -	$ 37.60	$ 5,226.40	$ 5,226.40	$ -	$ 10.70	$ 1,594.30	$ 1,594.30	$ -
Medical, Dental & Vision	US & Mexico-Spouse Cost	$ 1,321.22	$ 9,248.54	$ 7,150.97	$ 2,097.57	$ 75.19	$ 225.57	$ 98.62	$ 126.95				
Medical, Dental & Vision	US & Mexico-Child(ren) Cost	$ 1,321.22	$ 55,491.24	$ 42,905.83	$ 12,585.41	$ 75.19	$ 2,330.89	$ 1,019.07	$ 1,311.82				
Medical, Dental & Vision	Us & Mexico-Spouse & Child(ren) Cost	$ 2,021.09	$ 46,485.07	$ 35,942.26	$ 10,542.81	$ 93.85	$ 2,346.25	$ 1,025.55	$ 1,320.70	$ 23.00	$ 2,369.00	$ 1,102.06	$ 1,266.94
Medical, Dental & Vision	Mexico-Employee	$ 232.00	$ 928.00	$ 928.00	$ -	$ 16.78	$ 16.78	$ 16.78	$ -				
Medical, Dental & Vision	Mexico-Employee & Spouse	$ 481.39	$ 2,888.34	$ 2,233.26	$ 655.08	$ 33.55	$ 402.60	$ 176.06	$ 226.54				
Medical, Dental & Vision	Mexico-Employee & Children	$ 481.39	$ 3,851.12	$ 2,977.69	$ 873.43	$ 33.55	$ 503.25	$ 220.07	$ 283.18				
Medical, Dental & Vision	Mexico-Emp, Spouse & Child(ren) Cost	$ 702.95	$ 18,276.70	$ 14,131.54	$ 4,145.16	$ 44.73	$ 1,341.90	$ 586.81	$ 755.09				
	Monthly Premium Totals		**$ 226,302.81**	**$ 195,403.35**	**$ 30,899.46**		**$ 12,393.64**	**$ 8,369.35**	**$ 4,024.29**		**$ 3,963.30**	**$ 1,843.73**	**$ 2,119.57**
	Annual Premium Totals		**$ 2,715,633.72**	**$ 2,344,840.19**	**$ 370,793.53**		**$ 148,723.68**	**$100,432.22**	**$ 48,291.46**		**$ 47,559.60**	**$ 22,124.73**	**$ 25,434.87**

Combined Monthly Total	**$ 242,659.75**
Employer Contribution Monthly	**$ 205,616.43**
Other (see below)	**$ 138,129.54**
Annual Total	**$ 3,097,606.14**

	Changes from Current:
	Dollar Change
	Percent Change

Enrollment Counts	Medical	Dental		Healthiest You	Vision
US-Single	140	139		256	149
US-Employee + Spouse	7	3			
US-Employee + Child(ren)	42	31			
US-Family	23	25			103
MX-Single	4	1			
MX-Employee + Spouse	6	12			
MX-Employee + Child(ren)	8	15			
MX-Family	26	30			
	256	**256**		**256**	**252**

EAP	$	7,004.16	
Healthiest You $8.00 PEPM (256EE's)	$	24,576.00	
Short Term Disability	$	81,114.62	
Long Term Disability	$	6,430.00	
Basic Life Insurance	$	19,004.76	Total **$ 138,129.54**

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%

Contributions for 2020 - 2021

Benefit Type	Coverage	Premium	Employer Cost	Employee Cost	
Which Benefit	Who's Covered	Monthly	Monthly	Monthly	Per Pay Check (24)
Medical– US & Mexico (EBSO/ BCBS)	Employee Only	$604.84	$604.84	$0.00	$0.00
	Employee & Spouse	$1,255.16	$970.49	$284.67	$142.34
	Employee & Child(ren)	$1,255.16	$970.49	$284.67	$142.34
	Family	$1,920.04	$1,484.57	$435.47	$217.73
Medical– Mexico Only	Employee Only	$220.40	$220.40	$0.00	$0.00
	Employee & Spouse	$457.32	$353.60	$103.72	$51.86
	Employee & Child(ren)	$457.32	$353.60	$103.72	$51.86
	Family	$667.80	$516.34	$151.46	$75.73
Dental– US & Mexico	Employee Only	$36.47	$36.47	$0.00	$0.00
	Employee & Spouse	$72.93	$31.88	$41.05	$20.52
	Employee & Child(ren)	$72.93	$31.88	$41.05	$20.52
	Family	$91.03	$39.80	$51.23	$25.62
Dental – Mexico Only (Siarmed)	Employee Only	$16.28	$16.28	$0.00	$0.00
	Employee & Spouse	$32.54	$14.23	$18.31	$9.16
	Employee & Child(ren)	$32.54	$14.23	$18.31	$9.16
	Family	$43.39	$18.97	$24.42	$12.21
VSP-Vision Service Plan	Employee Only	$11.29	$11.29	$0.00	$0.00
	Family	$24.26	$11.29	$12.97	$6.49
Healthiest You	Employee	$8.00	$8.00	$0.00	$0.00
	Family	$0.00	$0.00	$0.00	$0.00
Standard Short-term Disability	All Employees	$ 0.58 per $10 of annual salary	$ 0.58 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	Family	$96.75	$0.00	$96.75	$48.38
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

Contributions for 2019 - 2020

Benefit Type	Coverage	Premium	Employer Cost	Employee Cost	
Which Benefit	Who's Covered	Monthly	Monthly	Monthly	Per Pay Check (24)
Medical– US & Mexico (Mayo/ BCBS)	Employee Only	$636.67	$636.67	$0.00	$0.00
	Employee & Spouse	$1,321.22	$1,021.62	$299.60	$149.80
	Employee & Child(ren)	$1,321.22	$1,021.62	$299.60	$149.80
	Family	$2,021.09	$1,562.79	$458.30	$229.15
Medical– Mexico Only	Employee Only	$232.00	$232.00	$0.00	$0.00
	Employee & Spouse	$481.39	$372.23	$109.16	$54.58
	Employee & Child(ren)	$481.39	$372.23	$109.16	$54.58
	Family	$702.95	$543.55	$159.40	$79.70
Dental– 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	$41.02	$52.83	$26.42
Dental – 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	$ 0.58 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	Family	$96.50	$0.00	$96.50	$48.25
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

City of San Luis
EMPLOYEE BENEFIT TRUST

SUMMARY PLAN DESCRIPTION AND
PLAN DOCUMENT

EBSO GROUP NUMBER: SLS001

Effective: July 1, 2018

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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	**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**
- **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
Physical, Speech, Occupational Therapy	100% after a $30 Copay per visit (Deductible waived)	60% after Deductible	Outpatient visits per Coverage Year, combined.
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

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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 with-in 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. **Hemantinics**.

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 immunodeficiency virus (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 trusteed 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 $25 Copay per visit (Deductible waived)	60% after Deductible	
Other X-rays and Laboratory tests – Specialist care	100% after a $15 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 Associated Office Visits	 80% after Deductible 100% after a $15 Copay per visit (Deductible waived)	 60% after Deductible 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

MASTER PLAN DOCUMENT AMENDMENT #2

Effective March 1, 2020, the Master Plan Document and Summary Plan Description for City of San Luis is hereby amended as follows:

The Plan will provide enhanced health benefits associated with testing for the 2019 Novel Coronavirus (COVID-19). Diagnostic laboratory testing for COVID-19 shall be eligible and paid with no cost-sharing.

The above benefits are specific to Diagnosis of COVID-19. Participants who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

The following item has been added to the Plan's Schedule of Coverage:

Benefit Description	**PPO pays**	**Non-PPO pays**	**Additional Limitations and Explanations**
Testing for the 2019 Novel Coronavirus (COVID-19)	100%, Deductible waived	100%, Deductible waived	Subject to Medical Necessity guidelines

Accepted By:

Maria Saborí Benefits Trust Secretary 3/19/20

Name: Title Date

For: City of San Luis

MASTER PLAN DOCUMENT AMENDMENT #3

Effective July 1, 2020, the Master Plan Document and Summary Plan Description for City of San Luis is hereby amended as follows:

SCHEDULE OF COVERAGE, Amendment #1, is hereby deleted and replaced with Attachment A.

PRE-CERTIFICATION, Amendment #1, page 2, 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)**
- **Complex Imaging services: CT/PET/MRI/MRA/SPECT**
- **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.

INCENTIVE PROGRAM FOR PPO PROVIDER SELECTED HOSPITAL/OUTPATIENT FACILITY AKA WIN/WIN INCENTIVE PROGRAM, Amendment #1, page 2-5, is hereby deleted and is no longer part of the plan.

The following is hereby added:

Exclusive Surgeries Solutions LLC (ESurgeries) – Surgical Management Program

You can save money and obtain better outcomes by participating in the Plan's Exclusive Surgeries Solutions LLC (ESurgeries) Surgical Management Program. The Plan has contracted with ESurgeries to provide you with a unique voluntary surgical management program. ESurgeries contracts with top area surgeons and imaging providers to perform many different surgical and complex imaging procedures in ambulatory care centers rather than in outpatient hospitals. ESurgeries' contracted case rates guarantee that the patient will have ***no out-of-network claims***, ***and***, when the patient participates in this voluntary program, ***the Plan waives all cost shares***, including deductible and coinsurance. If the participant agrees to participate, the Plan staff will assist him or her to enroll and ESurgeries will work with him or her to schedule all appointments and follow-ups. If the participant chooses not to participate, the matter is referred back to the Plan's utilization review vendor to complete the pre-certification. If you are going to have a surgical procedure or complex imaging service covered by the ESurgeries program, as part of the Plan's pre-certification of the procedure, ESurgeries or the Plan Office will contact you to explain the program and help you enroll, help schedule your appointments, and make sure you have everything you need post-surgery to make a full and speedy recovery.

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:	$4,500	INDIVIDUAL	**NON-PPO:**	$20,000	INDIVIDUAL
	$9,000	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)**
- **Complex Imaging services: CT/PET/MRI/MRA/SPECT**
- **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 higher reimbursement for services received through the Exclusive Surgeries Solutions LLC (ESurgeries) Surgical Management Program (surgery and complex imaging procedures.)

Benefit Description	**PPO Plan pays**	**Non-PPO Plan pays**	**Additional Limitations and Explanations**
Acupuncture	80% after Deductible	50% 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)	50% 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	50% 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	50% 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)	50% after Deductible	
ESurgeries Procedures	100% (Deductible waived)	Not applicable	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Home Health Care	80% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 60 visits per Coverage Year.
Hospice Care	80% after Deductible	50% 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			
ESurgeries providers	100% (Deductible waived).	Not Applicable	
All others	80% after Deductible	50% 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)	50% after Deductible	
Specialist Office Visits (includes lab and X-ray)	100% after a $25 Copay per visit (Deductible waived)	50% after Deductible	
Inpatient Visit	100% after a $15 Copay per visit (Deductible waived)	50% after Deductible	
Surgery (Physician's office)	100% after a $15 Copay per visit (Deductible waived)	50% after Deductible	
Surgery (other) – ESurgeries	100% (Deductible waived).	Not Applicable	
Surgery (other)	80% after Deductible	50% after Deductible	
Physician Services – Pathology, Anesthesiology , or Radiology	80% after Deductible	50% after Deductible	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Maternity			
Prenatal visits	100% (Deductible and Copays waived)	50% after Deductible	
Hospital Services	80% after Deductible	50% after Deductible	
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	50% after Deductible	
Outpatient treatment	100% after a $15 Copay per visit (Deductible waived)	50% after Deductible	
Outpatient Diagnostic Tests			
Complex - MRI, MRA, CT, PET, SPECT			
Through ESurgeries provider	100% (Deductible waived).	Not Applicable	
Other providers:	80% after Deductible	50% after Deductible	
Other X-rays and Laboratory tests			
Through ESurgeries provider	100% (Deductible waived).	Not Applicable	
Other providers	80% after Deductible	50% after Deductible	
Other X-rays and Laboratory tests – Primary care office visit	100% (Deductible waived)	50% after Deductible	
Other X-rays and Laboratory tests – Specialist care office visit	100% (Deductible waived)	50% after Deductible	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
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	
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)	50% after Deductible	
All Other	80% after Deductible	50% after Deductible	
Skilled Nursing Facility	80% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 90 days per Coverage Year.
Therapy services – Chemotherapy, Dialysis, Radiology	80% after Deductible	50% after Deductible	
Transplants			
Hospitalization	80% after Deductible	50% after Deductible	
Associated Office Visits	100% after a $15 Copay per visit (Deductible waived)	50% after Deductible	
All other Covered Expenses	80% after Deductible	50% 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

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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 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.

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 with-in 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 bicuspids 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 trusteed 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 applies, 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-pert 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 subepitehlial
- 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.

MASTER PLAN DOCUMENT AMENDMENT #2
(Dental Plan)

Effective July 1, 2020, 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.

The following provision has been added to the Plan:

> If a Plan member does not exceed 75% ($1,500) of the yearly maximum benefit for Class I, II & III Services in one Calendar Year, $250 may be carried over into the following year, for a maximum benefit of up to $2,250 per Calendar Year for Class I, II & III Services, combined. Carryover does not apply to Class IV Services.

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
Carryover Provision	
Applies Per Calendar Year for Class I, II & III Services	$250

If a Plan member does not exceed 75% ($1,500) of the yearly maximum benefit in one Calendar Year, $250 may be carried over into the following year, for a maximum benefit of up to $2,250 per Calendar Year for Class I, II & III Services, combined. Carryover does not apply to Class IV Services.

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

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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 Emergency visit Urgent Care	 100% after a $250 Copay per visit 100% after a $20 Copay per visit	 100% after a $250 Copay per visit 50%	In an Emergency, as defined by the Plan, Out-of-Network Covered Expenses will be paid at the Siarmed level. Copay is waived if hospitalized and benefits revert to applicable inpatient hospital benefit.
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 Outpatient surgery (less than 12 hours)	 100% after a $50 Copay per visit 100% after a $25 Copay per visit	 50% 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%	

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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 chiropody, 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 with-in 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 anesthetist, 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 Siarmed Plan, as shown on the Schedule of Coverage, a Qualified Individual who wishes to participate in an Approved Clinical Trial must use a Siarmed Provider if a Siarmed Provider is participating in the trial and the Siarmed Provider accepts the Qualified Individual as a participant in the trial. However, if a Plan Member is covered under a Siarmed 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 Siarmed 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 Siarmed 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 immunodeficiency virus (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.

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 trusteed 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.**

MASTER PLAN DOCUMENT AMENDMENT #1

Effective July 1, 2019, the Master Plan Document and Summary Plan Description for City of San Luis – 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 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 services rendered in Mexico, pre-certification is done by Siarmed.

FOR PRE-CERTIFICATION in the US 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.

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.

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

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**
- **Home Health Care**
- **Out-of-Network Durable Medical Equipment > $750 or when rental exceeds 4 months**
- **Inpatient Rehabilitation/Habilitation services**

For services rendered in Mexico, pre-certification is done by Siarmed.
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 Emergency visit Urgent Care (visit only)	 100% after a $150 Copay per visit 100% after a $20 Copay per visit	 100% after a $150 Copay per visit 50%	In an Emergency, as defined by the Plan, Out-of-Network Covered Expenses will be paid at the Siarmed level. Copay is waived if hospitalized and benefits revert to applicable inpatient hospital benefit.
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 Outpatient surgery (less than 12 hours)	 100% after a $50 Copay per visit 100% after a $25 Copay per visit	 50% 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%	

MASTER PLAN DOCUMENT AMENDMENT #2

Effective March 1, 2020, the Master Plan Document and Summary Plan Description for City of San Luis – Mexico Coverage is hereby amended as follows:

The Plan will provide enhanced health benefits associated with testing for the 2019 Novel Coronavirus (COVID-19). Diagnostic laboratory testing for COVID-19 shall be eligible and paid with no cost-sharing.

The above benefits are specific to Diagnosis of COVID-19. Participants who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

Mexico Out-of-Network Healthcare Providers will be allowed as eligible based on Emergency status.

The following item has been added to the Plan's Schedule of Coverage:

Benefit Description	**Mexico Coverage SIARMED - Plan pays**	**Out-of-Network – US or Mexico Healthcare Providers - Plan Pays**	**Additional Limitations and Explanations**
Testing for the 2019 Novel Coronavirus (COVID-19)	100%, Deductible waived	100%, Deductible waived	Subject to Medical Necessity guidelines

Accepted By:

Maria Sabori Benefits Trust Secretary 3/19/20

Name: Title Date

For: City of San Luis

MASTER PLAN DOCUMENT AMENDMENT #3

Effective July 1, 2020, the Master Plan Document and Summary Plan Description for City of San Luis – Mexico Coverage is hereby amended as follows:

SCHEDULE OF COVERAGE, Amendment #1, is hereby deleted and replaced with Attachment A.

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

There is no Deductible.

ANNUAL OUT-OF-POCKET MAXIMUM PER COVERAGE YEAR

Network:	$4,500	INDIVIDUAL	**Out-of-Network:**	$20,000	INDIVIDUAL
	$9,000	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**
- **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 and only in the case of an Emergency. All other Out-of-Network providers are NOT covered.

NOTE: The following out-of-network services will be eligible expenses during the course of public health emergency relating to COVID-19 : Procedures and services through Exclusive Surgeries Solutions LLC.

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	Included in Emergency Copay	Included in Emergency Copay	Out-of-Network only covered in the case of Emergency.
Dental Hospitalization and Dental Services Office Visits	100% after a $25 Copay per visit	Not Covered	
Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies	100% after a $5 Copay per visit	Hearing aids: 80% All other: Not Covered	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 Emergency visit Urgent Care (visit only)	 100% after a $150 Copay per visit 100% after a $20 Copay per visit	 100% after a $150 Copay per visit Not Covered	In an Emergency, as defined by the Plan, Out-of-Network Covered Expenses will be paid at the Siarmed level. Copay is waived if hospitalized and benefits revert to applicable inpatient hospital benefit.
Home Health Care	Not Covered	Not Covered	
Inpatient Hospital Services (Non-Emergency)/Outpatient Hospital Visits for more than 12 hours Outpatient surgery (less than 12 hours)	 100% after a $50 Copay per visit 100% after a $25 Copay per visit	 50% 50%	Out-of-Network only covered in the case of Emergency.

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	Not Covered	
Inpatient Visit	100%	Not Covered	
Surgery (Physician's office)	100%	Not Covered	
Surgery (other)	100%	Not Covered	
Physician Services – Pathology, Anesthesiology , or Radiology	100%	Not Covered	
Maternity			
Prenatal visits			
Initial visit	100% after a $5 Copay per visit	Not Covered	
All other visits	100%	Not Covered	
Hospital Services	100% after a $50 Copay per visit	Not Covered	
Birthing Centers	Not available	Not Covered	
Mental/Nervous Disorders and/or Substance Abuse			Inpatient treatment: Out-of-Network only covered in the case of Emergency.
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	Not Covered	

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	Not Covered	
Other X-rays and Laboratory tests	100% after a $5 Copay per visit	Not Covered	
Outpatient Prescription Drugs			
Generic Drugs	100% after a $2 Copay	Not Covered	
Name Brand Drugs	100% after a $5 Copay	Not Covered	
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%	Not Covered	
Immunizations, inoculations, vaccinations	100%	Not Covered	
Sterilization – limited to Employee and covered Spouse only	100%	Not Covered	
Rehabilitation and Habilitation Services	100% after a $5 Copay per visit	Not Covered	Siarmed covered services in Mexico include physical and speech therapy only.
Skilled Nursing Facility	Not Covered	Not Covered	
All other Covered Expenses	100%	Not Covered	

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

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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 with-in 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 bicuspids 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 trusteed 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 applies, 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
    - 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-pert 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 subepitehlial
- 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

MASTER PLAN DOCUMENT AMENDMENT #2
(Dental – Mexico Coverage)

Effective July 1, 2020, 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.

DENTAL BENEFITS, is hereby deleted and replaced with the following:

DENTAL BENEFITS

Subject to all the terms of the Plan, the Plan will pay a dental benefit for covered dental expenses incurred by a covered person. The dental benefit is a percentage of the customary and reasonable amount for incurred covered dental expenses, as shown on the Schedule of Benefits.

MAXIMUM BENEFIT

The maximum benefit year benefit payable on behalf of a covered person for covered dental expense is stated on the Schedule of Benefits. If the covered person's coverage under the Plan terminates and he subsequently returns to coverage under the Plan during the benefit year, the maximum benefit will be calculated on the sum of benefits paid by the Plan.

ALTERNATIVE TREATMENT

In the event the dentist recommends a particular course of treatment and a lower-cost alternative would be as effective, benefits shall be limited to the lower-cost alternative. Any balance remaining, as a result of the covered person's choice to obtain the higher-cost treatment will be the covered person's responsibility.

DENTAL INCURRED DATE

A dental procedure will be deemed to have commenced on the date the covered dental expense is incurred, except as follows:

1. For installation of a prosthesis, other than a bridge or crown, on the date the impression was made;
2. For a crown, bridge or gold restoration, on the date the tooth or teeth are first prepared;
3. For endodontic treatment, on the date the pulp chamber is opened.

There are times when one overall charge is made for all or part of a course of treatment. In this case the claims processor will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED EXPENSES
Subject to the limitations and exclusions, covered dental expenses shall include the necessary services, supplies, or treatment listed below and on the following pages. No dental benefit will be paid for any dental service, supply or treatment which is not on the following list of covered dental expenses.

Diagnostic and Preventive Dental Services

I. Routine oral examination: Initial or periodic, limited to twice per benefit year.

2. Prophylaxis: Scaling and cleaning of teeth, limited to twice per benefit year.

3. Dental x-rays as follows:

a. Supplementary bite-wing x-rays limited to twice per benefit year.
b. Panorex or full mouth series limited to one of each every thirty-six (36) months.
c. Other dental x-rays necessary for the diagnosis of a specific condition requiring treatment.

4. Topical application of fluoride for dependent children limited to one treatment per benefit year.

5. Space maintainers, fixed appliance (not made of precious metals), designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth) including all adjustments within six (6) months of installation, limited to dependent children. This does not include space maintainers used in orthodontics to create a space between teeth.

6. Topical application of sealant to permanent posterior teeth, for dependent children limited to one treatment per tooth every thirty-six (36) months.

7. Emergency palliative treatment primarily for relief of dental pain, not cure. Only paid as a separate benefit when no other treatment (except x-rays) is rendered during the visit.

Basic Dental Services

I. Sedative fillings covered as a separate procedure only if no other service (except x-rays) is rendered during the visit.

2. Restorations, using amalgam, silicate, acrylic, synthetic, and composite filling materials to restore teeth broken down by decay or injury.

3. Pin retention when part of the restoration instead of gold or crown retention.

4. Periodontics as follows:

   a. Gingivectomy/gingivoplasty, gingival curettage, gingival flap procedure or mucogingival surgery.
   b. Scaling and root planning limited to twice per quadrant in any benefit year.
   c. Pedicle and free soft tissue grafts, and vestibuloplasty.
   d. Occlusal adjustment, excluding charges for TMJ.
   e. Excision of pericoronal gingiva.
   f. Periodontal prophylaxis limited to twice per benefit year with proof of previous periodontal treatment.
   g. Osseous surgery.

5. Endodontics as follows:

   a. Pulp Capping.
   b. Pulpotomy.
   c. Root canal therapy on permanent teeth only.
   d. Apicoectomy.
   e. Hemisection.
   f. Retrograde fillings.

6. Oral surgery, including customary postoperative treatment furnished in connection with oral surgery, as follows:

   a. Simple extraction of one or more teeth.
   b. Surgical extraction of erupted teeth and of soft tissue, partially bony, and completely bony impacted teeth.
   c. Extraction of tooth root.
   d. Incision and drainage of a tumor or a cyst.
   e. Alveolectomy, alveoloplasty, and frenectomy.
   f. Exostosis or hyperplastic tissue and excision of oral tissue for biopsy.
   g. Re-implantation or transplantation of a natural tooth.
   h. General anesthesia, only when provided in conjunction with ***a surgical*** procedure.

7. Bacteriologic cultures in connection with a covered dental service.

8. Therapeutic injections administered by a dentist

9. Repairs and adjustments to full or partial dentures.

10. Relining of present dentures, but only if they were installed more than six (6) months earlier and if they have not been relined during the past twelve (12) months.

11. Rebasing of present dentures, but only if they were installed more than six (6) months earlier and if they have not been rebased during the past thirty-six (36) months.

12. Denture adjustment once per twelve (12) consecutive months, only if done more than six (6) months after the
initial insertion of the denture.

13. Repair or recementing of crowns, inlays, on lays or bridgework.

14. Specialists consultations and specialty examinations provided the covered person has been referred by a general dentist. These consultations and examinations are not restricted to the limitations for routine oral exams.

Major Dental Expenses

I. Post and core on permanent teeth only.

2. Plastic or stainless-steel crowns will be covered for primary teeth only and the five (5) year limitation, as noted below will not be applied.

3. Gold Inlays and Onlays: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement. Restorations on teeth which are anterior to the first bicuspid are not covered.

4. Porcelain Restorations: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement. Restorations on teeth which are posterior to the first bicuspid are not covered.

5. Crowns: Covered only when the tooth cannot be restored by a basic restoration, and then only if at least five (5) consecutive years have lapsed since the last placement. Crowns used to treat temporomandibular joint dysfunction will not be covered.

6. Initial installation of fixed bridge (including abutments) to replace one (I) or more natural teeth extracted.

7. Removable bridge, partial or complete dentures to replace one (I) or more natural teeth extracted.

8. Replacement of an existing partial or full removable denture or fixed bridge, or the addition of teeth to existing bridgework to replace extracted natural teeth. However, only replacement or additions that meet the "Prosthesis Replacement Rule" below will be covered.

9. Complete dentures for teeth extracted.

Prosthesis Replacement Rule

The Prosthesis Replacement Rule requires that replacements or additions to existing dentures or bridgework will be covered only if satisfactory evidence is furnished that one of the following services applies:

1. The replacement or addition of teeth is required to replace one (I) or more teeth extracted after the existing denture or bridgework was installed.

2. The existing denture or bridge cannot be made serviceable and was installed at least five (5) years prior to its replacement.

Covered expenses for a both a temporary and permanent prosthesis will be limited to the charge for the permanent prosthesis.

Orthodontic Services (for dependent children through age 19 only.)

Subject to the limitations specified on the Schedule of Benefits, covered expense shall include:

1. Any dental expense furnished in connection with the orthodontic treatment;

2. Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment. Includes routine x-rays, local anesthetics, and post-surgical care.

3. Active appliances, diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.

Orthodontic services are subject to a twelve (12) month waiting period after the covered person's effective date of coverage. Upon proof of twelve (12) months of previous creditable coverage, this waiting period shall be waived.

Orthodontia benefits will begin upon submission of proof that the orthodontia services have been received. Payments will be divided into equal installments, based upon the estimated number of months of treatment, and will be paid over the treatment period as proof of continuing treatment is submitted. The maximum benefit for orthodontia services is specified on the Schedule of Benefits. This maximum applies to the entire period(s) a person is covered under the Plan.

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 – <u>NETWORK ONLY</u>

Copays	
Class I Services – Diagnostic and Preventive Care	None
Class II Services - Basic Services	$5
Class III Services - Major Services	$10
Class IV Services – Orthodontics	None
Pharmacy Rx	
Generic	$2
Name Brand	$5
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
Carryover Provision	
Applies Per Calendar Year for Class I, II, & III Services, combined	$125

If a Plan member does not exceed 75% ($750) of the yearly maximum benefit in one Calendar Year, $125 may be carried over into the following year, for a maximum benefit of up to $1,125 per Calendar Year for Class I, II, & III Services, combined. Carryover does not apply to Class IV Services.

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. Prior authorization for orthodontia services must go through SIARMED.

THE NETWORK IS ADMINISTERED BY: SIARMED

AGENDA ITEM REVIEW FORM

Regular City Council Meeting **6. D.**

Meeting Date: 06/24/2020

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. 2020-15. An order of the Mayor and City Council of the City of San Luis, Arizona approving and adopting an amendment to the February 26, 2020, Development Agreement with Comite de Bien Estar, Inc. to create a lot split and to share responsibility for the construction of a street. **(Kay Marion Macuil, City Attorney)**

SUMMARY:

Need for Park

The East Mesa area of San Luis is growing with many residential subdivisions. Although there are retention basins that serve as the open space requirements under the subdivision and zoning regulations, there is now a need for a park.

Development Agreement

The Comite de Bien Estar, Inc. ("Comite") wishes to exercise its option on 40 acres in the East Mesa, on the south side of County 24th Street between Avenue E and Avenue F. The 40 acres currently belong to Border Ranches, L.L.C. under Joshua J. Meyer's management. It was proposed that the City of San Luis (city) purchase approximately 20 of those 40 acres at Comite's discounted option price. On February 26, 2020, City Council adopted a Development Agreement with Comite to that the city and Comite will be simultaneously entered into a separate agreement of escrow instructions for the purchase of the land. The city will be purchasing approximately 20 acres of the northern half for a park and Comite the remaining acres for housing development.

June 3rd Work Session on the street Between the Parcels

Comite informed the city that to build the full width of the street running east-west on the south side of the park (tentatively to be named San Antonio Street), Comite would need to build another row of houses to pay for it, reducing the land available for the park. Discussion landed on the idea not to reduce the park, but the city would build 1/2 of the street, but at a time convenient to the city.

Suggested Order and Amendment

The attached Order and Amendment creates a lot split, which puts 1/2 of the street into the purchase by the city. The Amendment creates shared responsibility between the parties for building the full width of the street, with the city having discretion as to when to build the north half of the street.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE AND ADOPT ORDER NO. 2020-15.

The final agreement to be provided at a later date.

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM:	Yes
CITY/STATE/FEDERAL FUNDS:	City
TOTAL:	TBD
BUDGETED AMOUNT:	No
AVAILABLE AMOUNT TO TRANSFER:	TBD
ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE:	TBD

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

The City is estimating this purchase will cost up to $680,000 plus closing costs. This expenditure has been included in our budget for FY 2020-2021. The City is currently negotiating a loan to complete this purchase which will be paid with impact fees funds.

Attachments

Order No. 2020-15
Amendment
Exhibit A - Lot Split
Development Agreement
Master Plan

OFFICE OF THE
MAYOR
CITY OF SAN LUIS

Order

No. 2020-15

An order of the Mayor and City Council of the City of San Luis, Arizona approving and adopting an amendment to the February 26, 2020, Development Agreement with Comite de Bien Estar, Inc. to create a lot split and to share responsibility for the construction of a street.

BE IT SO ORDERED by the Mayor and City Council of the City of San Luis, Arizona:

Section 1. It is deemed in the best interest of City of San Luis and its residents that the city enter into this Amendment to the February 26, 2020, Development Agreement with the Comite de Bien Estar, Inc. for the purchase of land for use as a city park, to create a lot split and to share responsibility construction of a road.

Section 2. A true copy of the Development Agreement is incorporated herein as though set forth again in full.

Section 3. The Mayor is authorized and directed to execute said Development Agreement for and on behalf of the City of San Luis and the City Clerk to attest the same.

Section 4. City officers and employees are authorized and directed to perform all acts necessary or desirable to give effect to this Order.

Section 5. The San Luis City Clerk and the City Clerk's designee are authorized and directed to deliver this Development Agreement to the Comite de Bien Estar, Inc. and to maintain a fully executed Development Agreement in the official files of the City Clerk.

PASSED, ADOPTED and APPROVED by the Mayor and City Council of the City of San Luis, Yuma County, Arizona this ____day of June 2020.

_____
Gerardo Sanchez, Mayor

ATTEST:

_____
Sonia Cornelio, City Clerk

APPROVED AS TO FORM:

_____
Kay Marion Macuil, City Attorney

AMENDMENT TO DEVELOPMENT AGREEMENT

COMES NOW Comite de Bien Estar, Inc., an Arizona non-profit corporation, (the "Developer") and the City of San Luis, an Arizona municipal corporation (the "City"), and in consideration of the mutual covenants in this Amendment to Development Agreement (the "Amendment"), hereby amend the Development Agreement between Developer and City dated the 26th day of February 2020 as approved by Order No. 2020-3 of the City Council of the City of San Luis (the "Agreement").

1. Amending Section 1.4. Attached, marked Exhibit A, is a proposed lot split map splitting certain lands and describing two parcels to be established by the map identified herein as Parcel A1 and Parcel A2. Parcel A1 describes the Park Property as referenced in subsection 1.4 of the Agreement. Parcel A2 describes the remainder of the Property after a split has occurred.

2. Approving the Lot Split. The Lot Split Map attached as Exhibit A is hereby approved, and recordation is hereby authorized and directed.

3. Amending Section 3.3. Section 3.3 of the Agreement is hereby amended to provide that the Developer shall be responsible only for the development and construction of a half street for any east/west street along the boundary line between Parcel A1 and Parcel A2. The City of San Luis is responsible for any development of the street into a full street. The Parties to this Amendment understand the City shall determine in the City's sole discretion the exact extent and timing of development for its responsibility to for the other half of the street.

4. Remaining Portions of the Agreement. All remaining portions of the Agreement not amended herein shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year first above written.

[Intentionally left blank, the signature page continues]

THE CITY OF SAN LUIS, an Arizona municipal corporation

By: _____
Gerardo Sanchez, Mayor

ATTEST:

By: _____
Sonia Cornelio, City Clerk

APPROVED AS TO FORM:

_____
Kay Marion Macuil, City Attorney

DEVELOPER, Comite de Bien Estar, Inc, an Arizona non-profit corporation

By: _____
Marco A. (Tony) Reyes, Executive Director

STATE OF ARIZONA)
) ss.
County of Yuma)

The foregoing instrument was acknowledged before me this _____ day of June 2020, by Gerardo Sanchez, Mayor of the City of San Luis, Arizona, a municipal corporation.

_____
Notary Public

My Commission Expires: _____

STATE OF ARIZONA)
) ss.
County of Yuma)

The foregoing instrument was acknowledged before me this _____ day of June 2020 by Marco A. (Tony) Reyes, Executive Director, on behalf of Comite de Bien Estar Inc., an Arizona non-profit corporation.

_____
Notary Public

My Commission Expires: _____

Exhibit A

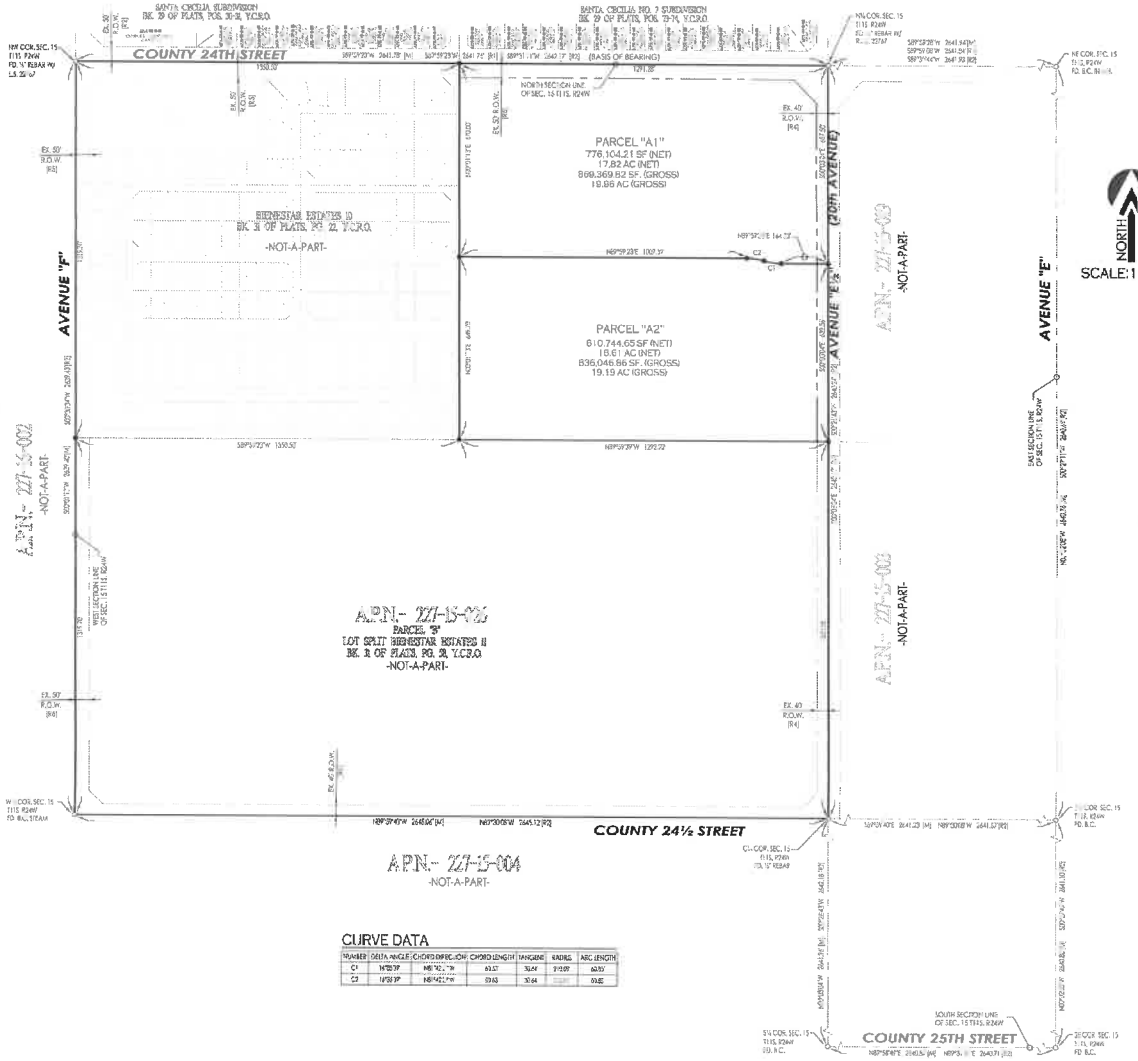
BIENESTAR ESTATES 11A

A LOT SPLIT OF A PORTION OF SECTION 15, T11S, R24W, G.&S.R.B.&M., YUMA COUNTY, ARIZONA., ALSO BEING PARCEL "A" OF THE BIENESTAR ESTATES 11 LOT SPLIT, AS RECORDED IN BOOK 31 OF PLATS, PAGE 58, YUMA COUNTY RECORDERS OFFICE, YUMA COUNTY, ARIZONA.

APRIL OF 2020 ACREAGE: 39.15 AC (GROSS)

BOOK _____ , OF _____

PAGE _____



SCALE: 1"=200'

CURVE DATA

NUMBER	DELTA ANGLE	CHORD DIRECTION	CHORD LENGTH	TANGENT	RADIUS	ARC LENGTH
C1	14°55'39"	N87°10'12"W	69.57	34.94	270.00	69.85
C2	14°55'39"	N87°42'17"W	69.63	35.04	270.00	69.85

LEGEND

———	INDICATES BOUNDARY LINE
———	INDICATES CENTER LINE
———	INDICATES RIGHT OF WAY LINE
———	INDICATES EASEMENT LINE
●	SET PROPERTY CORNERS TO BE MARKED BY ½" DIA. REBAR TAGGED WITH CAP L.S. 16568 (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&SR&BM, YUMA COUNTY, AZ. DATED JUNE/1977.
[R3]	DATA REFERS DOCKET 674, PG. 184, Y.C.R.O.
[R4]	DATA REFERS FEE #2001-36019, Y.C.R.O.
[R5]	DATA REFERS TO BIENESTAR ESTATES 10 SUBDIVISION, AS RECORDED IN BOOK 31 OF PLATS, PAGE 22, YUMA COUNTY RECORDERS OFFICE, YUMA COUNTY
[R6]	DATA REFERS TO BIENESTAR ESTATES 11 LOT SPLIT, AS RECORDED IN BOOK 31 OF PLATS, PAGES 58, YUMA COUNTY RECORDERS OFFICE, YUMA COUNTY.

OWNER OF RECORD:

BORDER RANCHES AZ, LLC
2901 B EXETER 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

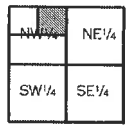
MY COMMISSION WILL EXPIRE _____

BASIS OF BEARING

THE NORTH LINE OF THE S ½ NE¼ 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 ½" DIAMETER REBAR TAGGED WITH CAP L.S. 16568



SEC. 15, T 11 S, R 24 W

LOCATION MAP

APPROVALS

APPROVED BY:

_____
CITY OF SAN LUIS, PLANNING & ZONING DIRECTOR

_____
CITY OF SAN LUIS, PUBLIC WORKS DIRECTOR

LEGAL DESCRIPTION

PARCEL "A1"

A PORTION OF THE NW¼ 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 AVENUE E/S AND CO. 24TH STREET BEING ALSO THE POINT THE NW¼ CORNER OF SAID SECTION 15, SAID POINT ALSO BEING THE TRUE POINT OF BEGINNING;

THENCE S00°03'04"E A DISTANCE OF 657.32', TO A POINT;
THENCE S89°59'23"W A DISTANCE OF 154.72' TO THE BEGINNING OF A CURVE TO THE RIGHT HAVING A RADIAL BEARING OF N00°03'37"W;
THENCE ALONG SAID CURVE TO THE RIGHT OF RADIUS 270.00', THROUGH A CENTRAL ANGLE OF 14°55'39" AND ARC DISTANCE OF 69.85' TO THE END OF THE CURVE HAVING A RADIAL BEARING OF S15°58'02"W TO THE BEGINNING OF A CURVE TO THE LEFT HAVING A RADIAL BEARING OF S74°55'02"W;
THENCE ALONG SAID CURVE TO THE LEFT OF RADIUS 210.00', THROUGH A CENTRAL ANGLE OF 14°55'39" AND ARC DISTANCE OF 54.72' TO THE END OF THE CURVE HAVING A RADIAL BEARING OF N89°57'23"W;
THENCE S89°59'23"W A DISTANCE OF 1307.39' TO A POINT;
THENCE N00°01'13" A DISTANCE OF 1317.32' TO A POINT;
THENCE N89°59'23" E A DISTANCE OF 1291.15' TO THE TRUE POINT OF BEGINNING;
EXCEPT THE NORTH 50', THE EAST 40.00' AND THE NORTHEAST 50' X 50' SIGHT VISIBILITY TRIANGLE EXISTING OR MAY THEREON.

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

CONTAINING 848,389.52 SF (19.84 AC.) MORE OR LESS. (GROSS)

PARCEL "A2"

A PORTION OF THE NE¼ 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 AVENUE E AND CO. 24TH STREET BEING ALSO THE POINT THE NW CORNER OF SAID SECTION 15;

THENCE S00°03'04"E A DISTANCE OF 657.32', TO A POINT; SAID POINT ALSO BEING THE TRUE POINT OF BEGINNING;
THENCE CONTINUING S00°03'04"E A DISTANCE OF 420.58' TO A POINT;
THENCE N89°59'19"W A DISTANCE OF 1291.92' TO A POINT;
THENCE N00°01'13"E A DISTANCE OF 649.70' A POINT;
THENCE N89°59'23"E A DISTANCE OF 1307.39' TO THE BEGINNING OF A CURVE TO THE LEFT HAVING A RADIAL BEARING OF S00°03'37"E;
THENCE ALONG SAID CURVE TO THE LEFT OF RADIUS 210.00', THROUGH A CENTRAL ANGLE OF 14°55'39" AND ARC DISTANCE OF 69.85' TO THE END OF THE CURVE HAVING A RADIAL BEARING OF N15°58'02"E TO THE BEGINNING OF A CURVE TO THE RIGHT HAVING A RADIAL BEARING OF N74°55'02"E;
THENCE ALONG SAID CURVE TO THE RIGHT OF RADIUS 270.00', THROUGH A CENTRAL ANGLE OF 14°55'39" AND ARC DISTANCE OF 69.85' TO THE END OF THE CURVE HAVING A RADIAL BEARING OF S89°57'23"E TO A POINT;
THENCE N89°59'23"E A DISTANCE OF 154.73' TO A POINT, SAID POINT BEING THE TRUE POINT OF BEGINNING;

EXCEPT THE EAST 40.00' RIGHT-OF-WAY THEREOF.

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

CONTAINING 836,046.86 SF. (19.19 AC.) MORE OR LESS. (GROSS)

SURVEYOR'S CERTIFICATE

I HEREBY CERTIFY THAT I AM A LAND SURVEYOR DULY REGISTERED 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 II R.L.S. NO. 16568



DEVELOPMENT AGREEMENT

THIS DEVELOPMENT AGREEMENT (the "Agreement") is entered into this _____ day of February 2020, by and between Comite de Bien Estar, Inc., an Arizona non-profit corporation, (the "Developer") and the City of San Luis, an Arizona municipal corporation (the "City"). This Agreement is entered into pursuant to City Order Number 2020-3.

The Developer and the City may be referred to singularly as the "Party" and collectively as the "Parties."

RECITALS

A. WHEREAS, A.R.S. § 9-500.05 authorizes the City to enter into development agreements with landowners and persons having an interest in real property that is located in the City; and

B. WHEREAS, Developer has an option to purchase land that is described on Exhibit A, attached hereto, and desires to exercise the said option; and

C. WHEREAS, the City desires to purchase a portion of said Property (the portion is described on Exhibit B) from Developer for the purpose of establishing a municipal park (hereinafter "Park"); and

D. WHEREAS, the Parties hereto desire to enter into an agreement to provide for the development of the property being retained by the Developer (hereinafter "Developer Property") after the sale to City; and

E. WHEREAS, the Parties will be simultaneously entering into escrow instructions for the purchase of property, said instructions constituting a separate and distinct agreement; and

F. WHEREAS, Developer and City desire to see the ultimate development of the properties of both Developer and City to be such as to be beneficial to both, with the understanding that the project will have a significant and positive impact upon the City and its residents; and

G. WHEREAS, the City's governing body has authorized the execution of this Agreement by Order Number 2020-3.

NOW, THEREFORE, the Parties agree as follows:

/ / /

/ / /

AGREEMENT

ARTICLE 1: DEFINITIONS

The following terms shall have the meanings set forth below whenever used in this Agreement, except where the context clearly indicates otherwise:

1.01. Agreement shall mean this agreement.

1.02. City shall mean and refer to the City of San Luis, an Arizona municipal corporation, and any successor public body or entity.

1.03. Developer shall mean and refer to the Comite de Bien Estar, Inc., an Arizona nonprofit corporation.

1.04. Improvements shall mean and refer to all public and private improvements which may be constructed from time to time on the Property, including, without limitation, all structures, buildings, roads, driveways, parking areas, walls, landscaping and other improvements of any type or kind, or any other alteration of the natural terrain to be built by the Developer or the City, as the case may be, pursuant to the terms of this Agreement.

1.05. Park shall refer to the municipal park property, which is described on Exhibit B, a portion that is approximately 20 acres in size.

1.06. Party may refer to the City and the Developer singularly. Parties may refer to the City and the Developer collectively.

1.07. Property, as used in this Agreement, shall mean and refer to all of the real property, which is legally described in Exhibit A, a portion of property that is approximately 40 acres in size.

2. RETENTION BASIN

2.01. Retention Basin. The Developer intends to develop a single-family residential subdivision on the portion of the Property that it will retain after selling the portion described on Exhibit B to the City. As part of the Subdivision Regulations and Public Works Standards of the City, the Developer will be required to develop a retention basin. The retention basin must meet all City standards for a retention basin for a residential subdivision and will be developed at the cost of Developer. The Parties intend for the retention basin to be built on the area of the Park (described in Exhibit B). It will be designed and graded in such a manner as to

be acceptable to the Parks and Recreation Director of the City. At the present time, it is anticipated that the retention basin will run along the south end of the property of the Park (as the property of the Park is described on Exhibit B). It will be connected to an appropriate water service with a meter. The Developer may use the area of the retention basin as "open space" in the meaning of the open space requirements of the City for the residential subdivision the Developer is building on the Developer Property.

2.02. Cost of Acquisition. The City will be purchasing the property (the Park) described on Exhibit B from Developer at the cost Developer paid to acquire it, plus the City's share of escrow fees and closing costs.

2.03. Manager's Power to Consent. The City hereby acknowledges and agrees that any unnecessary delay hereunder would adversely affect the Developer and/or the development of the Property, and/or development of the municipal park (the Park), and hereby authorizes and empowers the City Manager to consent to any and all requests of the Developer as well as taking such actions as may be needed or necessary to close escrow and acquire the property (the Park) described on Exhibit B requiring the consent of the City hereunder without further action of the City Council, except for any actions requiring City Council approval as a matter of law.

ARTICLE 3. ROADWAYS AND EASEMENTS

3.01. County 24th Street. The City will be responsible for developing, to City standards, the south one-half of 24th street as said street fronts the Park, Exhibit B.

3.02. 19th and 20th Avenues. The City will be responsible for developing, to City standards, the east half of 19th Avenue as 19th Avenue adjoins the land described in Exhibit B and the west half of 20th Avenue as 20th Avenue adjoins the land described in Exhibit B.

3.03. Other Streets. All other streets and Improvements needed for the development of Developer Property, the proposed subdivision anticipated to be named Bienestar Estates 11, shall be the responsibility of the Developer.

/ / /

ARTICLE 4. CONFLICT OF INTEREST AND REPRESENTATIVES NOT INDIVIDUALLY LIABLE

4.01. Conflict of Interest. Pursuant to Arizona law, rules and regulations, no City Council Member (including the Mayor), 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.

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

ARTICLE 5. MISCELLANEOUS PROVISIONS

5.01. Notices. All notices and communications provided for in this Agreement, or given in connection with this Agreement, shall be validly made if in writing and delivered personally or sent by registered or certified United States Postal Service mail, return receipt requested, postage prepaid to:

If to the City:
San Luis City Manager
City of San Luis
P.O. Box 1170
San Luis, AZ 85349

If to the Developer:
Comite de Bien Estar, Inc.
c/o Executive Director
963 E. B Street
San Luis, AZ 85349

or to 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 sent by the U.S. Postal Service shall be deemed delivered 72 hours following deposit in the United States Postal Service in the manner set forth above.

5.02. Waiver. No delay in exercising any right or remedy shall constitute a waiver of such right, 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.

5.03. 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 of the Agreement.

5.04. 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. The Developer 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 Developer 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 Developer represents to the City that by entering into this Agreement, the Developer has bound the Property and all persons and entities having any legal or equitable interest in it to the terms of the Agreement.

5.05. Entire Agreement. With the sole exception of the Escrow Instructions, this Agreement, including the following exhibits which are incorporated into this Agreement by this reference, constitutes the entire agreement between the Parties.

5.06. Amendment of the Agreement. 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 successors in interest or assigns. The City shall record the amendment or cancellation in the official records of the Yuma County Recorder.

5.07. Severability. 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.

5.08. Governing Law. The laws of the State of Arizona shall govern the interpretation and enforcement of this Agreement. The Parties agree that the 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.

5.09. Recordation of Agreement and Subsequent Amendment; Cancellation. 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 Developer execute such

agreement, amendment, or cancellation, as required by A.R.S. § 9-500.05.

5.10. Attorneys' Fees and Costs. 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 attorneys' fees and court costs.

5.11. Notice of Conveyance or Assignment. The Developer shall give notice to the City of any sale of the entire Property at least ten (10) days prior to the effective date of the sale.

5.12. No Third-Party Beneficiaries. There are no third-party beneficiaries to this Agreement, and no person or entity not a Party to this Agreement shall have any right or cause of action under this Agreement.

5.13. No Agency Created. Nothing contained in this Agreement shall create any partnership, joint venture, or agency relationship between the Parties.

5.14. Non-Liability of City Officials and Employees. Except for mandamus and other special actions, no member, official or employee of the City shall be personally liable to the Developer, 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 Developer or successor, or under any obligation under the terms of this Agreement.

5.15. Employment Eligibility. Under A.R.S. § 41-4401:

1. The Developer warrants 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.

2. A breach of a warranty under paragraph 1 above shall be deemed a material breach of this Agreement that is subject to penalties up to and including termination of the Agreement.

3. The City retains the legal right to inspect the papers of any contractor or subcontractor employee who works on this Agreement to ensure that the contractor or subcontractor is complying with the warranty under paragraph 1 above.

5.16. Boycott. The Developer certifies, to the extent permitted by law, that it does not participate in, and agrees not to participate in during the term of this Agreement a boycott of Israel under A.R.S. § 35-393.01.

[Intentionally left blank, signature page to follow]

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the day and year first above written.

THE CITY, THE CITY OF SAN LUIS,
an Arizona municipal corporation

By: _____
Gerardo Sanchez, Mayor

ATTEST:

By: _____
Sonia Cornelio, City Clerk

APPROVED AS TO FORM:

By: Kay Marion Macuil
Kay Marion Macuil, City Attorney

THE DEVELOPER, Comite De Bien Estar, Inc.,
an Arizona nonprofit corporation

By: _____
Marco Antonio Reyes, Executive Director

[Intentionally left blank, notarized acknowledgments follow next page]

STATE OF ARIZONA)
) ss.
County of Yuma)

The foregoing instrument was acknowledged before me this _____ day of _____, 2020, by Gerardo Sanchez, Mayor of the City of San Luis, Arizona, a municipal corporation.

_____
Notary Public

My Commission Expires: _____

STATE OF ARIZONA)
) ss.
County of Yuma)

The foregoing instrument was acknowledged before me this _____ day of _____, 2020 by Tony Reyes, Sr., Executive Director, on behalf of Comite de Bien Estar Inc., an Arizona non-profit corporation.

_____
Notary Public

My Commission Expires: _____

Exhibit A

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 E½, BEING THE N¼ CORNER OF SAID SECTION 15, BEING THIS POINT **THE TRUE POINT OF BEGINNING**;
THENCE S00°03'04"E A DISTANCE OF 1320.06' TO A POINT;
THENCE N89°59'39"W A DISTANCE OF 1292.92' TO A POINT;
THENCE N00°01'13"E A DISTANCE OF 1319.70' TO A POINT,
THENCE N89°59'23"E A DISTANCE OF 1291.28' TO A POINT;
THE TRUE POINT OF BEGINNING;

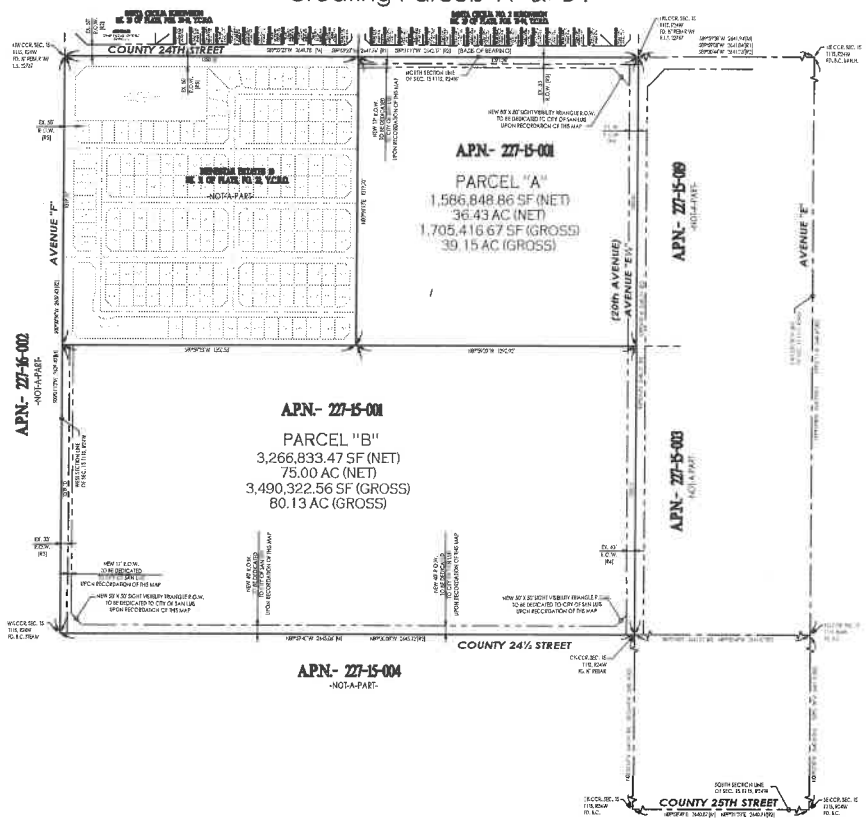
EXCEPT THE NORTH 50.00', THE EAST 40.00' AND THE NORTHEAST 80' X 80' SIGHT VISIBILITY TRIANGLE RIGHT-OF-WAY THEREOF;

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

CONTAINING 39.15 ACRES (1,705,416.67 SF) MORE OR LESS. (GROSS)
CONTAINING 36.43 ACRES (1,586,848.86 SF) MORE OR LESS. (NET)

BIENESTAR ESTATES 11 - LOT SPLIT

A Parcel Map of a portion of the Northwest Quarter Of Section 15, T11S, R24W, G&S.R.B.&M. Yuma County AZ. Creating Parcels "A" & "B".



SCALE: 1"=200'

BOOK _____ OF _____

PAGE _____

LEGEND

- INDICATES BOUNDARY LINE
- INDICATES CENTER LINE
- INDICATES ADJOIN-OWNER LINE
- INDICATES EASEMENT LINE
- ○ SET PROPERTY CORNERS TO BE MARKED BY 5/8" DIA. REBAR TAGGED WITH CAP I.S. 14286 UNLESS NOTED OTHERWISE
- ○ EXISTING MONUMENT AS SHOWN
- B.C. INDICATES BASIS OF BEARING
- Y.C.R. INDICATES YUMA COUNTY RECORDER
- O.L.O. INDICATES OFFICIAL LAND OFFICE
- M.A.E. INDICATES MOHAWK ACCESS EASEMENT
- PP INDICATES POWER POLE
- SS INDICATES EXISTING SANITARY SEWER
- (M) INDICATES MEASURED DATA
- (C) INDICATES CALCULATED DATA
- (R1) DATA REFERS TO NORTH RANCHES SUBDIVISION, AS RECORDED IN BOOK 27 OF PLATS, PAGES 9, 10, YUMA COUNTY RECORDER'S OFFICE, YUMA COUNTY.
- (R2) DATA REFERS TO U.S.B.R. BENCHMARK LOCATED IN SEC. 15, T11S, R24W, G&SRB&M, YUMA COUNTY, AZ. DATED 10/21/1977.
- (R3) DATA REFERS TO DOCKET 674, P.C. 184, Y.C.R.O.
- (R4) DATA REFERS TO FEE #2006-048191, Y.C.R.O.
- (R5) DATA REFERS TO BIENESTAR ESTATES 10 SUBDIVISION, AS RECORDED IN BOOK 31 OF PLATS, PAGE 22, YUMA COUNTY RECORDER'S OFFICE, YUMA COUNTY.

OWNER OF RECORD:

ESCALERA RANCHES 42 LLC
2701 N 24 NEW AVE
YUMA, AZ. 85365

YUMA WATER SHARES

ACKNOWLEDGMENT

THIS SUBDIVISION WAS ACKNOWLEDGED BEFORE ME THIS _____ DAY OF _____, 20___, BY ROSHUN L. MISTRY

NOTARY PUBLIC

MY COMMISSION EXPIRES _____

NOTICE OF DEFICIENCIES / ACKNOWLEDGMENT

A SIGNATURE BLOCK OF LANDOWNER(S) NOTICED RECORDED AT TIME OF WATER RIGHTS AND ASSURED SUBDIVISION REGULATIONS AND ALLOWING REQUIRES BUILDING PERMITS THAT MUST BE ISSUED BY THE PUBLIC RECORDS OF A PLAT BUILDING PERMIT OR OTHER USE PERMIT.

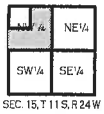
BASIS OF BEARING

THE NORTH LINE OF THE NW¼ OF SECTION 15, T11S, R24W, AS SHOWN ON ROBERT BRUCE SUBDIVISION AS RECORDED IN BOOK 32 OF PLAT, PAGES 14-15, YUMA COUNTY RECORDER OFFICE, YUMA COUNTY.

BEARING S89°59'23"W

NOTE

✦ PROPERTY CORNER TO BE MARKED BY 1/2" DIA. REBAR TAGGED WITH C.P.L.S. 14286



SEC. 15, T 11 S, R 24 W

LOCATION MAP

APPROVALS

APPROVED BY:

CITY OF SAN LUIS, TRAFFIC & ENGINEERING DEPARTMENT

CITY OF SAN LUIS, PUBLIC WORKS DEPARTMENT

LEGAL DESCRIPTION

PARCEL "A"

A PORTION OF THE NW¼ OF SECTION 15, T 11 S, R 24 W, G & S R.B.&M., YUMA COUNTY, ARIZONA MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BEGINNING AT THE INTERSECTION OF C.O., 14th STREET AND AVENUE EY, BEING THE W.C. CORNER OF SAID SECTION 15; BEING THE POINT OF BEGINNING;
THENCE S89°59'23"E A DISTANCE OF 1,705.00' TO A POINT;
THENCE N89°59'23"W A DISTANCE OF 1,705.00' TO A POINT;
THENCE N89°59'23"E A DISTANCE OF 1,705.00' TO A POINT;
THENCE N89°59'23"E A DISTANCE OF 581.28' TO A POINT;
THE TRUE POINT OF BEGINNING;

EXCEPT ALL NORTH 30.00' THEREOF AS USED BY AND THE MOHAWK VALLEY CANAL AND THE MOHAWK VALLEY DRAIN DITCH;

SUBJECT TO ALL EASEMENTS OF RECORD OR CHARGES APPARENT OR RECORDED.

CONTAINING 36.43 ACRES (1,586,848.86 SF) MORE OR LESS. (GROSS) CONTAINING 39.15 ACRES (1,705,416.67 SF) MORE OR LESS. (NET)

PARCEL "B"

A PORTION OF THE NW¼ OF SECTION 15, T 11 S, R 24 W, G & S R.B.&M., YUMA COUNTY, ARIZONA MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BEGINNING AT THE INTERSECTION OF C.O., 14th STREET AND AVENUE EY, BEING THE W.C. CORNER OF SAID SECTION 15;
THENCE S89°59'23"E A DISTANCE OF 1,705.00' TO A POINT; BEING THE POINT OF BEGINNING;
THENCE CONTINUING S89°59'23"E A DISTANCE OF 1705.00' TO A POINT;
THENCE N00°00'37"W A DISTANCE OF 2640.00' TO A POINT;
THENCE N89°59'23"W A DISTANCE OF 1339.72' TO A POINT;
THENCE S00°00'37"W A DISTANCE OF 1320.00' TO A POINT;
THENCE S89°59'23"E A DISTANCE OF 370.72' TO THE TRUE POINT OF BEGINNING;

EXCEPT THE EAST 40.00' THE SOUTH 40.00', THE PART IS SET THE CENTERLINE OF A 60' NEW MOHAWK ERA AND AND THE SOUTHERN 30.00' MOHAWK VALLEY ERA AND MOHAWK DRAIN WAY THEREOF;

SUBJECT TO ALL EASEMENTS OF RECORD OR CHARGES APPARENT OR RECORDED.

CONTAINING 80.13 ACRES (3,490,322.56 SF) MORE OR LESS. (GROSS) CONTAINING 75.00 ACRES (3,266,833.47 SF) MORE OR LESS. (NET)

SURVEYOR'S CERTIFICATE

I HEREBY CERTIFY THAT I AM A LAND SURVEYOR DULY REGISTERED BY THE STATE BOARD OF TECHNICAL REGISTRATIONS OF ARIZONA AND THAT THE 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.

RE: _____ R.L.S. NO. _____



Exhibit B

PARCEL "A1"

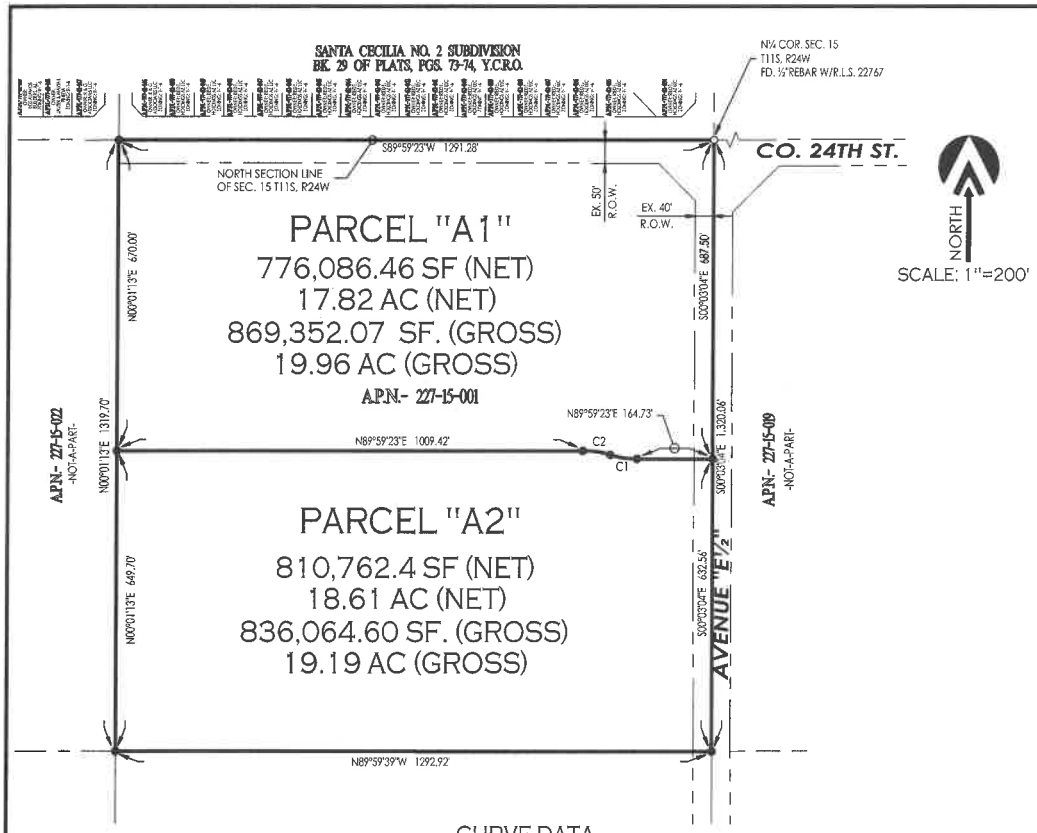
A PORTION OF THE NE¼ OF THE NW¼ OF SECTION 15, T11S, R24W, G. &S.R.B. &M. YUMA COUNTY, ARIZONA MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BEGINNING AT THE INTERSECTION OF AVENUE E½ AND Co. 24TH STREET, BEING ALSO THIS POINT THE N¼ CORNER OF SAID SECTION 15, SAID POINT ALSO BEING THE **TRUE POINT OF BEGINNING**;

THENCE S00°03'04"E A DISTANCE OF 687.50', TO A POINT;
THENCE S89°59'23"W A DISTANCE OF 164.73' TO THE BEGINNING OF A CURVE TO THE RIGHT HAVING A RADIAL BEARING OF N00°08'46"W;
THENCE ALONG SAID CURVE TO THE RIGHT OF RADIUS 200.00', THROUGH A CENTRAL ANGLE OF 17°08'49" AND ARC DISTANCE OF 59.85 FEET TO THE END OF THE CURVE HAVING A RADIAL BEARING OF S17°00'04"W TO THE BEGINNING OF A CURVE TO THE LEFT HAVING A RADIAL BEARING OF S17°00'04"W;
THENCE ALONG SAID CURVE TO THE LEFT OF RADIUS 200.00', THROUGH A CENTRAL ANGLE OF 17°08'49" AND ARC DISTANCE OF 59.85 FEET TO THE END OF THE CURVE HAVING A RADIAL BEARING OF N00°08'46"W TO A POINT;
THENCE S89°59'23"W A DISTANCE OF 1009.42' TO A POINT;
THENCE N00°01'13" E A DISTANCE OF 670.00' A POINT;
THENCE N89°59'23" E A DISTANCE OF 1291.28' TO THE **TRUE POINT OF BEGINNING**;
EXCEPT THE NORTH 50.00', THE EAST 40.00' AND THE NORTHEAST 80' X 80' SIGHT VISIBILITY TRIANGLE RIGHT-OF-WAY THEREOF;

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

CONTAINING 869,352.07 SF. (19.96 AC.) MORE OR LESS. (GROSS)



CURVE DATA

NUMBER	DELTA ANGLE	CHORD DIRECTION	CHORD LENGTH	TANGENT	RADIUS	ARC LENGTH
C1	17°08'49"	N81°34'21"W	59.63'	30.15'	200.00'	52.36'
C2	17°08'49"	N81°34'21"W	59.63'	30.15'	200.00'	52.36'

LEGAL DESCRIPTION

PARCEL "A1"

A PORTION OF THE NE¼ 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 AVENUE E½ AND Co. 24TH STREET, BEING ALSO THIS POINT THE N¼ CORNER OF SAID SECTION 15. SAID POINT ALSO BEING THE **TRUE POINT OF BEGINNING;**

THENCE S00°03'04"E A DISTANCE OF 687.50', TO A POINT;
THENCE S89°59'23"W A DISTANCE OF 164.73' TO THE BEGINNING OF A CURVE TO THE RIGHT HAVING A RADIAL BEARING OF N00°08'46"W;
THENCE ALONG SAID CURVE TO THE RIGHT OF RADIUS 200.00', THROUGH A CENTRAL ANGLE OF 17°08'49" AND ARC DISTANCE OF 59.85 FEET TO THE END OF THE CURVE HAVING A RADIAL BEARING OF S17°00'04"W TO THE BEGINNING OF A CURVE TO THE LEFT HAVING A RADIAL BEARING OF S17°00'04"W;
THENCE ALONG SAID CURVE TO THE LEFT OF RADIUS 200.00', THROUGH A CENTRAL ANGLE OF 17°08'49" AND ARC DISTANCE OF 59.85 FEET TO THE END OF THE CURVE HAVING A RADIAL BEARING OF N00°08'46"W TO A POINT;
THENCE S89°59'23"W A DISTANCE OF 1009.42' TO A POINT;
THENCE N00°01'13" E A DISTANCE OF 670.00' A POINT;
THENCE N89°59'23" E A DISTANCE OF 1291.28' TO THE **TRUE POINT OF BEGINNING;**
EXCEPT THE NORTH 50.00', THE EAST 40.00' AND THE NORTHEAST 80' X 80' SIGHT VISIBILITY TRIANGLE RIGHT-OF-WAY THEREOF;

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

CONTAINING 869,352.07 SF. (19.96 AC.) MORE OR LESS. (GROSS)

PARCEL "A2"

A PORTION OF THE NE¼ 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 AVENUE E½ AND Co. 24TH STREET, BEING ALSO THIS POINT THE N¼ CORNER OF SAID SECTION 15;

THENCE S00°03'04"E A DISTANCE OF 687.50', TO A POINT, SAID POINT ALSO BEING THE **TRUE POINT OF BEGINNING;**
THENCE S00°03'04"E A DISTANCE OF 632.56', TO A POINT;
THENCE N89°59'39"W A DISTANCE OF 1292.92' TO A POINT;
THENCE N00°01'13" E A DISTANCE OF 649.70' A POINT;
THENCE N89°59'23" E A DISTANCE OF 1009.42' TO THE BEGINNING OF A CURVE TO THE LEFT HAVING A RADIAL BEARING OF S0°08'46"E;
THENCE ALONG SAID CURVE TO THE LEFT OF RADIUS 200.00', THROUGH A CENTRAL ANGLE OF 17°08'49" AND ARC DISTANCE OF 59.85 FEET TO THE END OF THE CURVE HAVING A RADIAL BEARING OF N17°00'04"E TO THE BEGINNING OF A CURVE TO THE RIGHT HAVING A RADIAL BEARING OF N17°00'04"E;
THENCE ALONG SAID CURVE TO THE RIGHT OF RADIUS 200.00', THROUGH A CENTRAL ANGLE OF 17°08'49" AND ARC DISTANCE OF 59.85 FEET TO THE END OF THE CURVE HAVING A RADIAL BEARING OF S0°08'46"E TO A POINT;'
THENCE N89°59'23"E A DISTANCE OF 164.73' TO A POINT, SAID POINT BEING THE **TRUE POINT OF BEGINNING;**

EXCEPT THE EAST 40.00' RIGHT-OF-WAY THEREOF;

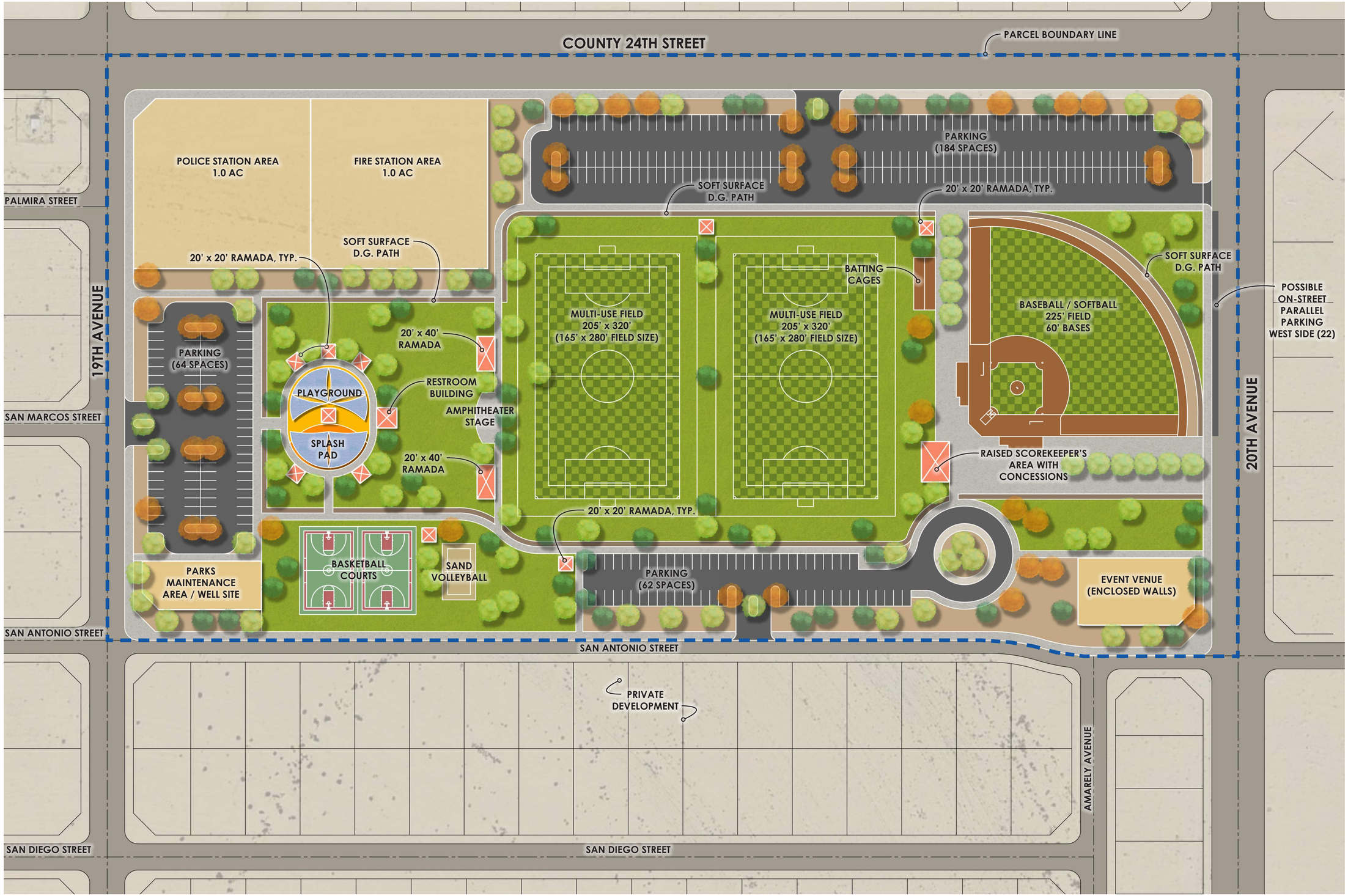
SUBJECT TO ALL EASEMENTS OR RIGHT-OF-WAYS APPARENT OR RECORD.

CONTAINING 836,064.60 SF. (19.19 AC.) MORE OR LESS. (GROSS)

VEGA VEGA
1946 S. 8th AVENUE 928-329-0003 TEL
YUMA, ARIZONA 85364 928-627-7744 FAX
V&V@vega-vega.com

EXHIBIT "A"
BIENESTAR ESTATES II

Sheet
EX-A



SAN LUIS COMMUNITY PARK

CONCEPTUAL MASTER PLAN (19.96 ACRES)

0 50' 100'
SCALE: 1"=50'

JUNE 16, 2020