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 22, 2022. The meeting will take place at the City Council Chambers, located at 1090 E. Union Street, San Luis, Arizona, 85349. 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, 22 de Junio del 2022. 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 invitado a la junta.

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

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

ESTE AVISO ES DADO POR:

/f/ Sonia Cornelio, Actuaria de la Ciudad

AMENDED ON 6/21/2022

AGENDA
Regular Meeting
San Luis City Council
San Luis Council Chambers
1090 E. Union Street
San Luis, AZ 85349
June 22, 2022
7:00 p.m.

For the safety of the public during the COVID-19 pandemic, members of the public may attend the City Council's Regular Meeting of June 22, 2022 in person if the 6-foot distance can be maintained which is 27 people. 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. Call to the Public will only be available to those attending the meeting in person.

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.

Por la seguridad del público durante la pandemia COVID-19, habrá asistencia en persona para los miembros del público en la Junta Regular del Cabildo del 22 de Junio del 2022, si la distancia de 6 pies puede mantenerse, que es de 27 personas. 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. Llamado al Publico estara disponible solo a quienes asistan a la junta en persona.

TENGA EN CUENTA QUE LOS MIEMBROS DEL CABILDO DE LA CIUDAD ASISTIRÁN EN PERSONA, TELÉFONO O COMUNICACIÓN POR VIDEO CONFERENCIA. EL ALCALDE O VICE-ALCALDE DE ESTA REUNIÓN PUEDE CAMBIAR EL ORDEN DE LOS TEMAS; SI ESTÁ AUTORIZADO POR LA LEY Y POR MAYORÍA DE VOTOS DE UN QUÓRUM DE MIEMBROS DEL CABILDO PRESENTES, SE LLEVARÁ A CABO UNA SESIÓN EJECUTIVA INMEDIATAMENTE DESPUÉS DE LA VOTACIÓN DE ACUERDO CON LOS ESTATUTOS DEL ESTADO DE ARIZONA A.R.S. §38-431.03 (A) Y LA REUNIÓN SERÁ TEMPORALMENTE RECESADA MIENTRAS EL CABILDO DE LA CIUDAD SE RETIRE A UNA SESIÓN EJECUTIVA QUE NO ESTARÁ ABIERTA AL PÚBLICO.

1. CALL TO ORDER/ROLL CALL 7:00 P.M.

2. PLEDGE OF ALLEGIANCE

3. INVOCATION

4. CONSENT AGENDA

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

4. A. MINUTES OF **Approved**

- Regular Council meeting held May 25, 2022
- Work Session held June 1, 2022
- Regular Council meeting held June 8, 2022

4. B. **Disbursements from June 1, 2022 to June 13, 2022** **Approved**
Total Disbursements $691,334.85
(Six Hundred Ninety-One Thousand, Three Hundred Thirty-Four Dollars and Eighty-Five Cents)

5. DISCUSSION AND POSSIBLE ACTION ITEMS:

5. A. Discussion and possible action on any and all matters regarding the approval of the estimate from ULTRA SHOW MAKERS, for sound, stage, and lighting for the 4th of July Celebration and waive formal purchasing procedures as allowed under the City Code-Purchasing § 3.05.010 (C). **(Maria A. Roldan, Acting Director of Parks & Recreation)** **Approved**

5. B. Discussion and possible action on any and all matters regarding Order No. 2022-08. An Order of the Mayor and City Council of the City of San Luis, Arizona, authorizing the entering into an Intergovernmental Agreement with the Bureau of Reclamation (BOR) for uniform license agreements permitting five specific crossings over BOR lands in the City of San Luis consolidated under BOR Contract No. 20-07-34-L2003. **(Kay Marion Macuil, City Attorney)** **Approved**

5. C. Discussion and possible action on any and all matters regarding Order No. 2022-09. 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 2022-2023 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. **(Kay Marion Macuil, City Attorney)** **Approved**

5. D. Discussion and possible action on any and all matters regarding Resolution No. 2220. A resolution of the Mayor and Council of the City of San Luis, Arizona, authorizing an Intergovernmental Agreement with the Arizona Department of Transportation (ADOT) for the use of Highway Users Revenue Fund (HURF) exchange funding for the construction of County 24th Street. **(Eulogio Vera, Director of Public Works)** **Approved**

5. E. Public hearing followed by discussion and possible action on any and all matters regarding Resolution No. 2221.
A resolution of the Mayor and City Council of the City of San Luis, Arizona, adopting the budget for Fiscal Year 2022-2023. **(Monica Castro, Director of Finance)** **Public Hearing Held/Approved**

A. Open Public Hearing

1. Staff Presentation
2. Call to the public on this item

B. Close Public Hearing

C. Action on Resolution No. 2221

5. F.	Discussion and possible action on any and all matters regarding Resolution No. 2222. A resolution of the Mayor and City Council of the City of San Luis, Arizona, approving the entering into a Pledgehold Agreement with Riedel Holdings to post land for assurances to construct a wastewater lift station and other commitments related to Los Mezquites Subdivision. **(Glenn Gimbut, Assistant City Attorney)**	**Approved**
5. G.	Discussion and possible action on any and all matters regarding Subdivision Case No. 2022-0043F. A request by Edais Engineering Inc., on behalf of Riedel Holdings LLC, for the approval of Los Mezquites Unit 2 final plat; the property is located on the southeast corner of Avenue E and County 23-1/2 Street (San Luis Lane) in San Luis Arizona. **(Jose A. Guzman, Director of Planning and Zoning)** A. Staff Presentation B. Action on Subdivision Case No. 2022-0043F	**Approved**
6.	**SUMMARY OF CURRENT EVENTS** Events by Mayor, Council Members and/or City Manager pursuant to A.R.S. §38-431.02 (K).	**Informational Update**
7.	**CALL TO THE PUBLIC** This is the time for the public to comment. Members of the City Council may not discuss items that are not specifically identified on the agenda. Therefore, pursuant to A.R.S. §38-431.01 (H), action taken as a result of public comment will be limited to directing staff to study the matter, responding to any criticism or scheduling the matter for further consideration and decision at a later date.	**No Legal Action Permitted**
8.	**ADJOURNMENT 7:26 P.M.**	

AGENDA ITEM REVIEW FORM

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

Meeting Date: 06/22/2022

Summary

MINUTES OF

- Regular Council meeting held May 25, 2022
- Work Session held June 1, 2022
- Regular Council meeting held June 8, 2022

Attachments

5/25/2022 RCM

06/1/22 WS

6/8/2022 RCM

M I N U T E S
Regular Council Meeting
San Luis City Council
San Luis Council Chambers
1090 E. Union Street
May 25, 2022
7:00 p.m.

1. CALL TO ORDER/ROLL CALL

Vice Mayor Mario Buchanan Jr. called the Regular City Council meeting to order at approximately 7:01 p.m.

PRESENT: Vice Mayor Mario Buchanan Jr.
Council Africa Luna-Carrasco (via Zoom)
Council Member Matias Rosales
Council Member Gloria Torres

ABSENT: Mayor Gerardo Sanchez
Council Member Luis Cabrera
Council Member Jose Ponce

OTHERS PRESENT: Lizandro Galaviz,
Kay Macuil, City Attorney
Sonia Cornelio, City Clerk
Angel Ramirez, Fire Chief
Eulogio Vera, Director of Public Works
Gilberto Torres, Wastewa ter Supervisor
Jenny Torres, Economic 0Development Manager
Jorge Perez, Assistant Director of Public Works
Jose Santiago, Maintenance Specialist
Jose Luis Cisneros, Executive Assistant
Leandro Valenzuela, Wastewater Plant Operator
Lupita Ochoa, Human Resources Coordinator
Marco Santana, Police Lieutenant
Maria Barajas, Human Resources Coordinator
Melissa Lopez, Deputy City Clerk
Michelle Boucher, Administrative Coordinator
Monica Castro, Director of Finance
Nancy Juarez, Administrative Coordinator
Nigel Reynoso, Police Lieutenant
Omar Velasquez, Parks Supervisor
Osvaldo Rodriguez, Lead Custodian
Richard Bauermann, Fire Inspector
Rogelio Martinez, Administrative Coordinator
Ruben Lopez, I.T. Techinician
Yolanda Dueñas, Facilities Supervisor
Christian Cuevas, Simultanous Translator

Cesar Neyoy, Reporter
Lucy Lopez, Reporter

2. PLEDGE OF ALLEGIANCE

Council Member Matias Rosales led the Pledge of Allegiance.

3. INVOCATION

Mr. Nigel Reynoso, Police Lieutenant, led the invocation.

4. PROCLAMATION/PRESENTATION

4. A. Proclamation - Men's Health Month June 2022

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

Vice Mayor Mario Buchanan Jr. added that it is never too late to start incorporating healthier habits into your daily life, he encouraged all to help increase the awareness of the importance of a healthy, active lifestyle and routine medical check-ups to ensure strong families and communities.

4. B. Presentation and recognition of the 2022 1st Quarter Awardees by the Employee Recognition and Awards Program (ERAP) for their outstanding work with the City of San Luis. (Maria Barajas, HR Coordinator)

Ms. Maria Barajas, Human Resources Coordinator, presented the certificates to recipients.

Vice Mayor Mario Buchanan Jr. congratulated and thanked all awardees.

5. CONSENT AGENDA

5. A. MINUTES OF

- Work Session held May 4, 2022
- Regular Council meeting held May 11, 2022
- Budget Retreat held May 14, 2022

5. B. Disbursements from May 3, 2022 to May 16, 2022
Total Disbursements $1,390,406.87
(One Million, Three Hundred Ninety Thousand, Four Hundred Six Dollars and Eighty-Seven Cents)

5. C. Discussion and possible action on any and all matters regarding the fiscal year 2022-2023 budget for City Council's contracts, contributions, sponsorships, dues, and subscriptions. (Lizandro Galaviz, Acting City Manager)

5. D. Discussion and possible action on any and all matters regarding the contract with Arizona Interagency Farmworkers Coalition, Inc for Fiscal Year 2022-2023. (Lizandro Galaviz, Acting City Manager)

5. E. Discussion and possible action on any and all matters regarding the contract with the Comité De Bien Estar for the Cancer Support Group of Yuma County for Fiscal Year 2022-2023. (**Lizandro Galaviz, Acting City Manager)**

5. F. Discussion and possible action on any and all matters regarding the contract with the Comité De Bien Estar, Inc. for the Off-Road Expo event in San Luis, Arizona for the fiscal year 2022-2023. (Lizandro Galaviz, Acting City Manager)

MOTION: Council Member Gloria Torres/Council Member Matias Rosales to approve the Consent Agenda as presented. Motion passed unanimously.
The vote was as follows:

Vice Mayor Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

6. DISCUSSION AND POSSIBLE ACTION ITEMS:

6. A. Discussion and possible update on any and all matters regarding the award of Construction Contract for Fire Station #2 to Merrill Development LLC. (Angel Ramirez, Fire Chief)

Mr. Angel Ramirez, Fire Chief, stated that staff is seeking approval of a construction contract to build Fire Station #2. This project has been in the making for the past two (2) years. He added that Fire Station #2 will provide better response times and meet the growing needs of the City of San Luis. The city published an invitation for bids for the construction of Fire Station #2 on March 24th through 25th 2022 and again from March 31st through April 1st, 2022. Bids were to be received no later than May 19th at 1300 hours. On May 19th staff confirmed receipt of bids from three interested bidders, Merrill Development LLC, Pilkington Contracting Company, LLC and Yuma Valley Contractors, Inc. The lowest responsible bidder is Merrill Development, LLC.

MOTION: Council Member Matias Rosales/Council Member Africa Luna-Carrasco to award the Fire Station #2 construction bid to Merrill Development, LLC in an amount not to exceed $1,091,088.00. Motion passed unanimously.

The vote was as follows:

Vice Mayor Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

6. B. Discussion and possible action on any and all matters regarding a contract with James Davey and Associates, Inc., to provide engineering services for the Mesa Street Improvements Project. (Jenny Torres, Economic Development Manager)

Ms. Jenny Torres, Economic Development Manager, explained that the Arizona Department of Housing (ADOH) awarded a Community Development Block Grant (CDBG) of $626,215.00 to the City of San Luis for the Mesa Street Improvements. The scope of work includes the construction of removal and re-pavement of streets, curb and gutter, sidewalks, driveways and installation of a retaining wall. The project will benefit 58% of low to moderate-income residents. The schedule for the project is to begin the bid process in May, start construction in August and complete the project by the end of the year. The City of San Luis will require assistance in the construction administration of the project. James Davey and Associates submitted a proposal that includes additional design services due to changes in the original project scope and engineering construction administration in the amount of $91,140.00.

MOTION: Council Member Gloria Torres/Council Member Matias Rosales to approve the contract with James Davey and Associates, Inc. in the amount of $91,140.00 for Engineering Services as presented. Motion passed unanimously.

The vote was as follows:

Vice Mayor Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

6. C. Discussion and possible action on any and all matters regarding Council ratification of an emergency purchase of a new Solid Waste – Side loader truck. (Eulogio Vera, Director of Public Works)

Mr. Jorge Perez, Assistant Director of Public Works, indicated that the Public Works Department had an urgent requirement to immediately move forward with a purchase of a new Solid Waste - Side loader truck to maintain the residential trash collection service for the residents of the City of San Luis. This new truck is being procured through a State Contract with RWC International, LTD, which provided a quote for a new Dennis Eagle cabin and chassis with a Spartan 300 Full Ejected Side Loader for a total cost of $409,311.87. This purchase falls under the provisions of City Code 3.05.090 Cooperative Purchasing.

Furthermore, the Solid Waste Division was approved for $312,530.00 for the purchase of a new truck for fiscal year 2021-2022, which was ordered back in July 2021. Due to the supply-chain issues, this truck is not scheduled for delivery until December 2022. The department has been struggling with deficiencies in the current fleet of trucks and started exploring options to mitigate the problems and continue to provide the needed service for the residents of San Luis.

RWC International in conjunction with Spartan Truck Company offered the city the option of the Dennis Eagle truck with the Spartan Side Loader system and is committed to fulfilling the purchase of this truck before the end of the ongoing fiscal year.

MOTION: Council Member Matias Rosales/Council Member Gloria Torres to ratify Purchase Order No. 2022-00003785 in the amount of $409,311.87 for the purchase of a new solid waste-side loader truck from RWC International, LTD and authorize the transfer of budget auhtority as stated in the fiscal statement of this item. Motion passed unanimously.

The vote was as follows:

Vice Mayor Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

6. D. Discussion and possible action on any and all matters regarding Council ratification of an emergency contract with Desert Excavating Inc. to lower and relocate water lines on north 4th Avenue. (Eulogio Vera, Director of Public Works)

Mr. Jorge Perez, Assistant Director of Public Works, stated that this item is for ratification for an emergency contract with Desert Excavating Inc. for the lowering and relocate of a waterline for the project on 4th Avenue. Due to the emergency nature of the water line lowering and reconfiguration (needed to mitigate adverse impact to the schedule and cost of the ongoing contract for realignment of north 4th Avenue), the Public Works Department could not wait for Council approval to proceed with the water line lowering and reconfiguration. Consequently, on April 28, 2022, the Department pursued and obtained the concurrence of the City Manager to proceed with the execution of a contract with Desert Excavating Inc., under the provisions of City Code 3.05.060 for emergency purchase actions. The contract between the City of San Luis and Desert Excavating Inc. was signed/executed on April 28, 2022. Council ratification of the City Manager's emergency approval is now required.

MOTION: Council Member Matias Rosales/Council Member Africa Luna-Carrasco under the provisions of City Code 3.05.060 to ratify award of an emergency contract in the amount of $112,688.00 to Desert Excavating, Inc. and to waive formal purchasing procedures per City Code 3.05.010 (F) for the good cause presented. Motion passed unanimoulsy.

The vote was as follows:

Vice Mayor Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

6. E. Discussion and possible action on any and all matters regarding the award of a Construction Contract for the East San Luis Community Park County 24th Street Improvements. (Eulogio Vera, Director of Public Works)

Mr. Jorge Perez, Assistant Director of Public Works, explained that the improvements are pertaining to the road at the East San Luis Community Park. Two (2) bids were received for this project and staff recommends awarding to the lowest responsible bidder who is Gutierrez Canales Engineering, PC in the amount of $527,777.37.

MOTION: Council Member Matias Rosales/Council Member Africa Luna-Carrasco to approve the award of a construction contract for the East San Luis Community Park County 24th Street Improvement project to Gutierrez Canales Engineering, PC in the amount of $527,777.37 and authorize the use of funds as stated in the fiscal impact of this item. Motion passed unanimously.

The vote was as follows:

Vice Mayor Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

6. F. Discussion and possible action on any and all matters regarding Order No. 2022-06. An Order of the Mayor and City Council of the City of San Luis, Arizona, implementing American Rescue Plan Act Funds for household assistance through a utility aid program and authorizing and directing the entering into an agreement with Western Arizona Council of Governments ("WACOG") to administer eligibility screening and other administrative services to reduce the negative economic impacts of the COVID-19 public health emergency. (Edgar Esparza, Acting Billing & Collections Manager)

Mr. Edgar Esparza, Acting Billing & Collections Manager, explained that the Billing & Collections Division has been working on establishing a low to moderate-income utility aid program for assistance to households to cope with the lingering negative economic impacts of the COVID-19 public health emergency. The utility aid program will implement a utility aid program created by the federal American Rescue Plan Act (ARPA) and using the city's ARPA fund allocation and the $50,000.00 designated by the city under Order No. 2022-01. Staff looked into the options with local non-profits to administer the eligibility portion of the program and also the possibility of staff administering the entire program. After negotiations, Western Arizona Council of Governments (WACOG) was agreeable to ten percent (10%) or $5,000.00 to administer the eligibility portion of the program. WACOG is a well-recognized non-profit organization that is dedicated to serve low-income households in Yuma County, Mohave, and La Paz. WACOG currently manages similar programs for our neighboring cities of Somerton and Yuma.

He added that under the agreement, WACOG is asking to keep 10% ($5,000.00) of the funding to cover administrative costs while the remaining 90% ($45,000.00) of the funding will go directly to the residents of San Luis in the form of utility assistance. Also, WACOG is going to be responsible for managing and ensuring customer eligibility under ARPA regulations. In order for customers to apply for the program, they will have to be referred by Billing & Collections personnel to WACOG to determine customer's eligibility. Also, eligible residents are going to be able to obtain no more than two (2) vouchers for a total of $250.00 assistance per a twelve-month period. Such vouchers are going to be emailed directly to the Billing & Collections Division. Within fifteen (15) calendar days after the end of each month, WACOG is going to send a check for the amount equal to the aggregate value of the vouchers distributed in the program for the preceding month.

MOTION: Council Member Gloria Torres/Council Member Africa Luna-Carrasco to approve Order No. 2022-06 as presented. Motion passed unanimously.

The vote was as follows:

Vice Mayor Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

6. G. Discussion and possible action on any and all matters regarding Order No. 2022-07. An order of the Mayor and City Council of the City of San Luis, Arizona, authorizing the extension of the public safety first responders emergency pay; repealing any conflicting provisions; and providing for severability. (Lizandro Galaviz, Acting City Manager and Monica Castro, Finance Director)

Mr. Lizandro Galaviz, Acting City Manager, stated that the Mayor and City Council had approved this order and will be ending this fiscal year. Staff is recommending that this order be extended to until the next fiscal year with the option that at any time the Mayor and City Council can end the date.

MOTION: Council Member Matias Rosales/Council Member Africa Luna-Carrasco to approve Order No. 2022-07 as presented. Motion passed unanimously.

The vote was as follows:

Vice Mayor Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

6. H. Discussion and possible action on any and all matters regarding Resolution No. 2218. A resolution of the Mayor and City Council of the City of San Luis, Arizona, approving and adopting the Intergovernmental Agreement between the City of San Luis and Yuma Union High School District (YUHSD) #70 for funds supporting the San Luis Police Department's participation in the School Resource Officer overtime assignment at the San Luis High School. (Richard Jessup, Chief of Police)

Mr. Nigel Reynoso, Police Lieutenant, mentioned that staff is seeking approval for the Intergovernmental Agreement with Yuma Union High School District for the overtime of the School Resource Officer at San Luis High School. This agreement is for a period of three (3) years expiring on June 30, 2025.

MOTION: Council Member Matias Rosales/Council Member Africa Luna-Carrasco to approve Resolution No. 2218 as presented. Motion passed unanimously.

The vote was as follows:

Vice Mayor Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Matias Rosales	Aye
Council Member Gloria Torres	Aye

7. SUMMARY OF CURRENT EVENTS

Council Member Matias Rosales reported that he attended the Innovating Commerce Serving Communities (ICSC) Expo in Las Vegas with other staff members. This Expo was very well attended and added that they had the opporunity to meet with different franchises. On a separate note, he congratulated all the graduates of Class 2022.

8. CALL TO THE PUBLIC

Ms. Selena Guzman, resident, mentioned that she wanted to address the City Council on a permit she had requested regarding a food truck. She was provided with a list of the requirements for the permit. It has now been five (5) months and today she received a call from Mr. Edgar Esparza stating that the permit was rejected and not authorized to get the license due to Mr. Jose Guzman stating that the location where they wanted to set up their food truck does not have a parking lot. She added that she needs more information on how to move forward with this request since she has all the documents on file.

Vice Mayor Mario Buchanan Jr. directed Mr. Lizandro Galaviz, Acting City Manager, to look into matter.

9. ADJOURNMENT

MOTION: Council Member Matias Rosales/Council Member Gloria Torres to adjourn the Regular Council meeting at approximately 7:42 p.m. Motion passed unanimously.

The vote was as follows:

Vice Mayor Mario Buchanan Jr.	Aye
Council Member Africa Luna-Carrasco	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 25, 2022. 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
Work Session
San Luis City Council
San Luis Council Chambers
1090 E. Union Street
June 1, 2022
6:30 p.m.

1. CALL TO ORDER/ROLL CALL

Mayor Gerardo Sanchez called the Work Session to order at approximately 6:31 p.m.

PRESENT: Mayor Gerardo Sanchez
Vice Mayor Africa Luna-Carrasco-joined at 6:38 p.m. via Zoom
Council Member Mario Buchanan Jr.
Council Member Luis Cabrera
Council Member Matias Rosales

ABSENT: Council Member Gloria Torres

OTHERS PRESENT: Lizandro Galaviz, Acting City Manager
Melissa Lopez, Deputy City Clerk
Kay Marion Macuil, City Attorney
Domingo Sosa, Graphics & Media Designer
Edgar Esparza, Acting Billing & Collections Manager
Eulogio Vera, Director of Public Works
Jorge Perez, Assistant Director of Public Works
Jose A. Guzman, Director of Planning & Zoning
Jose L. Cisneros, Executive Assistant
Miguel Ramirez, Accountant II
Monica Castro, Director of Finance
Nigel Reynoso, Police Lieutenant
Ralph Velez, City Consultant
Roula Encinas, Acting Assistant Director of Finance
Cesar Neyoy, Bajo El Sol
Nidya Mendenhall, Resident
Nieves Riedel, Resident

2. ITEMS FOR DISCUSSION ONLY:

2. A. Discussion and possible directions to staff on any and all matters regarding the approval of the Lighting and Retention Basin Assessment Districts Budget for Fiscal Year 2022-2023. (Roula Encinas, Acting Assistant Director of Finance)

Ms. Roula Encinas, Acting Assistant Director of Finance, presented to Mayor and City Council the Lighting and Retention Basin Assessment Districts budget for fiscal year 2022-2023. She explained that the districts are local taxes levied on homeowners to fund the maintenance of the retention basin and the street lighting located within the subdivisions where the improvement

districts were created. She added that the total assessment district budget for fiscal year 2022-2033 is $642,640.00. She informed that the County of Yuma requires City Council's approval to levy the assessments.

Mayor Gerardo Sanchez directed Ms. Encinas to proceed with this item as agreed by all members of the City Council.

2. B. Discussion and possible directions to staff on any and all matters regarding the creation of a time capsule. (Council Member Jose Ponce and Lizandro Galaviz, Acting City Manager)

Council Member Jose Ponce commented that this item was presented to the city manager approximately three (3) years ago, but nothing has been done. He mentioned that he had brought it back for discussion to see if this was something that could be done.

Mayor Gerardo Sanchez commented that his understanding is that there are two (2) time capsules in the city.

Mr. Lizandro Galaviz, Acting City Manager, replied that staff had scheduled to do a 40th Anniversary time capsule, but COVID-19 came on board, and everything was canceled. He commented that the recommendation was to come back with the plan for the 45th Anniversary in 2024. This information was provided to Council Member Jose Ponce, and it was also discussed to bring this before the city council to see if the direction is to do something different. He stated that if council desires to move this up and do it as planned during the 40th Anniversary or wait until the 45th Anniversary.

Vice-Mayor Mario Buchanan Jr. commented that he believes there is a time capsule in the Yuma County Library.

Mr. Galaviz stated that the idea during the 40th Anniversary time capsule was to place it by the flag poles at City Hall, and it would be up to the city council if the time capsule was going to be for 25 years, 40 years, or 100 years.

Council Member Matias Rosales asked if the city ever had a time capsule.

Mr. Galaviz replied that not to his understanding.

Mayor Sanchez also commented that his understanding was that there are two (2) time capsules, one (1) at the Yuma County Library and one (1) in the city, but he did not know where. He asked Mr. Galaviz if research could be done to find out if there is one in the city.

Mr. Galaviz stated that the rumor was that there was one located by the entrance of City Hall, but there is no record of it.

Mayor Sanchez directed Mr. Galaviz to research this.

Mr. Galaviz stated that if there is non, staff recommends doing the 45th Anniversary time capsule but will look into the council's direction.

Council Member Jose Ponce stated that he would like to move forward with this project.

Council Member Luis Cabrera asked how time capsules work.

Mr. Galaviz replied that a time capsule is to encapsulate items with the intent to inform people of what was going on when the time capsule was done.

Mayor Sanchez directed Mr. Galaviz to start the process now and if this can be done by the end of 2022 or at the beginning of 2023.

2. C. Discussion and possible directions to staff on any and all matters regarding benefits for City of San Luis employees. (Council Member Jose Ponce and Lizandro Galaviz, Acting City Manager)

Council Member Jose Ponce mentioned that currently, the city has 25 part-time employees that do not receive employee benefits; they work 20 to 30 hours a week. He commented that the city spends $200,000.00 on city council's salaries/benefits. He added that he feels it is unfair as he believes that city council is not even close to the hours that those employees work. Council Member Ponce presented Mayor and City Council salary samples from different cities/towns in Arizona. He proposed Mayor and City Council cut some of the benefits and show the community that city council does care about them and that council is not here because of the "freebies." He also proposed to utilize the money from the benefits to cover those 25 part-time employees.

Mayor Sanchez asked Mr. Ponce if his proposal is to make those part-time employees full-time.

Council Member Ponce replied that yes, that is his proposal.

Mayor Sanchez asked Council Member Ponce if he thinks that those $200,000.00 will cover the 25 employees to become full-time.

Council Member Ponce responded that the city is spending $200,000.00 from taxpayer money to pay the council, which is not fair.

Mayor Sanchez asked Council Member Ponce if he values his work.

Council Member Ponce replied that he does, but the part-time employees work 30 hours a week.

Mayor Sanchez asked Council Member Ponce if he would like to make those 25 part-time employees a full-time employees.

Council Member Ponce stated that his proposal is to keep the monthly salary, eliminate City Council benefits, and utilize the money for something else.

Council Member Matias Rosales asked Council Member Ponce if he is talking about giving employees the council's benefits.

Council Member Ponce replied that yes, that is his proposal, as most of the council members have a full-time jobs. He added that even though he is the only one (1) without a job, he is willing to give up his benefits as long as money is saved for the community. He suggested making a survey throughout the city on social media and see what the community thinks. He commented that this year is an election year, which is an excellent way to show people that the council is here to help the community and not to get "freebies."

Council Member Rosales asked what "freebies" he was referring to and informed that sometimes he spends over 30 hours for the city and that there is no "freebie." He asked Council Member Ponce if he would like to donate his pay and benefits. He is more than welcome to do that.

Council Member Africa Luna-Carrasco thanked Council Member Ponce for bringing this item for discussion as it is a great idea, and she supports him. She added that she did not realize that the city spends over $200,000.00 on council's benefits. She agreed with Council Member Rosales that many hours are put up, but it is also the council's civic duty.

Council Member Ponce commented that to pay the mayor and council, they must go through the voters insome cities.

Mayor Gerardo Sanchez agreed with Council Member Ponce and stated that one of them is the City of Yuma, but they are a charter city, while the City of San Luis is not a charter city.

Council Member Luna-Carrasco stated that, especially after the budget session, the director of finance stated that budgeted cuts were needed. She added that this would be a good area to make a cut. She mentioned that that amount of money is not feasible to make all those 25 employees full-time, but maybe five (5) or ten (10) would be a start.

Council Member Luis Cabrera stated that he agrees with Council Member Ponce and Council Member Rosales. He mentioned that his understanding is that the city pays over $7,000 for health insurance. He stated that in those 25 positions, some are temporary positions, like the lifeguards. He asked what canthe city do with a lifeguard do in December? He agreed that it is a good way to save the city money. He added that this could be brought up when Council Member Gloria Torres is present.

Council Member Matias Rosales stated that his understanding of the $200,000.00 is not only the health insurance and salaries but also travel budget. He added that the council approved the benefits sometime ago, and it was approved, and some of the current council members were present when this was approved. He mentioned that it is Council Member Ponce's choice; if he feels he needs to give up his benefits, he is more than welcome to do so. He agreed with Council Member Cabrera, as full-time jobs cannot be given to all part-time employees. The department head submits their budget requests as they need them for the positions, and if they request part-time employees, then that is their choice.

Council Member Jose Ponce stated that this is his recommendation and commented that the council could also ask the Finance Department to provide a breakdown of how much would be saved.

Council Member Rosales replied that the information is in the budget book provided by the Finance Department.

3. ADJOURNMENT

MOTION: Vice-Mayor Mario Buchanan Jr./Council Member Luis Cabrera to adjourn the meeting at approximately 6:38 p.m. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Africa Luna-Carrasco	Aye
Council Member Mario Buchanan Jr.	Aye
Council Member Luis Cabrera	Aye
Council Member Matias Rosales	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 Work Session minutes for the City Council of the City of San Luis, Arizona, held on June 1, 2022. 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
Regular Council Meeting
San Luis City Council
San Luis Council Chambers
1090 E. Union Street
June 8, 2022
7:00 p.m.

1. CALL TO ORDER/ROLL CALL

Mayor Gerardo Sanchez called the Regular City Council meeting to order at approximately 7:01 p.m.

PRESENT: Mayor Gerardo Sanchez
Vice Mayor Mario Buchanan Jr.
Council Member Luis Cabrera
Council Africa Luna-Carrasco
Council Member Jose Ponce
Council Member Matias Rosales

ABSENT: Council Member Gloria Torres

OTHERS PRESENT: Lizandro Galaviz, Acting City Manager
Kay Macuil, City Attorney
Sonia Cornelio, City Clerk
Adela Cortez, Human Resources Director
Crystal Ochoa, Acting Assistant to Council/PIO
Domingo Sosa, Graphics and Media Specialist
Edgar Esparza, Acting Billing and Collections Manager
Eulogio Vera, Director of Public Works
Fernando Corona, I.T. Specialist – Public Safety
Fernando Villegas, Principal Planner
Francia Alonso, Records Management Specialist
Jenny Torres, Economic Development Manager
Jonathan Dumadag, Systems Administrator
Jorge Perez, Assistant Director of Public Works
Jose Guzman, Director of Planning & Zoning
Jose Luis Cisneros, Executive Assistant
Marco Santana, Police Lieutenant
Maria A. Roldan, Acting Parks & Recreation Director
Melissa Lopez, Deputy City Clerk
Miguel Ramirez, Accountant II
Monica Castro, Director of Finance
Ralph Velez, Consultant
Roula Encinas, Accountant II
Rogelio Martinez, Administrative Coordinator
Ruben Lopez, I.T. Techinician
Yolanda Dueñas, Facilities Supervisor

Christian Cuevas, Simultanous Translator
Cesar Neyoy, Reporter
Lucy Lopez, Reporter
Maria Robles, Resident
Marco Ramirez, Rotary Club Secretary

2. PLEDGE OF ALLEGIANCE

Vice Mayor Mario Buchanan Jr. led the Pledge of Allegiance.

3. INVOCATION

Mr. Marco Santana, Police Lieutenant, led the invocation.

4. PROCLAMATIONS

4. A. - Elder Abuse Awareness Day - June 15th, 2022

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

Mayor Gerardo Sanchez mentioned it is important that one takes awareness everyday to understand the abuse and neglect of older persons.

4. B. - Waste & Recycling Workers Week - June 17 to 23, 2022

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

Mayor Gerardo Sanchez thanked the men and women who work daily to keep the neighborhoods and streets safe and clean.

4. C. - Juneteenth Day - June 19, 2022

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

Mayor Gerardo Sanchez mentioned that this is the first time this proclamation is placed on the agenda and added that one should not forget our past as it is part of one's history.

4. D. - LGBTQ Pride Month - June 2022

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

Mayor Gerardo Sanchez expressed that everyone is special and one's sexual preference does not make a person different adding that this month is to reflect on the work needed to increase awareness and establish support for the LGBTQ community.

4. E. - Posttraumatic Stress Disorder Month - June 2022

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

Mayor Gerardo Sanchez stated that PTSD affects many people, adding that this month is dedicated to raising awareness about the condition.

Mayor Gerardo Sanchez mentioned that before continuing to the next item on the agenda, he wanted to recognize a special person, Ms. Adela Cortez, Human Resources Director, who recently joined the City of San Luis.

5. CONSENT AGENDA

5. A. Disbursements from May 17, 2022 to May 31, 2022
Total Disbursements $1,072,820.72
(One Million, Seventy-Two Thousand, Eight Hundred, Twenty Dollars and Seventy-Two Cents)

5. B. Discussion and possible action on any and all matters regarding the approval of the Lighting and Retention Basin Assessment Districts Budget for Fiscal Year 2022-2023. (**Roula Encinas, Acting Assistant)**

MOTION: Council Member Luis Cabrera/Council Member Jose Ponce to approve the Consent Agenda as presented. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Mario Buchanan Jr.	Aye
Council Member Luis Cabrera	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye

6. DISCUSSION AND POSSIBLE ACTION ITEMS:

6. A. Discussion and possible action on any and all matters regarding the acceptance and approval of the Tentative Budget for Fiscal Year 2022-2023. (Monica Castro, Director of Finance)

Ms. Monica Castro, Director of Finance, presented a short PDF presentation filed with the complete agenda packet filed at the City Clerk's Office. She spoke about the Tentative Budget and added the requirements for the adoption of it. The proposed Tentative Budget is $110,670,742.00. She added that more projects will be completed next year due to the federal ARPA funds obtained from the governments and some reserves were accumulated due to the COVID-19 pandemic. The public can also access the budget books online for further details on the projects.

MOTION: Council Member Luis Cabrera/Vice Mayor Mario Buchanan Jr. to approve the Tentative Budget for the Fiscal Year 2022-2023 as presented. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Mario Buchanan Jr.	Aye
Council Member Luis Cabrera	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye

6. B. Discussion and possible action on any and all matters regarding a Memorandum of Understanding between the City of San Luis and Yuma Metropolitan Planning Organization for the funding of the circulation, parking, and origin and destination study. (Jenny Torres, Economic Development Manager)

Ms. Jenny Torres, Economic Development Manager, indicated that in October 2021, staff contracted Kimley Horn to develop a circulation study, parking study and origin and destination study. During this time, Yuma Metropolitan Planning Organization (YMPO) had committed to providing the City of San Luis $35,000.00 for the origin and destination study and they thought the city was going to contribute $75,000.00. The Memorandum of Understaning specifies that they will provide the City of San Luis the $110,000.00.

MOTION: Council Member Africa Luna Carrasco/Council Member Luis Cabrera to approve the Memorandum of Understanding between the City of San Luis and YMPO and approve fiscal impact as presented in this agenda item. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Mario Buchanan Jr.	Aye
Council Member Luis Cabrera	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye

6. C. Discussion and possible action on any and all matters regarding the replacement of the Ingraham Lateral Pipe Culvert at County 21st Street. (Eulogio Vera, Director of Public Works)

Mr. Eulogio Vera, Director of Public Works, stated that this is a non budget expenditure for an emergency culvert that was leaking for one of the canals that Yuma County Water Users' Association (YCWUA) maintains.

The estimated cost is $63,450.78, the city will be paying half of the cost and Yuma County will pay the other half. YCWUA went ahead and prepared a cost estimate for them doing the work (as that is the only option given to the city and county) and was split into an expense for the City of San Luis and expense for Yuma County Public Works. This project will be completed by the YCWUA and they will invoice both the City of San Luis and Yuma County Public Works.

MOTION: Council Member Luis Cabrera/Council Member Jose Ponce to approve the payment to Yuma County Water Users Association in the amount of $34,155.39 for the improvements of the Ingraham pipe at County 21st Street, waive formal procurement code and authorizethe use of the funds as described in the fiscal impact statement of this item. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Mario Buchanan Jr.	Aye
Council Member Luis Cabrera	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye

6. D. Public hearing followed by discussion and possible action on any and all matters regarding the recommendation of a Special Event Liquor License Application to the Arizona Department of Liquor Licenses and Control to authorize the San Luis FRONTERA Rotary Club to sell alcohol at the 4th of July Celebration to be held July 4, 2022. (Maria A. Roldan, Acting Director of Parks and Recreation)

A. Open Public Hearing

MOTION: Vice Mayor Mario Buchanan Jr./Council Member Jose Ponce to open the Public Hearing. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Mario Buchanan Jr.	Aye
Council Member Luis Cabrera	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye

1. Presentation by staff and/or applicant

Mr. Marco Ramirez, Rotary Club Secretary, stated that their application is for the 4th of July festivities and are ready for the event.

2. Call to the public on this item

There were no comments from the public on this item.

B. Close Public Hearing

MOTION: Vice Mayor Mario Buchanan Jr./Council Member Luis Cabrera to close the Public Hearing. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Mario Buchanan Jr.	Aye
Council Member Luis Cabrera	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye

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

MOTION: Council Member Luis Cabrera/Vice Mayor Mario Buchanan Jr. to recommend approval to the Arizona Department of Liquor Licenses as presented. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Mario Buchanan Jr.	Aye
Council Member Luis Cabrera	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye

6. E. Discussion and possible action on any and all matters regarding Resolution No. 2219. A resolution of the City of San Luis, Arizona Mayor and Common Council, designating the Chief Fiscal Officer for officially submitting the fiscal year 2022- 2023 expenditure limitation report to the Arizona Auditor General. (Lizandro Galaviz, Acting City Manager)

Mr. Lizandro Galaviz, Acting City Manager, mentioned that this is the annual designation the city is required by resolution to designate the Chief Fiscal Officer (CFO) to the Arizona Auditor General. Staff is requesting that Ms. Monica Castro, Director of Finance, be designated as the CFO.

MOTION: Council Member Africa Luna-Carrasco/Council Member Luis Cabrera to approve Resolution No. 2219 designating Monica Castro as the CFO to submit the annual expenditure report to the Auditor General as presented. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Mario Buchanan Jr.	Aye
Council Member Luis Cabrera	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye

6. F. Public Hearing followed by discussion and possible action on any and all matters regarding Rezoning Case No. 2022-0190 and Ordinance No. 426. 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 20 acres from Light Industrial (LI) to Medium Density Residential (R1-6) for property located on the northeast corner of 20th Avenue alignment and County 24-1/2 Street in San Luis, Arizona. (Fernando Villegas, Principal Planner)

A. Open Public Hearing

MOTION: Vice Mayor Mario Buchanan Jr./Council Member Luis Cabrera to open the Public Hearing. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Mario Buchanan Jr.	Aye
Council Member Luis Cabrera	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye

1. Staff presentation

Mr. Fernando Villegas, Principal Planner, explained that the applicant is requesting to rezone 20 acres from Light Industrial to Medium Density Residential for the construction of a residential subdivision consisting of 87 lots. As part of the review process, staff held a Citizens Review meeting with no opposition. This was also presented to the Planing & Zoning Commission and they recommend approval with the following conditions:

1. The owner/applicant shall submit a preliminary plat application in compliance with the City of San Luis subdivision regulations.

2. 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.

3. Owner/applicant must provide a road connection along 20th Avenue from the northwest corner of the subdivision to Belleza Del Desierto Phase 2 subdivision.

2. Call to the public on this item

There were no comments from the public on this item.

B. Close Public Hearing

MOTION: Vice Mayor Mario Buchanan Jr./Council Member Luis Cabrera to close the Public Hearing. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Mario Buchanan Jr.	Aye
Council Member Luis Cabrera	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye

C. Action on Ordinance No. 426

MOTION: Council Member Luis Cabrera/Council Member Africa Luna-Carrasco to approve the reading of Ordinance No. 426 by title only. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Mario Buchanan Jr.	Aye
Council Member Luis Cabrera	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye

Mrs. Sonia Cornelio, City Clerk, read Ordinance No. 426 by title only.

MOTION: Council Member Matias Rosales/Vice Mayor Mario Buchanan Jr. to approve and adopt Ordinance No. 426. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Mario Buchanan Jr.	Aye
Council Member Luis Cabrera	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	Aye

7. SUMMARY OF CURRENT EVENTS

Mayor Gerardo Sanchez reported that today was the ground breaking for Fire Station No. 2. This project has been planned since four (4) years ago; it is a $1.4 million investment and hopefully it will be completed by May 2023. He clarified that the City of San Luis residents do not pay property taxes to the city rather property taxes are paid to the county. He clarified that property tax money was not used to pay for this fire station rather sales tax money. Residents pay property taxes for the county's court house and library and not for streets. He added that it is about working together for the City of San Luis.

Council Member Luis Cabrera reported that he attended the Innovating Commerce Serving Communities (ICSC) Expo in Las Vegas and advocate for the businesses. Citizens ask themselves why doesn't the city bring other major businesses but it is not up to the City Council, they do not come because the city does not meet the criteria such as population.

Council Member Matias Rosales mentioned that the way he sees it, it took four (4) years to bring in Denny's, eight (8) years for a Starbucks and will take another eight (8) years to bring another major business. Staff will continue to promote the city at events like these and hopefully attract more businesses.

Mayor Gerardo Sanchez said that it takes years to bring a business, therefore just because one says it or posts it does not mean it is going to happen. For example, the Port of Entry I took almost nine (9) years to complete, the Port of Entry II has been worked on for four (4) years; there is an investment of time, staff and effort and Ports of Entry do not open because of a person or a Mayor says it is going to open. It requires an act from Congress and it is difficult for everyone to agree.

8. CALL TO THE PUBLIC

There were no comments from the public.

9. ADJOURNMENT

MOTION: Vice Mayor Mario Buchanan Jr./Council Member Africa Luna-Carrasco to adjourn the Regular Council meeting at approximately 7:51 p.m. Motion passed unanimously.

The vote was as follows:

Mayor Gerardo Sanchez	Aye
Vice Mayor Mario Buchanan Jr.	Aye
Council Member Luis Cabrera	Aye
Council Member Africa Luna-Carrasco	Aye
Council Member Jose Ponce	Aye
Council Member Matias Rosales	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 June 8, 2022. I further certify that the meeting was duly called and held and that a quorum was present.

_____
Sonia Cornelio, City Clerk

AGENDA ITEM REVIEW FORM

Regular City Council Meeting **4. B.**

Meeting Date: 06/22/2022

Summary

Disbursements from June 1, 2022 to June 13, 2022
Total Disbursements $691,334.85
(Six Hundred Ninety-One Thousand, Three Hundred Thirty-Four Dollars and Eighty-Five Cents)

Attachments

Disbursements

City of San Luis
Finance Department

COUNCIL MEETING JUNE 22, 2022
Disbursement Report from 06/01/2022 TO 06/13/2022

Bank Accounts	Check Date	Amount	Schedule
Accounts Payable Check Account	06/02/2022	$ 74,783.71	Schedule A
Payroll Check Account	06/02/2022	$ 4,663.03	Schedule B
Payroll Check Account	06/08/2022	$ 398,433.23	Schedule C
Accounts Payable Check Account	06/09/2022	$ 213,454.88	Schedule D
	Total Disbursements:	**$ 691,334.85**	

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

Prepared by David A. Espitia: David Espitia

Verified by Director of Finance: _____

For Council approval on: _____

Mayor: _____

Council: _____

_____

_____

_____

_____

_____

RECEIVED
2022 JUN 13 A 11:43
CITY OF SAN LUIS
OFFICE OF THE CITY CLERK

City of San Luis

Payment Register

From Payment Date: 5/31/2022 - To Payment Date: 6/2/2022

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source	Payee Name	Transaction Amount	Reconciled Amount	Difference
1BYPAYABLE - 1st BY Accounts Payable									
Check									
102263	05/31/2022	Open			Accounts Payable	MANN, MARY , JO	$1,500.00		
102264	06/02/2022	Open			Accounts Payable	AIRGAS USA LLC	$420.51		
102265	06/02/2022	Open			Accounts Payable	ALLUVIAL MEDIA LLC	$699.00		
102266	06/02/2022	Open			Accounts Payable	ANGEL'S TOWING SERVICE/AUTO SALES	$375.00		
102267	06/02/2022	Open			Accounts Payable	ARIZONA PUBLIC SERVICE	$40.36		
102268	06/02/2022	Open			Accounts Payable	CASTRO, MONICA	$193.00		
102269	06/02/2022	Open			Accounts Payable	CENTURYLINK	$422.32		
102270	06/02/2022	Open			Accounts Payable	CHAPMAN DCJR YUMA LLC	$197.31		
102271	06/02/2022	Open			Accounts Payable	CORRAL, RICARDO	$130.00		
102272	06/02/2022	Open			Accounts Payable	DELL MARKETING L.P.	$308.01		
102273	06/02/2022	Open			Accounts Payable	EMPIRE MACHINERY	$485.01		
102274	06/02/2022	Open			Accounts Payable	FREIGHTLINER OF ARIZONA, LLC	$326.40		
102275	06/02/2022	Open			Accounts Payable	GALLS, AN ARAMARK CO., LLC	$3,116.52		
102276	06/02/2022	Open			Accounts Payable	IMLA	$775.00		
102277	06/02/2022	Open			Accounts Payable	IPS GROUP INC	$513.01		
102278	06/02/2022	Open			Accounts Payable	ITURBIDE, VANESSA, C	$75.00		
102279	06/02/2022	Open			Accounts Payable	JOUANNE DE ENCINAS, ROULA	$193.00		
102280	06/02/2022	Open			Accounts Payable	KONICA MINOLTA BUSINESS SOLUTIONS USA INC	$95.54		
102281	06/02/2022	Open			Accounts Payable	LOPEZ, MIGUEL	$150.00		
102282	06/02/2022	Open			Accounts Payable	NAVARRETE PAINTING LLC	$6,560.00		
102283	06/02/2022	Open			Accounts Payable	O'REILLY AUTO PARTS	$43.23		
102284	06/02/2022	Open			Accounts Payable	OFFICE DEPOT	$1,696.52		
102285	06/02/2022	Open			Accounts Payable	PIERCE COLEMAN PLLC	$12,000.00		
102286	06/02/2022	Open			Accounts Payable	PITNEY BOWES GLOBAL FINANCIAL SERVICES LLC	$714.54		
102287	06/02/2022	Open			Accounts Payable	POLICIA INTERNACIONAL SONORA ARIZONA INC.	$500.00		
102288	06/02/2022	Open			Accounts Payable	QUINONEZ, FRANCISCO	$375.00		
102289	06/02/2022	Open			Accounts Payable	RAMIREZ, MIGUEL	$193.00		
102290	06/02/2022	Open			Accounts Payable	SAFE KIDS WORLDWIDE	$190.00		
102291	06/02/2022	Open			Accounts Payable	SAN LUIS WALK IN CLINIC, INC	$57.50		
102292	06/02/2022	Open			Accounts Payable	THE HOME DEPOT	$145.55		
102293	06/02/2022	Open			Accounts Payable	W.W.GRAINGER, INC	$21.34		
102294	06/02/2022	Open			Accounts Payable	YUMA WINLECTRIC CO.	$465.13		
102295	06/02/2022	Open			Accounts Payable	VALLEY COLLECTION SERVICE, LLC	$46.13		
102296	06/02/2022	Open			Accounts Payable	ARIZONA AUTOMOTIVE EQUIPMENT LLC	$1,456.00		
Type Check Totals:					34 Transactions		$34,478.93		
EFT									
1454	06/02/2022	Open			Accounts Payable	4 IMPRINT	$7,853.32		
1455	06/02/2022	Open			Accounts Payable	ALSCO, INC	$166.98		
1456	06/02/2022	Open			Accounts Payable	AMAZON.COM SALES, INC.	$85.26		
1457	06/02/2022	Open			Accounts Payable	ARIZONA MUNICIPAL RISK RETENTION POOL P&C	$1,675.00		
1458	06/02/2022	Open			Accounts Payable	BILL ALEXANDER FORD	$654.36		
1459	06/02/2022	Open			Accounts Payable	BTE BODY COMPANY INC	$2,100.67		

Schedule A

City of San Luis

Payment Register

From Payment Date: 5/31/2022 - To Payment Date: 6/2/2022

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source	Payee Name	Transaction Amount	Reconciled Amount	Difference
1460	06/02/2022	Open			Accounts Payable	CSC OF YUMA	$1,458.50		
1461	06/02/2022	Open			Accounts Payable	CUEVAS, CHRISTIAN	$75.00		
1462	06/02/2022	Open			Accounts Payable	DESERT VALLEY SERVICES, INC	$79.52		
1463	06/02/2022	Open			Accounts Payable	DESERT WATER STORE INC	$63.08		
1464	06/02/2022	Open			Accounts Payable	DICKINSON WRIGHT PLLC	$350.00		
1465	06/02/2022	Open			Accounts Payable	FRESH TERRA SERVICES LLC	$125.00		
1466	06/02/2022	Open			Accounts Payable	HILL BROTHERS CHEMICAL CO.	$6,923.25		
1467	06/02/2022	Open			Accounts Payable	PURCHASE POWER	$1,020.99		
1468	06/02/2022	Open			Accounts Payable	RAMIREZ ADVISORS INTER-NATIONAL,LLC	$4,583.33		
1469	06/02/2022	Open			Accounts Payable	RDO EQUIPMENT CO.	$884.19		
1470	06/02/2022	Open			Accounts Payable	REAL PURIFIED WATER LLC	$68.82		
1471	06/02/2022	Open			Accounts Payable	RM GRAPHICS	$100.00		
1472	06/02/2022	Open			Accounts Payable	SAM'S CLUB	$4,379.02		
1473	06/02/2022	Open			Accounts Payable	SOUTHERN TIRE MART LLC	$1,329.90		
1474	06/02/2022	Open			Accounts Payable	SPECTRUM BUSINESS	$720.00		
1475	06/02/2022	Open			Accounts Payable	TORRES, ALEJANDRA , S	$555.54		
1476	06/02/2022	Open			Accounts Payable	VAPEX ENVIRONMENTAL TECHNOLOGIES, LLC	$388.39		
1477	06/02/2022	Open			Accounts Payable	WAXIE SANITARY SUPPLY	$262.17		
1478	06/02/2022	Open			Accounts Payable	YUMA CO. AIRPORT AUTHORITY INC	$167.79		
1479	06/02/2022	Open			Accounts Payable	YUMA FARM & HOME SUPPLY INC.	$935.25		
1480	06/02/2022	Open			Accounts Payable	YUMA SUN INC	$830.69		
1481	06/02/2022	Open			Accounts Payable	YUMA TRUCK PARTS	$1,092.38		
1482	06/02/2022	Open			Accounts Payable	YUMA WINNELSON CO.	$817.11		
1483	06/02/2022	Open			Accounts Payable	ZOLL MEDICAL CORP	$559.27		
Type EFT Totals:					30 Transactions		$40,304.78		

1BYPAYABLE - 1st BY Accounts Payable Totals

Checks	Status	Count	Transaction Amount	Reconciled Amount
	Open	34	$34,478.93	$0.00

City of San Luis

Payment Register

From Payment Date: 5/31/2022 - To Payment Date: 6/2/2022

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source		Payee Name	Transaction Amount	Reconciled Amount	Difference
					Reconciled	0	$0.00		$0.00	
					Voided	0	$0.00		$0.00	
					Stopped	0	$0.00		$0.00	
					Total	34	$34,478.93		$0.00	
					EFTs	Status	Count	Transaction Amount	Reconciled Amount	
						Open	30	$40,304.78	$0.00	
						Reconciled	0	$0.00	$0.00	
						Voided	0	$0.00	$0.00	
						Total	30	$40,304.78	$0.00	
					All	Status	Count	Transaction Amount	Reconciled Amount	
						Open	64	$74,783.71	$0.00	
						Reconciled	0	$0.00	$0.00	
						Voided	0	$0.00	$0.00	
						Stopped	0	$0.00	$0.00	
						Total	64	$74,783.71	$0.00	

Grand Totals:

Checks	**Status**	**Count**	**Transaction Amount**	**Reconciled Amount**
	Open	**34**	**$34,478.93**	**$0.00**
	Reconciled	**0**	**$0.00**	**$0.00**
	Voided	**0**	**$0.00**	**$0.00**
	Stopped	**0**	**$0.00**	**$0.00**
	Total	**34**	**$34,478.93**	**$0.00**
EFTs	**Status**	**Count**	**Transaction Amount**	**Reconciled Amount**
	Open	**30**	**$40,304.78**	**$0.00**
	Reconciled	**0**	**$0.00**	**$0.00**
	Voided	**0**	**$0.00**	**$0.00**
	Total	**30**	**$40,304.78**	**$0.00**
All	**Status**	**Count**	**Transaction Amount**	**Reconciled Amount**
	Open	**64**	**$74,783.71**	**$0.00**
	Reconciled	**0**	**$0.00**	**$0.00**
	Voided	**0**	**$0.00**	**$0.00**
	Stopped	**0**	**$0.00**	**$0.00**
	Total	**64**	**$74,783.71**	**$0.00**

David Espitia

Digitally signed by: David Espitia
DN: CN = David Espitia email = despitia@sanluisaz.gov C = AD O = City of San Luis OU = Finance
Date: 2022.06.02 17:36:48 -07'00'

Pay Day Register

Pay Date Range 06/01/22 - 06/30/22
Pay Batch 202206M

Pay Batch 202206M Total

Employees in Pay Batch 7
Female Employees in Pay Batch 2

Hours Description	Hours	Gross
102 - SALARY	.0000	7,550.00
806 - TELEPHONE STIPEND	.0000	150.00
Total	0.0000	$7,700.00

Withholdings and Deductions		Gross Base
Gross	7,700.00	
Imputed Income		
FEDERAL TAX WITHHOLDING	58.75	5,656.97
SOCIAL SECURITY TAX	477.41	7,700.00
MEDICARE	111.67	7,700.00
STATE WITHHOLDING	118.29	5,656.97
ASRS Council	109.98	900.00
ASRS LTD Council	1.71	900.00
Council Retirement EORP	419.50	4,450.00
Dental Council	174.38	.00
EODCRS - COUNCIL	176.00	2,200.00
EODCRS - DISABILITY	2.76	2,200.00
GARNISHMENT	221.11	.00
Medical Council	1,108.53	.00
MISCELLANEOUS	5.00	.00
Vision Council	51.88	.00
Net	$4,663.03	

Benefits		Gross Base
ASRS Council	109.98	900.00
ASRS LTD Council	1.71	900.00
ASRS/EORP - LEGACY RATE	442.89	900.00
Dental Council	244.85	.00
EODCRS - COUNCIL	132.00	2,200.00
EODCRS - DISABILITY	2.76	2,200.00
EODCRS/EORP LEGACY RATE	1,219.46	2,200.00
Health Council	5,593.67	.00
Retirement Council EORP	2,733.64	4,450.00
Vision Council	79.03	.00
Total	$10,559.99	

Workers' Comp		Gross Base
MUNICIPAL/ TOWN/	134.77	7,700.00
Total	$134.77	

Direct Deposits	Amount
1st Bank Yuma	734.11
Chase Bank	1,068.42
Federal Credit Union	1,087.99
Navy Federal	523.36
REALTORS FED CRED UNION	22.52
WASHINGTON FEDERAL	797.17
Wells Fargo	429.46
Total	$4,663.03

Check $0.00

71520fd3-6a42-489c-8186-a0ff5b636259

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Date: 2022.06.02 14:28:17 -07'00'

Schedule

Pay Day Register

Pay Date Range 05/21/22 - 06/03/22

Pay Batch 202212

PSPRS FIRE DC RATE - TIER 3	258.08	2,867.52
PSPRS FIRE DISABILITY RATE	25.23	2,867.52
PSPRS POLICE DB RATE - TIER	4,005.15	52,354.92
PSPRS POLICE DB RATE - TIER	2,500.81	21,466.11
PSPRS POLICE DB RATE - TIER 2	1,309.52	11,240.46
PSPRS POLICE DB RATE - TIER 3	4,341.79	43,680.08
STANDARD LIFE ADDTNL	1,031.38	.00
TRANSWESTERN MEXICAN	97.00	.00
U.S. MEX DENTAL - EE &	595.37	.00
U.S. MEX DENTAL - EE &	164.24	.00
UNITED WAY	14.00	.00
US & MEX DENTAL= FAMILY	614.88	.00
US & MEX HEALTH = C	6,120.62	.00
US & MEX HEALTH = FAMILY	6,532.20	.00
US & MEX HEALTH = SP	1,423.40	.00
VSP - VISION CHILDREN	253.11	.00
VSP - VISION FAMILY	363.44	.00
VSP - VISION SPOUSE	97.35	.00
Net	$398,433.23	

FIREFIGHTERS & DRIVERS	6,215.10	130,843.57
GARBAGE/ ASH/ REFUSE	376.09	6,017.47
Homemaker Service	14.17	618.78
MUNICIPAL/ TOWN/	331.70	18,955.26
PARKS- NOC ALL EMPLOYEES	691.05	22,291.86
POLICE OFFICERS	6,268.43	131,966.84
RECREATION- ALL EMPLOYEES/	226.10	16,504.50
SEWAGE DISPOSAL/ PLANT	761.57	22,138.50
Street or Road Construction	1,724.98	19,535.45
WATERWORKS OPERATIONS	564.92	16,279.97
Total	$19,374.94	

Direct Deposits	Amount
1st Bank Yuma	30,609.34
ACADEMY BANK	2,302.61
Bank of America	200.00
Bankcorp	200.00
Charles Sch	200.00
Chase Bank	191,393.68
CHASE BANK MORGAN	816.93
chase centro	1,153.71
Federal Credit Union	44,367.25
FF CREDIT UNION	3,536.75
FIREFIGHTER FIRST CREDIT UNION	5,615.12
MIT FEDERAL CREDIT UNION	441.17
National Bank	1,956.50
Navy Federal	19,365.33
NetSpend Corporation DD	120.00
NORTH ISLAND CREDIT UNION	701.91
Sunbank	1,561.64
THE FOOTHILLS BANK	804.84
VANTAGE WEST	1,370.21
WASHINGTON FEDERAL	992.53
Wells Fargo	85,521.32
WELLS FARGO CALE	1,079.08
Total	$394,309.92
Check	$4,123.31

Monica Castro

Digitally signed by: Monica Castro
DN: CN = Monica Castro email = mcastro@sanluisaz.gov C = AD
Date: 2022.06.08 12:54:46 -07'00'

Schedule C

City of San Luis

Payment Register

From Payment Date: 6/6/2022 - To Payment Date: 6/9/2022

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source	Payee Name	Transaction Amount	Reconciled Amount	Difference
1BYPAYABLE - 1st BY Accounts Payable									
Check									
102297	06/07/2022	Open			Accounts Payable	SECRETARY OF STATE	$25.00		
102298	06/07/2022	Open			Accounts Payable	SECRETARY OF STATE	$43.00		
102299	06/08/2022	Open			Accounts Payable	ARIZONA STATE RETIREMENT SYSTEM	$132.88		
102300	06/08/2022	Open			Accounts Payable	BASS & ASSOCIATES P.C.	$100.00		
102301	06/08/2022	Open			Accounts Payable	FOP/ALC	$420.00		
102302	06/08/2022	Open			Accounts Payable	GARCIA & CORNEJO, SERGIO & OSCAR	$311.10		
102303	06/08/2022	Open			Accounts Payable	INTERNAL REVENUE SERVICE	$221.11		
102304	06/08/2022	Open			Accounts Payable	SAN LUIS POLICE OFFICERS ASSOC	$330.00		
102305	06/08/2022	Open			Accounts Payable	SUPPORT PAYMENT CLEARINGHOUSE	$3,245.79		
102306	06/08/2022	Open			Accounts Payable	UNITED WAY OF YUMA COUNTY INC.	$14.00		
102307	06/08/2022	Open			Accounts Payable	UNITED YUMA FIRE FIGHTERS ASSOC	$88.50		
102308	06/08/2022	Open			Accounts Payable	UNITED YUMA FIRE FIGHTERS-IAFF	$1,050.00		
102309	06/09/2022	Open			Accounts Payable	AMERICAN FIDELITY ASSURANCE CO	$2,583.58		
102310	06/09/2022	Open			Accounts Payable	AMERICAN FIDELITY ASSURANCE CO	$40.00		
102311	06/09/2022	Open			Accounts Payable	ANGEL'S TOWING SERVICE/AUTO SALES	$150.00		
102312	06/09/2022	Open			Accounts Payable	ARIZONA DEPARTMENT OF PUBLIC SAFETY	$12.36		
102313	06/09/2022	Open			Accounts Payable	ARIZONA PROSECUTING ATTORNEY'S ADVISORY COUNCIL	$100.00		
102314	06/09/2022	Open			Accounts Payable	AZ STATE PRISON COMPLEX - YUMA	$89.00		
102315	06/09/2022	Open			Accounts Payable	AZ STATE PRISON COMPLEX - YUMA	$84.00		
102316	06/09/2022	Open			Accounts Payable	BOBADILLA, YADIRA	$360.00		
102317	06/09/2022	Open			Accounts Payable	CHAPMAN DCJR YUMA LLC	$174.77		
102318	06/09/2022	Open			Accounts Payable	COMITE DE BIEN ESTAR INC.	$250.00		
102319	06/09/2022	Open			Accounts Payable	CORRAL, RICARDO	$130.00		
102320	06/09/2022	Open			Accounts Payable	EMAZON, JESUS	$156.00		
102321	06/09/2022	Open			Accounts Payable	ENTERPRISE FM TRUST	$755.68		
102322	06/09/2022	Open			Accounts Payable	FERGUSON WATERWORKS	$8,311.71		
102323	06/09/2022	Open			Accounts Payable	FERRELLGAS, LP	$441.85		
102324	06/09/2022	Open			Accounts Payable	FNP-C & ASSOCIATES PLLC	$90.00		
102325	06/09/2022	Open			Accounts Payable	FUENTES, CARLOS	$1,000.00		
102326	06/09/2022	Open			Accounts Payable	GARCIA, JESUS	$90.00		
102327	06/09/2022	Open			Accounts Payable	HEALTH FIT CLINIC	$30,631.00		
102328	06/09/2022	Open			Accounts Payable	HERNANDEZ, JERRY	$400.00		
102329	06/09/2022	Open			Accounts Payable	IMLA	$900.00		
102330	06/09/2022	Open			Accounts Payable	IRON MOUNTAIN INC	$55.65		
102331	06/09/2022	Open			Accounts Payable	LASTRA, KARLA	$328.49		

Schedule D

City of San Luis

Payment Register

From Payment Date: 6/6/2022 - To Payment Date: 6/9/2022

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source	Payee Name	Transaction Amount	Reconciled Amount	Difference
102332	06/09/2022	Open			Accounts Payable	LAWSON PRODUCTS INC.	$773.32		
102333	06/09/2022	Open			Accounts Payable	LOPEZ, ENRIQUE	$220.00		
102334	06/09/2022	Open			Accounts Payable	LUNA, ENRIQUE	$150.00		
102335	06/09/2022	Open			Accounts Payable	MANHATTANLIFE ASSURANCE CO	$583.08		
102336	06/09/2022	Open			Accounts Payable	MARTINEZ, JOSE ALFREDO	$220.00		
102337	06/09/2022	Open			Accounts Payable	MASSMUTUAL FINANCIAL GROUP	$20.00		
102338	06/09/2022	Open			Accounts Payable	MILLER, DAMIAN	$145.00		
102339	06/09/2022	Open			Accounts Payable	MUELA, CARLOS	$680.00		
102340	06/09/2022	Open			Accounts Payable	MUNOZ, MARIA	$328.00		
102341	06/09/2022	Open			Accounts Payable	NEW BORDER TACTICAL, INC.	$345.00		
102342	06/09/2022	Open			Accounts Payable	O'REILLY AUTO PARTS	$473.67		
102343	06/09/2022	Open			Accounts Payable	OFFICE DEPOT	$952.65		
102344	06/09/2022	Open			Accounts Payable	PREPAID LEGAL SERVICES	$112.60		
102345	06/09/2022	Open			Accounts Payable	QUINONEZ, FRANCISCO	$75.00		
102346	06/09/2022	Open			Accounts Payable	RAMIREZ, FELIPE	$96.00		
102347	06/09/2022	Open			Accounts Payable	RODRIGUEZ, GUSTAVO	$150.00		
102348	06/09/2022	Open			Accounts Payable	RUIZ, OSCAR	$145.00		
102349	06/09/2022	Open			Accounts Payable	RUSH TRUCK CENTER	$2,412.68		
102350	06/09/2022	Open			Accounts Payable	SANDOVAL, MONTSERRAT	$150.00		
102351	06/09/2022	Open			Accounts Payable	STANDARD INSURANCE CO.	$1,811.35		
102352	06/09/2022	Open			Accounts Payable	TEXAS LIFE INSURANCE COMPANY	$588.74		
102353	06/09/2022	Open			Accounts Payable	TORRES, GILBERTO	$200.00		
102354	06/09/2022	Open			Accounts Payable	TRANSWESTERN INSURANCE ADMIN	$194.00		
102355	06/09/2022	Open			Accounts Payable	VALENZUELA, JAIME	$145.00		
102356	06/09/2022	Open			Accounts Payable	VALENZUELA, SERGIO	$200.00		
102357	06/09/2022	Open			Accounts Payable	VISION SERVICE PLAN OF ARIZONA	$4,421.91		
102358	06/09/2022	Open			Accounts Payable	RAMIREZ, TERESITA, D	$132.00		
102359	06/09/2022	Open			Accounts Payable	SANTANA, MARCO	$145.00		
Type Check Totals:					63 Transactions		$68,985.47		
EFT									
1486	06/09/2022	Open			Accounts Payable	ALSCO, INC	$2,619.82		
1487	06/09/2022	Open			Accounts Payable	AMAZON.COM SALES, INC.	$152.46		
1488	06/09/2022	Open			Accounts Payable	ARIZONA EMERGENCY PRODUCTS, INC.	$1,080.06		
1489	06/09/2022	Open			Accounts Payable	BILL ALEXANDER FORD	$187.75		
1490	06/09/2022	Open			Accounts Payable	BLUE STREAK SIGNS, LLC	$693.29		
1491	06/09/2022	Open			Accounts Payable	CDWG	$1,952.98		
1492	06/09/2022	Open			Accounts Payable	CITY OF YUMA	$1,069.24		
1493	06/09/2022	Open			Accounts Payable	DANA KEPNER COMPANY LLC	$3,160.47		
1494	06/09/2022	Open			Accounts Payable	DESERT VALLEY SERVICES, INC	$413.68		
1495	06/09/2022	Open			Accounts Payable	DESERT WATER STORE INC	$146.00		
1496	06/09/2022	Open			Accounts Payable	DESTINY SOFTWARE, INC	$6,200.00		
1497	06/09/2022	Open			Accounts Payable	FRESH TERRA SERVICES LLC	$330.00		
1498	06/09/2022	Open			Accounts Payable	FRUTH GROUP INC	$3,103.18		
1499	06/09/2022	Open			Accounts Payable	HAAKER EQUIPMENT COMPANY	$328.82		
1500	06/09/2022	Open			Accounts Payable	HILL BROTHERS CHEMICAL CO.	$4,153.95		

City of San Luis

Payment Register

From Payment Date: 6/6/2022 - To Payment Date: 6/9/2022

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source	Payee Name	Transaction Amount	Reconciled Amount	Difference
1501	06/09/2022	Open			Accounts Payable	JAMES DAVEY AND ASSOCIATES INC	$2,565.00		
1502	06/09/2022	Open			Accounts Payable	MCNEECE BROS. OIL COMPANY, INC	$55,363.34		
1503	06/09/2022	Open			Accounts Payable	MENDEZ ROBLES, NAZZER, O	$5,225.89		
1504	06/09/2022	Open			Accounts Payable	ORDUNO-CROUSE, CANDICE	$1,400.00		
1505	06/09/2022	Open			Accounts Payable	PLOTTER DOCTORS, LLC	$1,001.19		
1506	06/09/2022	Open			Accounts Payable	PRECISION PROTECTIVE SERVICES LLC	$520.38		
1507	06/09/2022	Open			Accounts Payable	RALPH VELEZ CONSULTING SERVICES	$14,657.25		
1508	06/09/2022	Open			Accounts Payable	REPUBLIC EVS LLC	$138.68		
1509	06/09/2022	Open			Accounts Payable	RM GRAPHICS	$616.81		
1510	06/09/2022	Open			Accounts Payable	ROACH PEST CONTROL	$1,515.00		
1511	06/09/2022	Open			Accounts Payable	SAN LUIS AIR CONDITIONING LLC	$7,250.00		
1512	06/09/2022	Open			Accounts Payable	SOUTHERN TIRE MART LLC	$7,477.06		
1513	06/09/2022	Open			Accounts Payable	THOMSON WEST PUBLISHING CO.	$352.44		
1514	06/09/2022	Open			Accounts Payable	USA BLUE BOOK	$458.11		
1515	06/09/2022	Open			Accounts Payable	YUMA COUNTY TREASURER'S OFFICE	$157.86		
1516	06/09/2022	Open			Accounts Payable	YUMA WINNELSON CO.	$20,178.70		
Type EFT Totals:					31 Transactions		$144,469.41		

1BYPAYABLE - 1st BY Accounts Payable Totals

Checks	Status	Count	Transaction Amount	Reconciled Amount
	Open	63	$68,985.47	$0.00
	Reconciled	0	$0.00	$0.00
	Voided	0	$0.00	$0.00
	Stopped	0	$0.00	$0.00
	Total	63	$68,985.47	$0.00

EFTs	Status	Count	Transaction Amount	Reconciled Amount

City of San Luis

Payment Register

From Payment Date: 6/6/2022 - To Payment Date: 6/9/2022

Number	Date	Status	Void Reason	Reconciled/ Voided Date	Source		Payee Name	Transaction Amount	Reconciled Amount	Difference
					Open	31	$144,469.41		$0.00	
					Reconciled	0	$0.00		$0.00	
					Voided	0	$0.00		$0.00	
					Total	31	$144,469.41		$0.00	

All	Status	Count	Transaction Amount	Reconciled Amount
	Open	94	$213,454.88	$0.00
	Reconciled	0	$0.00	$0.00
	Voided	0	$0.00	$0.00
	Stopped	0	$0.00	$0.00
	Total	94	$213,454.88	$0.00

Grand Totals:

Checks	**Status**	**Count**	**Transaction Amount**	**Reconciled Amount**
	Open	**63**	**$68,985.47**	**$0.00**
	Reconciled	**0**	**$0.00**	**$0.00**
	Voided	**0**	**$0.00**	**$0.00**
	Stopped	**0**	**$0.00**	**$0.00**
	Total	**63**	**$68,985.47**	**$0.00**

EFTs	**Status**	**Count**	**Transaction Amount**	**Reconciled Amount**
	Open	**31**	**$144,469.41**	**$0.00**
	Reconciled	**0**	**$0.00**	**$0.00**
	Voided	**0**	**$0.00**	**$0.00**
	Total	**31**	**$144,469.41**	**$0.00**

All	**Status**	**Count**	**Transaction Amount**	**Reconciled Amount**
	Open	**94**	**$213,454.88**	**$0.00**
	Reconciled	**0**	**$0.00**	**$0.00**
	Voided	**0**	**$0.00**	**$0.00**
	Stopped	**0**	**$0.00**	**$0.00**
	Total	**94**	**$213,454.88**	**$0.00**

David Espitia

Digitally signed by: David Espitia
DN: CN = David Espitia email = despitia@sanluisaz.gov C = AD O = City of San Luis OU = Finance
Date: 2022.06.09 17:11:08 -07'00'

AGENDA ITEM REVIEW FORM

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

Meeting Date: 06/22/2022

Department Head: Maria A Roldan, Acting Director of Parks & Recreation, Parks & Recreation Department

Submitted By: Crystal Ochoa, Administrative Coordinator, Parks & Recreation Department

Action Requested: Motion

ITEM:

Discussion and possible action on any and all matters regarding the approval of the estimate from ULTRA SHOW MAKERS, for sound, stage, and lighting for the 4th of July Celebration and waive formal purchasing procedures as allowed under the City Code-Purchasing § 3.05.010 (C). **(Maria A. Roldan, Acting Director of Parks & Recreation)**

SUMMARY:

The Parks & Recreation Department would like to create a memorable 4th of July event for our community. Staff has been in communication with ULTRA SHOW MAKERS, to provide us with professional lighting, stage, and sound for all of our musical guest performers for the 2022 4th of July Celebration. The Recreation Department worked with ULTRA SHOW MAKERS for past events and the quality of their work and services was great. ULTRA SHOW MAKERS carries all the required and necessary equipment needed for our 4th of July performers in which we will not need to worry about any last-minute additions or riders. ULTRA SHOW MAKERS has provided staff with an estimate for sixteen thousand, one hundred one dollars and thirty-two cents ($16,101.32).

City Code § 3.05.010 (C) states that whenever any contemplated purchase for the sum of at least $10,000.00 but not more than $44,999.99 the requisitioning department with the assistance of the purchasing department shall solicit three (3) written quotations (inclusive of all cost) from vendors and submit them to the purchasing department, for awarding to the lowest responsive quote. If three (3) written quotations cannot be obtained, documentation showing vendors contacted that did not offer price quotations, or explaining why price quotations were not obtained, shall be maintained with the purchasing documents.

Staff would like to request that these formal purchasing procedures be waived for good cause because ULTRA SHOW MAKERS has previously worked with one of the 4th of July Bands and has all the necessary equipment requested in the rider, and has a record of quality work for the city's 4th of July celebration.

Staff would like to request Mayor and City Council to approve this purchase as presented.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE ULTRA SHOW MAKERS FOR SOUND, STAGE, AND LIGHTING FOR THE MUSICAL PERFORMANCES FOR THE 4TH OF JULY CELEBRATION IN THE AMOUNT OF $16,101.32 AND TO WAIVE THE FORMAL PURCHASING PROCEDURES FOR THE GOOD CAUSE PRESENTED.

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM:	YES
CITY/STATE/FEDERAL FUNDS:	CITY
TOTAL:	$16,101.32
BUDGETED AMOUNT:	See fiscal impact statement
AVAILABLE AMOUNT TO TRANSFER:	See fiscal impact statement
ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE:	See fiscal impact statement

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

Fiscal impact as described above. This expense was budgeted within the Recreation Department budget for Fiscal Year 2023 which is currently in progress.

Attachments

Ultra Show Makers Quote

ULTRA SHOW MAKERS
511 N Main Street
San Luis AZ , 85336

ESTIMATE

City Of San Luis
PO Box 1170
1090 E Unica Street
San Luis AZ 85336

Estimate # 000000131

Estimate Date 04/03/2022

Item	Description	Unit Price	Quantity	Amount
Product	RCF TTS-56A Active High Power Subwoofer 2X21"	100.00	8.00	800.00
Product	RCF HDL20-A Active Line Array Module	100.00	16.00	1,600.00
Product	RCF TT45-CXA Active High Power Stage Monitor	100.00	6.00	600.00
Product	RCF TTL-6a Active Three Way Line Array	100.00	2.00	200.00
Product	RCF Pro Series 9006 Active High Power Subwoofer 2X18" (Sidefill)	100.00	2.00	200.00
Product	RCF Pro Series 8004 1X18" Subwoofer (Drumfill)	50.00	2.00	100.00
Product	YAMAHA CL5 Digital Console (includes 2 Rio 32 chanel each)	1000.00	1.00	1,000.00
Product	SHURE PSM 1000 In Ear System	100.00	2.00	200.00
Product	SHURE Beta 91 Mic (kick in)	25.00	1.00	25.00
Product	SHURE BETA 52 Mic (kick out & bass amp)	25.00	2.00	50.00
Product	SHURE SM57 Mic (percussion & guitar amp's)	25.00	11.00	275.00
Product	SHURE SM81 Mic (hh & oh)	25.00	4.00	100.00
Product	SHURE Beta 98 (toms)	25.00	3.00	75.00
Product	SHURE Beta 98 w/clip (horns & accordion) no wireless	25.00	3.00	75.00
Product	SHURE Beta 87 Wireless Mic (vocals & MC)	50.00	6.00	300.00
Product	WHIRLWIND Direct Box	10.00	3.00	30.00
Product	Microphone Boom Stand	5.00	20.00	100.00
Product	Microphone Boom Stand Short	5.00	6.00	30.00
Product	ALL TERRAIN Stage 28'X24'X4' w/stairs X2 + Drum Set Riser + Percussion Riser + Horns Riser	1000.00	1.00	1,000.00
Product	FENIX TRC-700 Ground Support System 21'	1000.00	1.00	1,000.00

Product	DiColor Phantom Series Led Display 20'X6'	1000.00	1.00	1,000.00
Product	VDWALL LVP 605s Led Video Processor	100.00	1.00	100.00
Product	DW Drum Set Collector's Series 23" Kick 10" Rack Tom 14" Floor Tom 16" Floor Tom 14" Snare DW Machine Direct Drive Double Pedal DW Machine Direct Drive Hi Hat Stand DW 9000 Series Snare Stand (2) DW 9000 Series Cymbal Boom Stand (6) DW 9000 Series Drum Throne PAISTE Signature 16" full crash PAISTE Signature 18" full crash PAISTE Signature 22" power ride PAISTE Rude 18" heavy china PAISTE Signaure 14" hi hats (2)	400.00	1.00	400.00
Product	AMPEG Bass Amp SVT-4 Pro	75.00	1.00	75.00
Product	AMPEG Speaker SVT-810	75.00	1.00	75.00
Product	FENDER Deville 2X12" Guitar Amp	75.00	1.00	75.00
Product	FENDER Twin Reverb Guitar Amp	75.00	1.00	75.00
Product	LP Giovanni Series (conga, quinto,tumbadora) with stand	150.00	1.00	150.00
Product	LP Bongos with Stand	50.00	1.00	50.00
Product	LP Timbales with Stand (cowbell stand inc)	25.00	2.00	50.00
Product	DW Collector's Series 16" Floor Tom	40.00	1.00	40.00
Product	DW 9000 Series Cymbal Boom Stand	20.00	2.00	40.00
Product	PAISTE Signature 16 " full crash	25.00	1.00	25.00
Product	CHAUVET Wash Moving Light	35.00	5.00	175.00
Product	ADJ Matrix Dot Wash Light	35.00	2.00	70.00
Product	MEGALITE 230W Beam	35.00	8.00	280.00
Product	MEGALITE O Blinder 400	75.00	3.00	225.00
Product	MEGALITE FS-LED Drama Follow Spot	75.00	1.00	75.00
Product	ANTARI F7 Smaze Fog Machine	130.00	2.00	260.00
Expense	Sales Tax 10.012 on rent ($11,000.00)	1101.32	1.00	1,101.32
Service	Labor	3700.00	1.00	3,700.00
Service	DJ Performance	300.00	1.00	300.00

NOTES: NOTES : Ultra Show Makers need full access to Joe Orduño Park 3 Days before The Event .
Event Day 07/04/2022 6:00 pm to 11:00 pm
50% Down Payment is required 60 days prior the event .

Subtotal	16,101.32
Total	16,101.32
Amount Paid	0.00
Estimate	$16,101.32

AGENDA ITEM REVIEW FORM

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

Meeting Date: 06/22/2022

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. 2022-08. An Order of the Mayor and City Council of the City of San Luis, Arizona, authorizing the entering into an Intergovernmental Agreement with the Bureau of Reclamation (BOR) for uniform license agreements permitting five specific crossings over BOR lands in the City of San Luis consolidated under BOR Contract No. 20-07-34-L2003. **(Kay Marion Macuil, City Attorney)**

SUMMARY:

The United States Department of the Interior, Bureau of Reclamation, Yuma Area Office (BOR) identified five (5) crossings over BOR canals or rights of way within the City of San Luis. To build four (4) of these crossings, the City of San Luis entered into license agreements through the Yuma County Water Users Association (YCWUA) and a fifth (5th) license (for Highway 95), the Arizona Department of Transportation (ADOT) transferred to the city. (The five (5) licenses are attached).

The first attachment is the order and contract before the City Council. The contract standardizes and consolidates the five (5) license agreements into one (the BOR Contract). The Contract is for 25 years with a renewal for another 25 years with 180 days notice. The following explains how the BOR Contract retains the city's current obligations to BOR and how it varies.

First, the BOR Contract preserves ***basically the same*** obligations that currently exist under the five (5) separate license agreements:

- The five (5) crossings are licenses to cross the canals of YCWUA, which exist on BOR land, but neither the City nor ADOT has any permanent interests in the land of the United States.
- For the five (5) crossings, the BOR Contract gives license to cross the YCWUA-constructed canals and clarifies that the YCWUA has the right to be on the United States' property.
- The BOR or the YCWUA can cancel the five (5) licenses with 30 days' notice.
- If the BOR or the YCWUA cancels the licenses, the city or ADOT has 180 days to remove the crossing and restore the property to its original condition.
- The city or ADOT (and ***not*** BOR nor YCWUA) have the duties to:
  - maintain the crossings,
  - inspect the crossings, and
  - indemnify and hold BOR and YCWUA harmless.

Second, the following provisions in the BOR Contract ***vary*** from the licenses we have now in these ways:

- It clarifies that the standard of maintenance of the crossings to be those standards of the National

Highway Administration Standards. We would have the present duty to inspect and maintain to those standards.

- It approves the licenses being now the responsibility of the city. (There is a current legal cloud regarding the ADOT license, and the BOR Contract removes that cloud).

The City Attorney's Office has reviewed the documents. The attorneys determined that this new arrangement, as a practical matter, has not changed the liability the city has with the current license agreements. The BOR Contract sets out the terms that allow the city to have crossings over the canals for the convenience of the public. Therefore, staff recommends approval.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE ORDER NO. 2022-08 TO EXECUTE BOR CONTRACT NO. 20-07-34-L2033.

Fiscal Impact

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

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

The is no dollar sum associated with this contract. The city currently has a duty to maintain five crossings over United States property at the canals, and the duty continues under this contract.

Attachments

Order No. 2022-08 Contract & Exhibits

Current License 017-95-001

Current License 015-97-002

Current License 017-03-002

Current License 017-20-001

Current License 017-22-001

OFFICE OF THE
MAYOR
CITY OF SAN LUIS

Order

No. 2022-08

AN ORDER OF THE MAYOR AND CITY COUNCIL OF THE CITY OF SAN LUIS, ARIZONA, AUTHORIZING THE ENTERING INTO AN INTERGOVERNMENTAL AGREEMENT WITH THE BUREAU OF RECLAMATION ("B.O.R.") FOR UNIFORM LICENSE AGREEMENTS PERMITTING FIVE SPECIFIC CROSSINGS OVER B.O.R. LANDS IN THE CITY OF SAN LUIS CONSOLIDATED UNDER B.O.R. CONTRACT NO. 20-07-34-L2003.

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

Section 1. The Mayor and City Council deem that it is in the best interest of the City of San Luis' residents to enter into an intergovernmental agreement with the United States of America through the Department of the Interior, Bureau of Reclamation to permit the city to have crossings over canals and use of Highway 95 for the public to travel more conveniently.

Section 2. A true copy of the intergovernmental agreement (B.O.R. Contract No. 20-07-34-L2003) is incorporated herein as though set forth again in full.

Section 3. The Mayor is authorized and directed to execute said agreement for and on behalf of the City of San Luis.

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

PASSED, ADOPTED, and APPROVED by the Mayor and City Council of the City of San Luis, Yuma County, Arizona, this ____day of June 2022.

_____
Gerardo Sanchez, Mayor

ATTEST:

_____
Sonia Cornelio, City Clerk

APPROVED AS TO FORM:

_____
Kay Marion Macuil, City Attorney

Contract No. 20-07-34-L2033

UNITED STATES
DEPARTMENT OF THE INTERIOR
BUREAU OF RECLAMATION
INTERIOR REGION 8: LOWER COLORADO BASIN
YUMA AREA OFFICE
YUMA, ARIZONA

YUMA PROJECT, VALLEY DIVISION, ARIZONA

1. THIS CONSENT AGREEMENT (Consent) is made this _____ day of _____, 2022, pursuant to provisions of the Reclamation Act of June 17, 1902 (32 Stat. 388); the Reclamation Project Act of August 4, 1939 (53 Stat. 1187), as amended August 18, 1950 (64 Stat. 463); and acts amendatory thereof or supplementary thereto; and the provisions of 43 CFR § 429, between the United States of America, acting through the Bureau of Reclamation, hereinafter referred to as "Reclamation," represented by the officer executing this Consent, hereinafter referred to as the "Area Manager," and the City of San Luis, hereinafter referred to as the "Consentee," with the concurrence of the Yuma County Water Users' Association, hereinafter referred to as the "Association."

WITNESSETH THAT:

2. WHEREAS, Reclamation, under the authority of the Act of August 30, 1890, entitled Rights-of-Way Reserved to United States for Ditches and Canals (26 Stat. 391), holds a reserved Federal right-of-way for the canals identified as the Yuma Valley Main Drain and East Main Canal, features of the Yuma Project, Valley Division, hereinafter referred to as the Drain and Canal; and

3. WHEREAS, the Drain and Canal were authorized under the authority of the Secretary of the Interior on May 10, 1904, for the Yuma Project, Valley Division; and

4. WHEREAS, Reclamation's Drain and Canal are administered, operated and maintained by the Association; and

5. WHEREAS, the United States, through Public Notice No. 77 dated February 12, 1960, granted the Association authority to process and approve requests for certain uses of Valley Division, Yuma Project rights-of-way when the applicant's proposed use of such rights-of-way is compatible with the care, operation, and maintenance of the Valley Division; and

6. WHEREAS, the Association issued Encroachment License No. 017-95-001, dated February 7, 1996, to the Consentee for the construction and maintenance of a bridge and roadway, including sidewalks and guardrails, across the Drain rights-of-way at County 23rd Street (G Street); and

7. WHEREAS, the Association issued Encroachment License No. 015-97-002, dated August 31, 1998, to the Arizona Department of Transportation for the widening, reconstruction, operation, and maintenance of U.S. Highway 95 from Gadsden to San Luis, Arizona, including the bridge and associated appurtenances across the Drain and Canal rights-of-way within portions of section 1, Township 11 South, Range 25 West, Gila and Salt River Meridian, Arizona; and

8. WHEREAS, Reclamation issued a Letter of No Objection dated May 3, 1996, to the Association for Encroachment License No. 015-97-002; and

9. WHEREAS, the Arizona Department of Transportation abandoned a portion of highway, San Luis to Gadsden from County 23rd Street to County 22nd Street, identified as U.S. Route 95, by Resolution of Abandonment No. 2010-030A-023 dated March 19, 2010, recorded April 1, 2010, in Document # 2010-08182; and

10. WHEREAS, said highway was abandoned to the City of San Luis for a continued public transportation use as provided in Arizona Revised Statute Section 28-7207 and 28-7209, and 23 CFR § 620, Subpart B; and

11. WHEREAS, pursuant to Title 23 of the Code of Federal Regulations, Part 650 Subpart C, National Bridge Inspection Standards (NBIS), 1971; revised in December 2004, Reclamation is required to perform an inventory of bridges that cross Reclamation facilities in order to verify ownership and determine the appropriate level of inspection to ensure the safety of the bridge users, and to ultimately prolong the lives of the bridges through an effective operation and maintenance program; and

12. WHEREAS, during the bridge inventory performed by Reclamation, the following vehicular bridges, hereinafter referred to as Bridges, of undetermined origin or ownership were identified as located across the Drain and Canal, which Bridges have been identified as Reclamation Bridge Nos. LCYA0126, LCYA0127, LCYA0128, LCYA0297, and LCYA1095; and

13. WHEREAS, the determination of bridge type and ownership of the Bridges was established by a Reclamation letter dated October 1, 2015, and entitled: "Confirmation of Ownership and Operation and Maintenance (O&M) Responsibility for Bridges that Cross Bureau of Reclamation Facilities or are Located on Reclamation Land – City of San Luis," as part of the ongoing Reclamation bridge inventory process; and

14. WHEREAS, the above-noted letter notified Consentee that Reclamation Bridge Nos. LCYA0126, LCYA0297, and LCYA1095 have been removed from the bridge inventory as they do not meet the 20-foot length requirement to be classified bridges, and will hereinafter be referred to as "Crossings;" and

15. WHEREAS, Reclamation has determined that said Bridges and Crossings are not necessary for Reclamation project purposes; but are currently used and required by the Consentee and/or its authorized agents, representatives and residents as ingress and egress to privately and publicly owned lands, in which there is no other reasonable option for access; and

16. WHEREAS, Reclamation and the Association have no objection to such use of the Drain and Canal reserved rights-of-way; and

17. WHEREAS, the granting of such authorization and right-of-use by Reclamation and the exercise of such right-of-use by the Consentee under the terms and conditions herein provided shall be compatible with the purposes for which the lands and rights-of-way are administered by Reclamation on behalf of the United States.

18. NOW THEREFORE, in consideration of the mutual agreements and covenants contained herein, Reclamation, on behalf of the United States, by this Consent Agreement, hereby grants to the Consentee, except as otherwise provided herein, the following described authorization for the ownership, use, operation, maintenance, and replacement of said Bridges and Crossings, to wit:

DESCRIPTION OF PREMISES

Gila and Salt River Meridian, Arizona

LCYA0126
Township 10 South, Range 24 West
SW¼SW¼SW¼SE¼SW¼, SE¼SE¼SE¼SW¼SW¼, section 31, portions of.

Township 11 South, Range 24 West
NW¼NW¼NW¼NE¼NW¼, NE¼NE¼NE¼NW¼NW¼, section 6, portions of.

LCYA0127
Township 11 South, Range 25 West
W½W½NW¼SW¼, section 1, portions of.

LCYA0128
Township 11 South, Range 25 West
SW¼SW¼SW¼SW¼, section 1,
SE¼SE¼SE¼SE¼, section 2,
NE¼NE¼NE¼NE¼, section 11,
NW¼NW¼NW¼NW¼, section 12, portions of.

LCYA0297 and LCYA1095
Township 11 South, Range 25 West
N½, section 1, portions of.

Said lands are more fully described by location map, contained in Exhibit A, attached hereto and by this reference made a part hereof.

(a) By accepting and signing this Consent, and by using the Premises described herein, the Consentee agrees to comply with and be bound by the terms and conditions described or referenced herein during all ownership, use, operation, maintenance, termination, and relocation (if required and as hereinafter provided) activities of said Bridges and Crossings.

19. ADMINISTRATIVE COSTS AND USE FEES: In accordance with regulations found at 43 CFR § 429.26 (a)(9), consideration for this Consent shall be waived.

20. OWNERSHIP OF BRIDGES AND CROSSINGS:

(a) Ownership of said Bridges and Crossings was established by a Reclamation letter dated October 1, 2015, entitled: "Confirmation of Ownership and Operation and Maintenance (O&M) Responsibility for Bridges that Cross Bureau of Reclamation Facilities or are Located on Reclamation Land – City of San Luis," as part of the ongoing Reclamation bridge inventory process, hereinafter described on Exhibit B, attached hereto and by this reference made a part hereof.

(b) The Consentee shall at all times and at its sole expense, without any expense and/or liability whatsoever to the United States, Reclamation and/or the Association, own, use, operate, maintain, and make necessary repairs to or replacements of the Bridges and Crossings in a manner so as not to interfere with the proper use and operation of or cause injury or damage to any property or waters of the United States, property of the Association, and/or any facilities or project works of Reclamation and/or the Association. The Consentee shall reimburse

Reclamation and/or the Association for all injury or damage to said property, waters, facilities, and/or project works arising out of the utilization of the rights granted pursuant to this Consent which is caused by the Consentee; and the Consentee shall promptly pay any invoice rendered by Reclamation and/or the Association.

21. BRIDGE LISTING AND INSPECTION: The Consentee shall:

(a) Comply with NBIS procedures, to include bridge inspection and reporting procedures in compliance with NBIS and 23 CFR § 650, Subpart C, implementing any access restrictions, and resolving any safety issues in order to safeguard employees and the general public. Any access restrictions, major structural repairs, removals, and/or replacements must be approved by Reclamation in advance.

(b) List the Bridges with the Federal Highway Administration; and

(c) Provide Reclamation with any and all listing and/or inspection reports. This requirement also applies to bridges that are closed and then reopened to the public; and

(d) Complete any and all maintenance, repairs, and/or replacements to the Bridges required by the Federal Highway Administration and/or Reclamation in a manner satisfactory to the Federal Highway Administration, Reclamation, and the Association.

22. WATER: Nothing contained in this Consent shall be deemed to entitle the Consentee to, nor shall be construed as granting any rights to obtain water from the United States, and no wells shall be constructed or installed on the lands covered by this Consent.

23. TERM: This Consent, unless terminated sooner as provided for in Article 24 herein, shall terminate twenty-five (25) years from the date hereof. This Consent may, upon written agreement of the parties, be extended for an additional twenty-five (25) year term. Any request for extension shall be filed by the Consentee, in writing, with the Area Manager not less than one hundred eighty (180) days prior to termination of the Consent.

24. TERMINATION:

(a) This Consent shall terminate and all rights granted to the Consentee hereunder shall cease, and the Consentee shall quietly deliver to Reclamation possession of the Premises in like condition as when taken, reasonable wear and tear excepted:

(1) At the expiration of the term as provided in Article 23.

(2) For nonuse of the Premises by the Consentee for a period of two (2) years following the execution of this Consent, at the option of Reclamation.

(3) After failure of the Consentee to observe any of the conditions of this Consent, and on the tenth (10^{th}) day following service of written notice on the Consentee of termination because of failure to observe such conditions. Any notice required by this Article shall be served by certified mail addressed to the respective post office addresses provided in Article 35, and the mailing of any such notice properly enclosed, addressed, stamped, and certified, shall be considered service.

(4) Reclamation may, at any time and at no cost or liability to the United States, terminate this Consent in the event of a natural disaster, a national emergency, a need arising from security requirements, or an immediate and overriding threat to public health and safety.

(5) Reclamation may, at any time and at no cost or liability to the United States, terminate any use authorization for activities other than existing authorized private exclusive recreational or residential use as defined under 43 CFR § 429.2 (2016) if Reclamation determines that any of the following apply:

(i) The use has become incompatible with authorized project purposes, project operations, safety, and security;

(ii) A higher public use is identified through a public process described at 43 CFR § 429.32(a)(1) (2016); or

(iii) Termination is necessary for operational needs of the project.

(6) Reclamation may, at any time and at no cost or liability to the United States, terminate this Consent if it determines that the Consentee has used this Consent for any purpose other than its intended purpose.

(7) Reclamation may, at any time and at no cost or liability to the United States, terminate this Consent if the Consentee fails to comply with all applicable Federal, State, and local laws, regulations, ordinances, Executive Orders, and Reclamation Laws, policies, and directives and standards, existing or hereafter enacted or promulgated, or terms and conditions of any use authorization, or to obtain any required permits or authorizations.

(8) Upon the expiration, termination, or revocation of this Consent, if all use fees and damage claims due Reclamation have been paid, the Consentee may be required, at the option of Reclamation, to remove any or all of the Bridges and Crossings placed upon the Premises and shall restore the Premises to a condition satisfactory to the Area Manager. Should Consentee fail to remove the Bridges and Crossings within sixty (60) days of expiration, termination, or revocation of this Consent, the Area Manager may, on behalf of Reclamation, deny and prohibit any or all access to the Bridges, Crossings, and Premises. At the option of

Reclamation, any remaining Bridges and Crossings may become property of the United States or be removed at the expense of the Consentee. The Consentee shall promptly pay all expenses incurred by Reclamation for removal and restoration upon its receipt of an invoice for the same.

(9) Should this Consent be terminated, Reclamation, reserves the right to bar the Consentee from the authorization to use Reclamation lands and rights-of-way for a period of time, as determined by the Area Manager.

25. TERMINATION OF CONSENT BY THE CONSENTEE: This Consent may be terminated at any time by the Consentee upon sixty (60) days written notice to Reclamation. Should the Consentee exercise its option to terminate this Consent, all rights granted the Consentee hereunder shall cease, and the Consentee shall quietly deliver to Reclamation possession of the Premises in like condition as when taken, reasonable wear and tear excepted.

26. EXCEPTIONS AND RESERVATIONS:

(a) Reclamation and the Association reserve the right of their officers, employees, and agents to at all times have unrestricted access and ingress to, passage over, and egress from all of the Premises to make investigations of all kinds, dig test pits and drill test holes, to survey for, operate, and maintain existing Reclamation works and facilities, and to construct reclamation and irrigation works and other structures incident to Reclamation project needs and purposes. Reclamation and the Association shall have no obligation to restore the Consentee's Bridges and Crossings if Reclamation and the Association exercise their rights reserved herein. All costs, expenses, obligations, and duties, to restore any part of the Consentee's Bridges and Crossings shall be incurred by the Consentee.

(b) The rights granted hereunder shall not be exclusive in character and Reclamation and the Association reserve to themselves, their successors and assigns, the right against the Consentee to use any or all of the Premises, which is or may be crossed, or upon which irrigation and drainage facilities and works of Reclamation and the Association have been constructed, and to construct, reconstruct, operate, and maintain therein and thereon works including, but not limited to, dams, dikes, canals, waste ways, laterals, ditches, telephone and telegraph lines, electric transmission lines, roadways, and appurtenant irrigation and drainage structures which may be needed or useful in connection with or as part of canals, laterals, and other irrigation and drainage facilities without any payment by Reclamation or the Association, its successors and assigns, for the exercise of such right. The Consentee agrees that if the construction, reconstruction, installation, operation, or maintenance of any or all of such works of Reclamation, on or across the Premises, should be made more expensive by reason of the existence of the Consentees' Bridges and Crossings, such additional expense may be estimated

by Reclamation or the Association whose estimate shall be final and binding upon the parties hereto, and within thirty (30) days after demand is made upon the Consentee for payment of any such sums, the Consentee shall make payment thereof to Reclamation and the Association, its successors and assigns, for constructing, operating, or maintaining such works across, over, under or upon the Premises.

(c) Reclamation and the Association reserve the right to inspect the Consentee's Bridges and Crossings under the terms of this Consent both during the progress of construction and upon completion thereof and anytime thereafter.

(d) Jurisdiction of and supervision by Reclamation over the Premises is not surrendered or subordinated by issuance of this Consent and Reclamation reserves the right to issue additional use authorizations and other agreements for compatible use of the Premises.

27. TERMS AND CONDITIONS: In use of the Premises, the Consentee shall faithfully observe each of the following conditions:

(a) The Consentee, at its sole expense, shall own, use, operate, and maintain Consentee's Bridges and Crossings in conformity with all applicable Federal, State, and local laws, regulations, ordinances, Executive Orders, and Reclamation Laws, policies, and directives and standards, existing or hereafter enacted or promulgated, including but not limited to, those relating to pollution and environmental control.

(b) All ownership, use, operation, and maintenance activities undertaken pursuant to this Consent shall be in conformity with the specifications approved in advance by the Area Manager and the Association and shall be conducted by the Consentee at all times in a manner satisfactory to the Area Manager and the Association. It shall be incumbent upon the Consentee to obtain an encroachment license from the Association prior to undertaking such installation activities.

(c) The Consentee shall at all times, and at its sole expense, operate and maintain and make necessary repairs and replacements on said Consentee's Bridges and Crossings in a good and workmanlike manner so as not to interfere with the proper use and operation of, or cause injury or damage to any property, irrigation, and drainage facilities, or works of Reclamation. All equipment installed, operated, and maintained pursuant to this Consent shall be maintained in a safe condition satisfactory to the Area Manager and the Association. The Consentee shall reimburse Reclamation for all injury or damage to property, irrigation and drainage facilities, or works of Reclamation arising out of the utilization of the rights granted pursuant to this Consent which is caused by the Consentee, its officers, agents, or employees, and the Consentee shall promptly pay any bills rendered therefore by Reclamation.

(d) During construction and use of the Premises, the Consentee shall carry out proper and efficient measures wherever and as often as necessary to reduce nuisance by dust, and to prevent dust which has originated from its operations from damaging any other properties or causing a nuisance to persons.

(e) The Consentee shall reimburse Reclamation and the Association for any and all costs and expenses incurred in the defense of any action which challenges the Consentee's use of the Premises.

(f) The rights granted by this Consent are subject to any and all applicable Federal, State, and local laws, regulations, ordinances, Executive Orders, and Reclamation Laws, policies, and directives and standards, existing or hereafter enacted or promulgated, and rights of Reclamation, the United States, and to existing rights in favor of the public or third parties. The Consentee agrees that it is its sole responsibility to make whatever arrangements as are necessary to obtain such rights as may be required of the Consentee from any other party or parties holding any other interests.

(g) The Consentee shall notify the Area Manager and Association within ninety (90) days of substantial completion of use, and within said ninety (90) days shall undertake customary and prudent measures to smooth, recontour, clean, remove debris, grade, scarify, repair, restore, or otherwise rehabilitate the lands, water, structures, and facilities of Reclamation that were disturbed to a condition of appearance and stability comparable to the surrounding undisturbed lands, to the satisfaction of the Area Manager and Association.

(h) The Consentee shall not issue or grant easements, rights-of-way, land rights, leases, licenses, permits, crossing agreements, recreational or special use agreements, and shall not allow commercial ventures on the Premises. Any such use instruments shall be issued by Reclamation only.

(i) The Consentee shall ensure the Premises and surrounding area are maintained in a sanitary condition at all times. All trash and debris shall be removed upon leaving the Premises.

(j) The Consentee shall not make any alteration of said Drain and Canal within the Reclamation lands and rights-of-way without prior written concurrence of Reclamation and the Association.

(k) The Consentee shall ensure that no unauthorized encroachment occurs, and no waste is committed, on Reclamation lands and rights-of-way under this Consent.

(l) The Consentee shall have the right to allow its agents, representatives and residents to use Reclamation lands and rights-of-way under this Consent for the purposes stated herein.

(m) The Consentee shall promptly reimburse Reclamation and/or the Association for all damages to Reclamation lands, waters, facilities, and/or project works, arising out of the construction, installation, operation, maintenance, use, replacement, termination, or removal by the Consentee of the Consentee's Bridges and Crossings located on Reclamation lands and rights-of-way under this Consent, provided, however, that if Reclamation and/or the Association does not use the payment to repair such damages, Reclamation and/or the Association shall not recover additional payment for such damages at the time of termination of this Consent.

(n) The Consentee shall not use the Premises or permit the use thereof for any purposes except as set forth herein.

28. SPECIAL CONDITIONS: In use of the Premises, the Consentee shall faithfully observe each of the following conditions:

(a) Any Bridges and Crossings activity beyond the Premises is not authorized by the United States, Reclamation, or this Consent.

(b) In the event the Consentee is not the underlying fee owner of the land encumbered by Reclamation's rights-of-way, it shall be incumbent on the Consentee to secure permission of the fee owner(s) for approval to enter upon, cross, or use the land, including the Reclamation rights-of-way.

(c) Upon termination of this Consent for any reason, the Consentee may be required, at the option of Reclamation, to remove said Bridges and Crossings placed in or upon the Premises and shall restore the Premises to a condition satisfactory to Reclamation.

(d) When the said Bridges and Crossings, existing at the time of execution of this Consent, are modified and/or replaced, construction plans shall be submitted to Reclamation for review and approval prior to construction. Additionally, "as built" drawings shall be provided within ninety (90) calendar days of the completion of the modified and/or replaced Bridges and Crossings to Reclamation and the Association by the Consentee. The as-built drawings shall depict the location, elevation and dimensions of the modified and/or replaced Bridges and Crossings. Said drawings shall be provided to Reclamation and the Association in AutoCAD Civil 3D 2013 format, or compatible, to include one (1) 11x17 sized set of drawings, and electronic copy (CD) of the drawings.

(1) For any modification and/or replacement of said Bridges and Crossings, the Consentee must follow Reclamation's requirements for crossings of Reclamation projects and facilities which are found in Reclamation's "Engineering and O&M Guidelines for Crossings – Bureau of Reclamation Water Conveyance Facilities (Canals, Pipelines, and Similar Facilities)" as described and depicted in Exhibit C, attached hereto and by this reference made a part hereof.

(2) If the condition of the Bridges and Crossings are known to threaten the operation of a Reclamation facility, or the Bridges and Crossings present an immediate danger to the public or operating personnel, then Reclamation shall notify the Consentee for their attention and correction in a timeframe that is prompt and mutually agreeable to Reclamation, Association and the Consentee.

(3) Prior to commencing any construction activities, the Consentee shall obtain the Association's written approval and stipulations as indicated by the Association's issuance of an Encroachment License to the Consentee and/or its contractor for the installation of Consentees' Bridges and Crossings. Consentee shall ensure coordination with Association prior to commencing any construction or installation activity, and during all construction, installation, operation, maintenance, replacement, repair and termination activities of the Consentee's Bridges and Crossings within Reclamation's lands and/or Drain and Canal rights-of-way, including inspection as required by Reclamation and/or the Association during and after construction, and shall be conducted in strict compliance with all stipulations as set forth in said Encroachment License.

(4) The Consentee shall provide a construction schedule and seventy-two (72) hour notice to Reclamation prior to the start of any construction activity. Said seventy-two (72) hour notice shall be provided to Reclamation's Technical Support Office, Construction Services Group Manager, Mr. Alex Belous, at telephone No. (928) 343-8314 and/or by electronic mail at abelous@usbr.gov, so that a Reclamation Inspector can attend any pre-construction meetings and be on-site during construction and installation activities.

(5) The Consentee shall provide a construction schedule and seventy-two (72) hour notice to the Association prior to the start of any construction activity. Said seventy-two (72) hour notice shall be provided to the Association's Senior Engineering Technician, Mr. Omar Peñuñuri, at telephone No. (928) 627-8824 so that an Association representative can attend any pre-construction meetings and be on-site during construction and installation activities.

(e) The Consentee shall be solely responsible for, and ensure that, appropriate and necessary traffic signs are installed at regular intervals on the approach to and along the Bridges and Crossings.

(f) The Consentee shall be solely responsible for, and ensure that, Reclamation and Association projects and facilities, and Reclamation lands and rights-of-way and waters, including the Drain and Canal, are protected during the use, operation, maintenance, replacement, and termination activities authorized herein.

(g) The Consentee accepts all liability for any costs associated with repairs of Reclamation and/or Association facilities, structures, or project works of Reclamation if damaged during the use, operation, maintenance, replacement, and termination activities authorized herein.

(h) The Consentee shall ensure that any disturbed banks on the Drain and Canal are stabilized in a manner approved by Reclamation and the Association prior to any construction.

(i) The Consentee shall protect all properties owned and/or previously permitted by Reclamation within its lands and rights-of-way for the Drain and Canal.

(j) The Consentee shall be solely responsible for, and ensure that, no material of any kind is discharged into Reclamation and/or Association facilities.

(k) The Consentee shall be solely responsible for, and ensure that, Reclamation and the Association have access to the Premises at all times during use, operation, maintenance, replacement, and termination activities of the Bridges and Crossings, and/or Reclamation facilities. Nothing shall prevent Reclamation and/or the Association from construction, operation, maintenance, removal, expansion, improving, relocation and/or replacement of the Drain and Canal and/or Reclamation facilities, or the delivery of water through these facilities.

(l) Any provider intending to install or construct any utilities and/or other improvements on the Premises not specifically authorized by this Consent shall make separate application to Reclamation and/or the Association for authorization and right-of-use prior to any construction or installation.

(m) In case of emergency involving the Drain and Canal, its lands and/or facilities, the Consentee shall immediately notify Reclamation at telephone No. (928) 343-8100 and the Association at telephone No. (928) 627-8824.

(n) The Consentee shall restore and repair, if necessary, the Premises and surrounding area to its original condition or improved and in a manner satisfactory to Reclamation and the Association.

(o) The Consentee acknowledges and agrees that Reclamation and/or the Association may require the Consentee to close the Bridges and Crossings, for maintenance activities related to the Drain and Canal and related appurtenances, with reasonable advance notice to the Consentee, as determined by Reclamation and/or the Association.

(p) The Consentee acknowledges and agrees that Reclamation and/or the Association may require the Consentee to cease all use, operation and maintenance activities related to the Bridges and Crossings, for project purposes related to the lands and rights-of-way, with reasonable advance notice to the Consentee, as determined by Reclamation and/or the Association.

(q) Reclamation and the Association retain all rights previously reserved and the authority to enter upon the Premises. The Consentee shall ensure that Reclamation and the Association continues to have operational and maintenance access to all Reclamation and Association lands and/or infrastructure.

(r) Reclamation and the Association maintain the right to require that Consentee remove the Bridges and Crossings if deemed necessary for maintenance or related activities performed within the Drain and Canal, lands and/or facilities.

(s) Any damage to the Consentee's Bridges and Crossings or their related features caused by operation and maintenance activities of Reclamation and/or the Association on project works and/or facilities shall be the sole responsibility of the Consentee to repair and/or replace, and the United States, Reclamation, and/or the Association shall have no financial responsibility for any such repairs and/or replacements.

(t) The Consentee shall reimburse Reclamation and/or the Association for any additional costs incurred in the operation and maintenance of Reclamation and/or Association facilities which are attributable to the Consentee's Bridges and Crossings and their related features.

(u) The Consentee hereby agrees to incur all costs, expenses, obligations, and duties to restore the Consentee's Bridges and Crossings in the event Reclamation and/or the Association exercise their rights reserved herein.

(v) Reclamation will accept no responsibility for the structural adequacy of the Bridges and Crossings.

(w) Within ninety (90) days of execution of this Consent, Reclamation requires the Consentee to furnish Reclamation and the Association each with as-built drawings of the existing Bridges and Crossings. The as-built drawings shall depict the location, elevation and dimensions of the existing Bridges and Crossings, as installed. Said drawings shall be provided to Reclamation and the Association in AutoCAD Civil 3D 2013 format, or compatible, to include one (1) 11x17 sized set of drawings, and electronic copy (CD) of the drawings.

(x) This authorization to use Reclamation's lands and rights-of-way shall not be construed as a grant of any permanent ownership and/or interest or as abandonment by the United States or Reclamation of any rights, including but not limited to, use and occupancy of the Premises, and/or Reclamation's lands and rights-of-way.

(y) All on-site personnel shall be personally instructed by Consentee regarding the above-listed conditions.

GENERAL PROVISIONS

29. HOLD HARMLESS:

(a) Reclamation: The Consentee hereby agrees to indemnify and hold harmless Reclamation, its officers, employees, agents, and assigns, from any loss or damage and from any liability on account of personal injury, property damage, or claims for personal injury or death arising out of the Consentee's activities under this Consent. Additionally, except for acts of negligence, the Consentee releases Reclamation, its officers, employees, agents, and assigns, from any and all liability for damage arising from injury to persons or damage to structures, equipment, improvements, or works of the Consentee resulting from the construction, reconstruction, operation, or maintenance of any of the works of Reclamation. Provided, however, that nothing contained in this clause shall be deemed to modify or limit any liability which may be imposed by the Federal Tort Claims Act, 28 U.S.C. § 2671-2680.

(b) Association: The Consentee shall indemnify, defend, and hold harmless the Association, its officers, directors, employees, agents, representatives, successors, and assigns, from and against all claims, costs, losses, damages, demands, liabilities, and expenses (including, but not limited to, all fees and charges of attorneys and other professionals, and all court or arbitration or other dispute resolution costs) of any kind or character arising out of or relating to:

(1) Any act or omission by the Association or its representatives, to include its employees, agents, contractors, subcontractors, or any other persons directly or indirectly employed by any one of the foregoing, or reasonably under the control of any of the foregoing, or for whose acts any of the foregoing may be liable (collectively, "Representatives"), in connection with the rights granted to Consentee pursuant to this Consent;

(2) Any violation or alleged violation by the Consentee or its Representatives of any law or regulation now or hereafter enacted;

(3) Any breach by Consentee of its obligations under this Consent; and

(4) Any enforcement by the Association of any provision of this Consent; provided, however, the foregoing indemnification shall not apply to the extent any claim is ultimately established by a court of competent jurisdiction to have been caused by the gross negligence or willful misconduct of the Association, its officers, directors, employees, agents, representatives, successors, and assigns.

30. DISCOVERY OF CULTURAL RESOURCES: The Consentee shall immediately provide a verbal notification to Reclamation of the discovery of any and all antiquities or other objects of archaeological, cultural, historic or scientific interest on or within the Premises. The Consentee shall follow up with a written report of their finding(s) to Reclamation within forty-eight (48) hours. Objects under consideration include but are not limited to historic or prehistoric ruins, human remains, funerary objects, and artifacts discovered as a result of activities authorized under this Consent. The Consentee shall immediately cease its activity in the area of the discovery, make a reasonable effort to protect such discovery, and wait for written approval from Reclamation before resuming activity. Protective and mitigative measures specified by Reclamation shall be the responsibility of the Consentee.

31. CLEAN AIR AND WATER: The Consentee agrees as follows:

(a) To comply with all Federal, State, and local requirements of the Clean Air Act of 1955, Pub. L. No. 84-159, 69 Stat. 322, as supplemented and amended (CAA), and the Federal Water Pollution Control Act of 1948, Pub. L. No. 80-845, 62 Stat. 1155, as supplemented and amended (CWA); and

(b) To obtain written permission from Reclamation prior to conducting any activities that require permits, plans, or certificates under the CAA or the CWA; and

(c) To provide Reclamation with a copy of any correspondence between the Consentee and any regulatory agency concerning CAA or CWA compliance, including but not limited to copies of permit applications, permits, reports, notices of violation, or enforcement actions; and

(d) To take immediate and effective action to correct any violation related to the CAA or the CWA. The Consentee shall provide Reclamation with a narrative description of the violation, the actions taken by the Consentee, the date the violation began, the date that the Consentee became aware of the violation, and the date that the Consentee returned to compliance; and

(e) To take action to comply with any changes to the CAA and the CWA within the schedule required by the regulation, rule, or guidance.

32. HAZARDOUS MATERIALS: During the performance of any activity on the Premises, the Consentee agrees as follows:

(a) The Consentee shall not allow contamination or pollution of lands, waters, facilities, and/or project works of Reclamation for which the Consentee has the responsibility for care, operation, and maintenance by its Representatives and shall take reasonable precautions to prevent such contamination or pollution by third parties. Substances causing contamination or pollution shall include but are not limited to hazardous materials, thermal pollution, refuse, garbage, sewage effluent, industrial waste, petroleum products, mine tailings, mineral salts, misused pesticides, pesticide containers, or any other pollutants.

(b) The Consentee shall comply with all applicable Federal, State, and local laws, regulations, ordinances, Executive Orders, and Reclamation Laws, policies, and directives and standards, existing or hereafter enacted or promulgated, concerning any hazardous material that will be used, produced, transported, stored, or disposed of on or in Reclamation lands, waters, facilities, and/or project works.

(c) "Hazardous material" shall mean any substance, pollutant, or contaminant listed as hazardous under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended, 42 U.S.C. §§ 9601-9675 (2012), and the regulations promulgated pursuant to that Act.

(d) Upon discovery of any event which may or does result in contamination or pollution of Reclamation lands, waters, facilities, and/or project works, the Consentee shall initiate emergency measures to protect health and safety and the environment if necessary and shall provide notice of such discovery with full details of the actions to Reclamation's Environmental Planning and Compliance Group Manager at telephone No. (928) 343-8100. Additionally, all spills regardless of size shall be reported to Reclamation's Environmental Planning and Compliance Group Manager. Such notice shall be within a reasonable time period but not to exceed twenty-four (24) hours from the time of discovery if it is an emergency, and the first (1st) working day if it is a non-emergency. An emergency is any situation that requires immediate action to reduce or avoid endangering public health and safety or the environment.

(e) Violation of any of the provisions of this Article, upon which the Consentee does not take immediate corrective action, shall constitute grounds for termination of this Consent and shall make the Consentee liable for the cost of the full and complete remediation and/or restoration of any resources, lands, waters, projects and/or facilities of Reclamation that are adversely affected as a result of the violation.

(f) The Consentee agrees to include the provisions contained in paragraphs (a) through (e) of this Article in any entered subcontract or third-party contract authorized by this Consent.

(g) Reclamation agrees to provide information necessary to the Consentee for using reasonable diligence to comply with the provisions of this Article.

33. PESTICIDES: In use of the Premises:

(a) The Consentee shall not permit the use of any pesticides on lands, waters, facilities, or project works of Reclamation without prior written authorization from Reclamation. The Consentee shall submit to Reclamation for approval an Integrated Pest Management Plan (IPMP) thirty (30) days prior to pesticide application.

(b) All pesticides used shall be in accordance with the current registration, label direction, or other directives regulating their use (State Department of Agriculture, Department of Ecology, OSHA, etc.) and with applicable Reclamation policy and directives and standards. Applicators will meet applicable State training or licensing requirements. Records maintenance shall be in accordance with State requirements and furnished to Reclamation not later than five (5) working days after application of a pesticide.

(c) Any equipment, tools, and machines used for pesticide application shall be in good repair and suitable for such use. Equipment shall be calibrated prior to the spraying season and as deemed necessary by Reclamation.

(d) Mixing, disposal, and cleaning shall be done where pesticide residues cannot enter storm drains, sewers, or other non-target areas.

(e) The Consentee shall initiate any necessary measures for containment and clean up of pesticide spills. Spills shall be reported to Reclamation with full details of the actions taken. Reporting must be made within a reasonable time period. A reasonable time period means within twenty-four (24) hours of the spill if it is an emergency or by the first (1st) working day if it is a non-emergency. An emergency is any situation that requires immediate action to reduce or avoid endangering public health and safety or the environment.

(f) Aerial application of pesticides is prohibited without prior written authorization from Reclamation.

(g) The Consentee agrees to include the provisions contained in paragraphs (a) through (f) of this Article in any entered subcontract or third-party contract authorized by this Consent.

34. NONDISCRIMINATION: The Consentee hereby agrees as follows:

(a) To comply with Title VI of the Civil Rights Act of 1964, § 601, Pub. L. No. 88-352, 78 Stat. 241, as supplemented and amended, which provides that "[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from

participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity receiving Federal financial assistance," and to be bound by the regulations of the Department of the Interior for the effectuation thereof, as set forth in 43 CFR § 17 (2016). For purposes of this subpart, "Federal financial assistance" shall have the meaning prescribed to it by 43 CFR § 17.202(h) (2016).

(b) To comply with the Rehabilitation Act of 1973, § 504, Pub. L. No. 93-112, 87 Stat. 355, as supplemented and amended, which is designed to eliminate discrimination on the basis of disability in any program or activity receiving Federal financial assistance. For purposes of this subpart, "Federal financial assistance" shall have the meaning prescribed to it by 43 CFR § 17.12(e) (2016).

(c) To comply with the Age Discrimination Act of 1975, as supplemented and amended, 42 U.S.C. §§ 6101-6107, and the general age discrimination regulations at 45 CFR § 90 (2016) which are designed to prohibit discrimination on the basis of age in programs and activities receiving Federal financial assistance, as set forth in 43 CFR § 17 (2016). For purposes of this subpart, "Federal financial assistance" shall have the meaning prescribed to it by 43 CFR § 17.303(h) (2016).

(d) To obligate its subcontractors, subgrantees, transferees, successors in interest, or any other participates receiving Federal financial assistance hereunder, to comply with the requirements of these provisions.

35. NOTICES: Any notice, demand, authorization, or request required to be made or given herein shall be served via hand delivery, with signed receipt of acceptance, or by certified mail addressed to the respective addresses given herein and the hand delivery or mailing of any such notice properly enclosed, addressed, stamped, and certified, shall be considered service.

(a) Any notice, demand, authorization, or request required by this Consent to be made or given to or upon Reclamation, or the United States, except as otherwise provided herein, shall be deemed properly given or made if hand delivered or mailed postage-prepaid, to the Area Manager, Yuma Area Office, Bureau of Reclamation, 7301 Calle Agua Salada, Yuma, Arizona 85364.

(b) Any notice, demand, authorization, or request required by this Consent to be made or given to or upon the Association shall be deemed properly given or made if hand delivered or mailed postage-prepaid, to the Manager, Yuma County Water Users' Association, P.O. Box 5775, Yuma, Arizona 85366.

(c) Any notice, demand, authorization, or request required by this Consent to be made or given to or upon the Consentee shall be deemed properly given or made if hand delivered or mailed postage-prepaid, to the Director of Public Works, City of San Luis, P.O. Box 3750, San Luis, Arizona 85349.

(d) The designation of the person to or upon whom any notice, demand, authorization, or request is to be given or made, or the address of any such person, may be changed at any time by notice given in the same manner as provided in this Article for other notices.

36. OFFICIALS NOT TO BENEFIT: No member of or delegate to Congress or Resident Commissioner, and no officer, agent, or employee of the Department of the Interior, shall be admitted to any share or part of this Consent or to any benefit that may arise herefrom, but this restriction shall not be construed to extend to this Consent if made with a corporation or contractor for its general benefit.

37. COVENANT AGAINST CONTINGENT FEES: The Consentee warrants that no person or agency has been employed or retained to solicit or secure this Consent upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established agencies maintained by the Consentee for the purpose of securing business. For breach or violation of this warranty, Reclamation shall have the right to annul this Consent without liability or in its discretion to require the Consentee to pay, in addition to the right-of-use consideration, the full amount of such commission, percentage, brokerage, or contingent fee.

38. ILLEGAL USE: Any activity deemed to be illegal on Reclamation lands, waters, project works, or facilities, shall be cause for immediate termination of this Consent.

39. EFFECT OF CONSENT: This Consent sets forth the intention of the parties hereto as to the purposes set forth herein and Reclamation, makes no other claim or warranty, expressed or implied, as to its extent or validity.

40. NO WARRANTY: Reclamation makes no warranty, expressed or implied, as to the extent or validity of the grant contained herein.

41. FURTHER ASSURANCES: The parties hereto shall execute, acknowledge, and deliver such other instruments and documents as may be necessary or appropriate to carry out the full intent and purpose of this Consent.

42. ARTICLE HEADINGS: The Article headings referenced in this Consent are included for convenience only and the parties intend that they shall be disregarded in interpreting this Consent.

43. EXHIBITS: Except as otherwise provided herein, all exhibits attached to this Consent are incorporated into this Consent by reference herein and made a part hereof.

44. SUCCESSORS AND ASSIGNS: This Consent is personal, revocable, and nontransferable and except as otherwise provided herein, shall not be construed as granting to the Consentee any permanent right, title, or interest in the Premises, facilities, or project works of Reclamation. This Consent shall be binding upon and inure to the benefit of the successors and/or assigns of the parties hereto; provided, however, that no assignment or transfer of any of the rights of the Consentee hereunder shall be made without the prior written consent of Reclamation.

45. SEVERABILITY: Each provision of this use authorization shall be interpreted in such a manner as to be valid under applicable law, but if any provision of this use authorization shall be deemed or determined by competent authority to be invalid or prohibited hereunder, such provision shall be ineffective and void only to the extent of such invalidity or prohibition, but shall not be deemed ineffective or invalid as to the remainder of such provision or any other remaining provisions, or of the use authorization as a whole.

IN WITNESS WHEREOF, the parties hereto have signed their names to this CONSENT AGREEMENT which shall become effective the day and year first above written.

THE UNITED STATES OF AMERICA

By: _____
Christopher M. Wallis
Chief, Resource Management Office
Yuma Area Office
Interior Region 8: Lower Colorado Basin
Bureau of Reclamation
Department of the Interior

Date: _____

ACCEPTANCE:

CITY OF SAN LUIS

By: _____

Title: _____

Date: _____

CONCURRENCE:

YUMA COUNTY WATER USERS' ASSOCIATION

By: _____

Title: _____

Date: _____

NOTARIAL ACKNOWLEDGEMENT

State of Arizona)

County of Yuma)

On this ___ day of _____, 2022, before me, _____, a Notary Public in and for said County and State personally appeared _____, _____ of
Name Title

City of San Luis (Consentee), known to me to be the person described in the foregoing instrument, and acknowledged to me that _____ executed the same on behalf of the Consentee in the capacity therein stated and for the purpose therein contained.

(Notary Seal)

_____
Notary Public

Description of document this notarial certificate is being attached to:	
Type/Title	Contract No. 20-07-34-L2033
Date of Document	
Number of Pages	23 and Exhibits A, B, and C
Additional Signers (other than those named in the notarial certificate)	Bureau of Reclamation Yuma County Water Users' Association

Certification of City Attorney

Contract 20-07-34-L2033 with the Bureau of Reclamation

Under A.R.S. § 11-952(D), I certify that I have determined that this agreement is in proper form, and it is within the powers and authority granted to the City of San Luis under the laws of Arizona.

_____ Date: _____

Kay Marion Macuil, San Luis City Attorney

LOCATION MAP

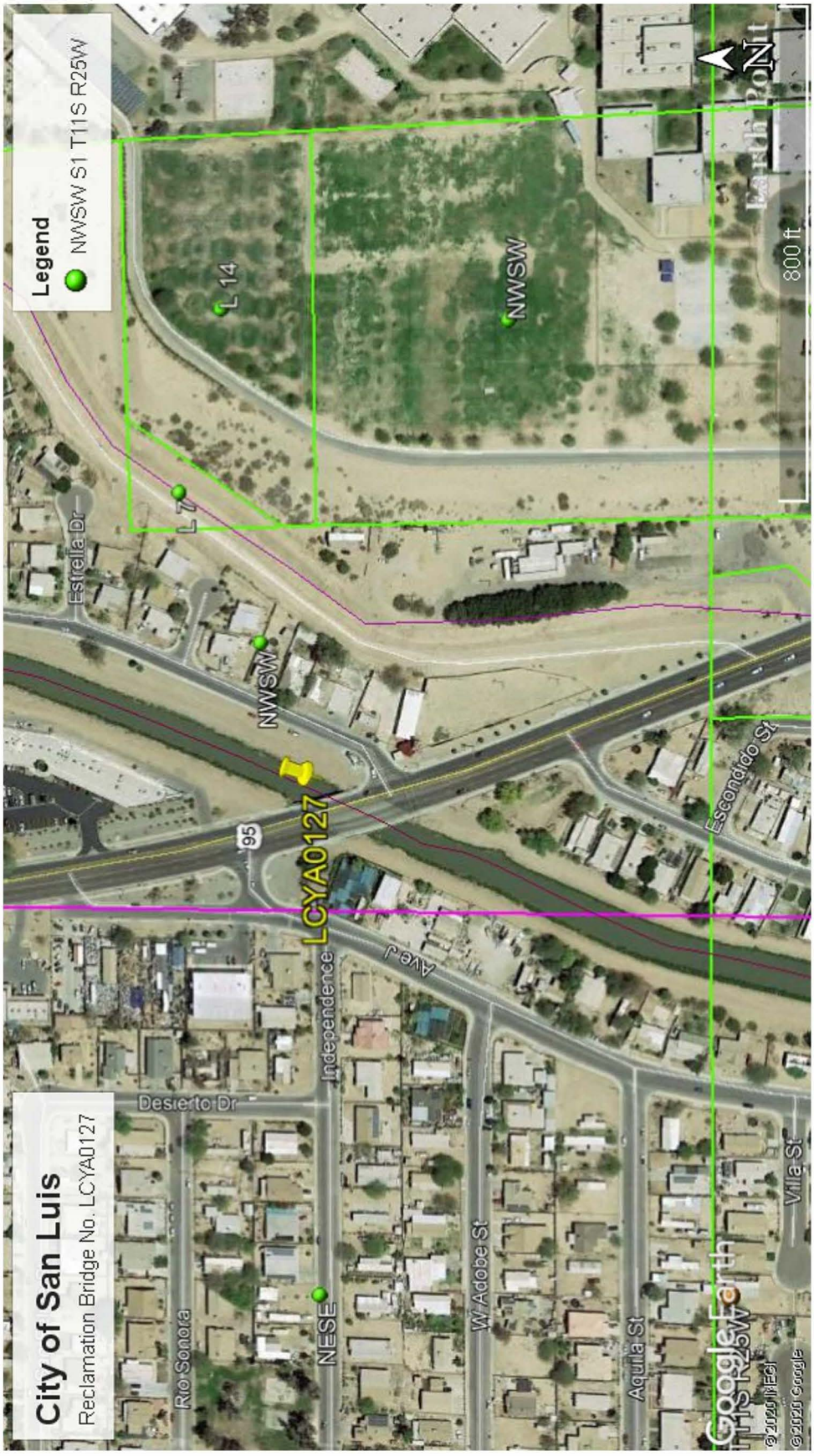
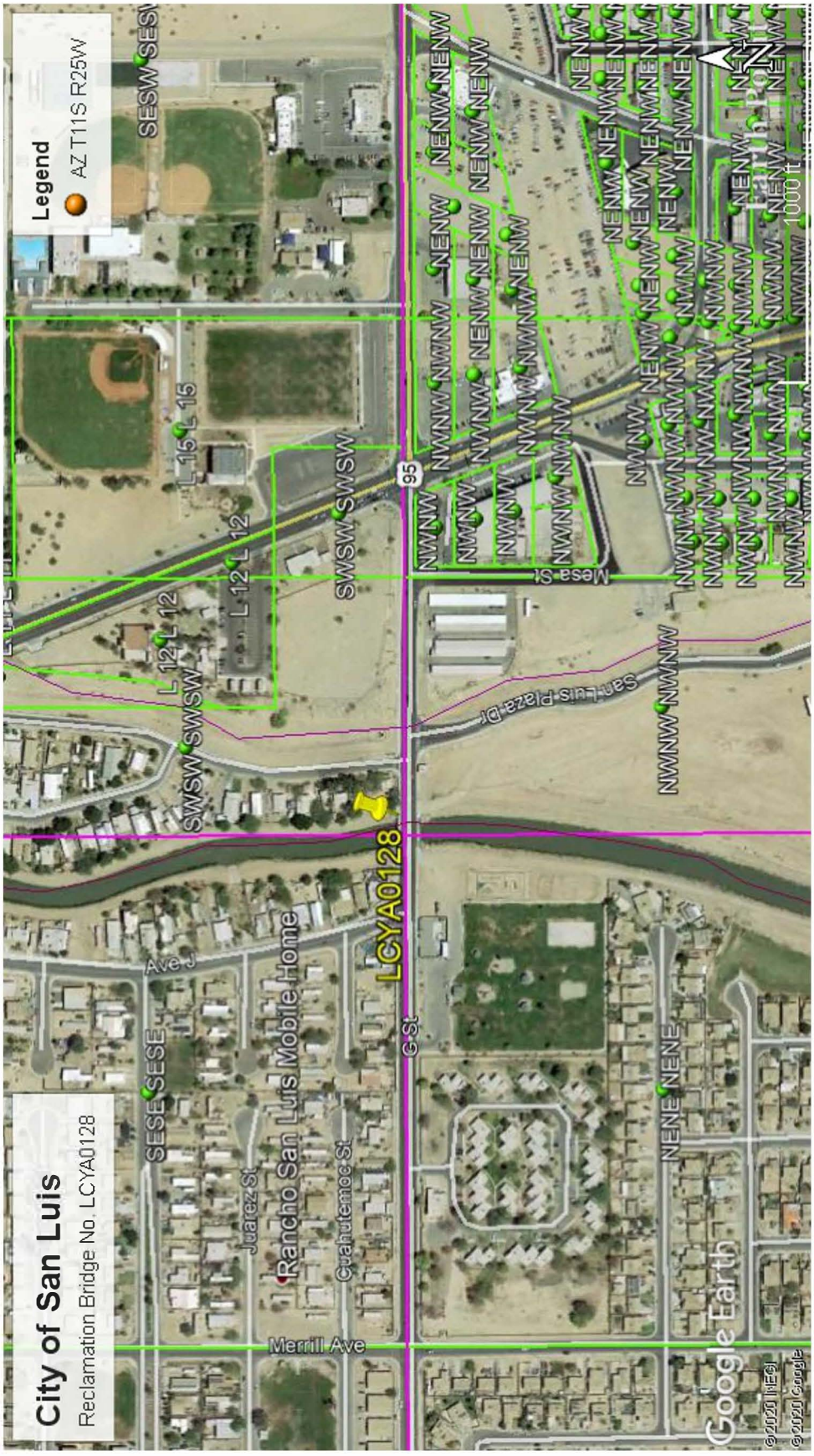
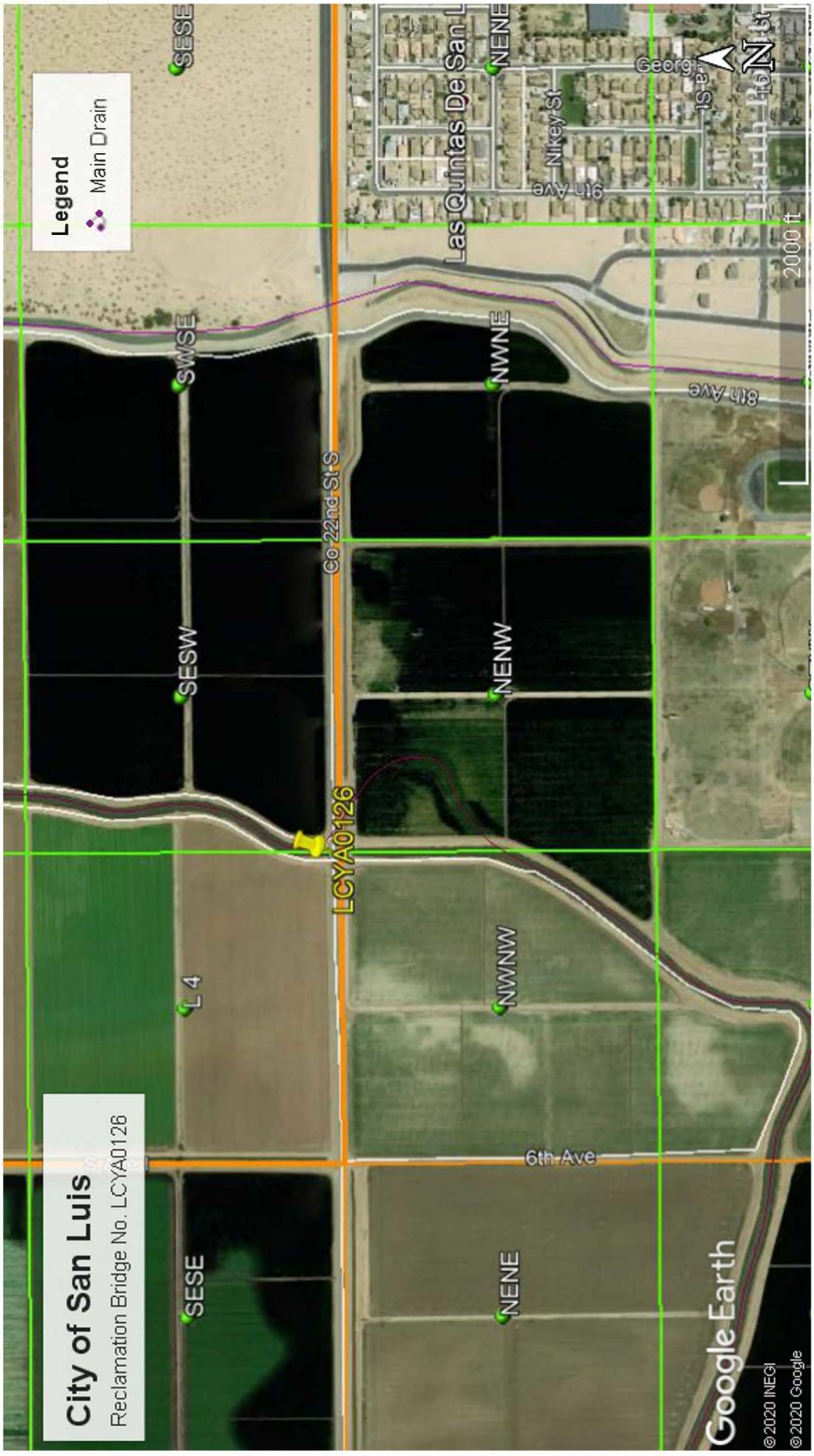


EXHIBIT A
CONTRACT NO. 20-07-34-L2033
PAGE 1 OF 4

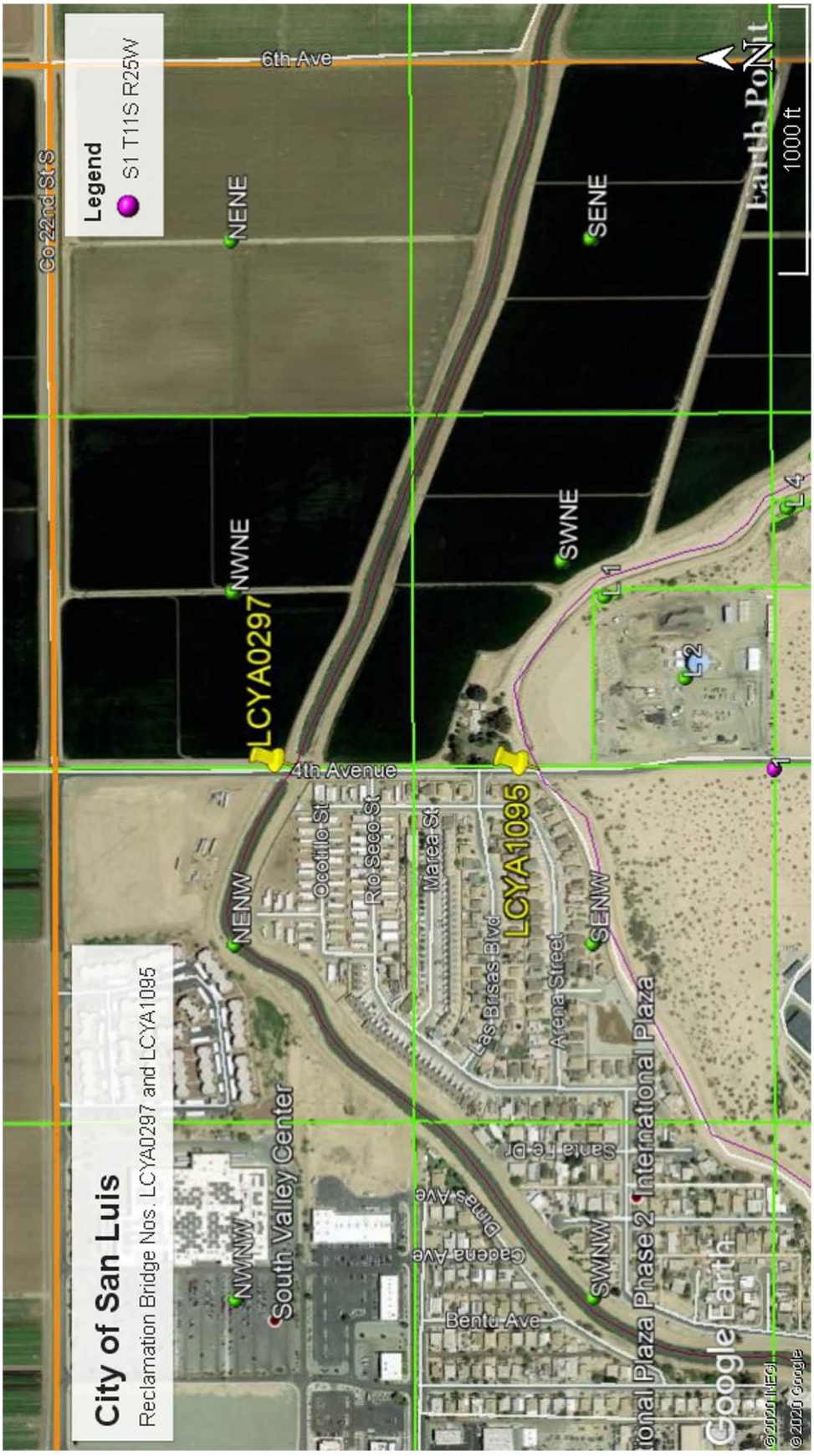
LOCATION MAP



LOCATION MAP



LOCATION MAP



United States Department of the Interior

BUREAU OF RECLAMATION
Lower Colorado Region
Yuma Area Office
7301 Calle Agua Salada
Yuma, AZ 85364

IN REPLY REFER TO:

OCT 01 2015

YAO-2300
PRJ-15.00

CERTIFIED – RETURN RECEIPT REQUESTED (70142120000185143669)

Mr. Eulogio Vera, P.E.
Public Works Director
City of San Luis
P.O. Box 3750
San Luis, AZ 85349

Subject: Confirmation of Ownership and Operation and Maintenance (O&M) Responsibility for Bridges That Cross Bureau of Reclamation Facilities or are Located on Reclamation Land – City of San Luis (City) – Yuma Project, Valley Division, Arizona

Dear Mr. Vera:

Reclamation continues its comprehensive inventory of bridges that cross Reclamation facilities or are located on Reclamation land. When completed, the bridge inventory will confirm ownership, identify inspection requirements, and ultimately prolong the useful life of each bridge through the application of effective O&M policies and procedures.

On May 22, 2015, a phone conversation occurred between Reclamation and you to discuss the status of the November 18, 2014, letter regarding bridge ownership and O&M responsibility. Based on the results of that conversation and some additional research, the following changes have been made to Enclosure 1:

- Bridges Y126, Y297, and Y1095 have been removed from the bridge inventory as they do not meet the 20 foot length requirement to be classified as bridges.

- Bridge Y127 has been identified as a bridge that is owned, operated, and maintained by the City and has been added to Enclosure 1. Arizona Department of Transportation Resolution of Abandonment No. 2010-03-A-023 is enclosed (Enclosure 4) for your reference.

- Bridge Y128 remains listed on Enclosure 1 as being owned, operated, and maintained by the City. Yuma County Water Users' Association License No. 017-95-001 (Enclosure 3) permits the City to construct, install, operate and maintain the subject bridge for use by the City and its residents. Although "ownership" of the bridge is not specified, it is the position of Reclamation that the intent of the license and use of the bridge infers ownership by the City.

The purpose of this letter is to advise the City, as the owner of the Type 3 bridges listed in Enclosure 1, of the responsibilities that come with bridge ownership as specified by the National Bridge Inspection Standards (NBIS). Reclamation does not conduct inspections of Type 3 bridges; however, deficiencies observed during Reclamation's Review of Operation & Maintenance (RO&M) facility examinations may

be transmitted to the City for corrective action. Reclamation RO&M inspections focus on the facility and typically do not include a certified bridge inspection.

As explained in Enclosure 1, Type 3 bridge inspection procedures must be conducted in accordance with the NBIS and must meet all the requirements set forth in 23 CFR Part 650, Subpart C. In general, Type 3 bridge inspection requirements include load rating certification, inspection by a qualified bridge inspector, inspection report, and submittal of inspection data to the Federal Highway Administration for inclusion in the National Bridge Inventory.

As the owner of a Type 3 bridge, the City is responsible for complying with NBIS procedures, implementing any access restrictions, and resolving any safety issues in order to safeguard employees and the general public. Please note that any access restrictions, major structural repairs, removals, and/or replacements must be approved by Reclamation in advance. Enclosure 2 is a Standard Form 299, Application for Transportation and Utility Systems and Facilities on Federal Lands, and should be used to initiate Reclamation's review and prior approval of those activities, except in the event of an emergency, in which case closures and/or repairs should be reported to Reclamation within 10 business days.

This is a courtesy notification and no response is required. If for any reason you do not concur with the information included in Enclosure 1, please respond with an explanation as to why you do not concur within 30 calendar days of the date of this letter.

Your prompt consideration is greatly appreciated. If you have any questions, please contact me at 928-343-8342 or cmscott@usbr.gov.

Sincerely,

Carrie M. Scott, P.E., PMP
Chief, Technical Support Office

Enclosures - 4

RECLAMATION

Enclosure 1 – City of San Luis, Arizona (City) – September 16, 2015

The contract number associated with a given bridge is noted in the row above the bridge(s).

Bridge Inventory No.[1]	Reclamation Facility Crossed or Located On	Road or Access Name	Latitude	Longitude	Owner	Operation & Maintenance Responsibility	Bridge Type (1, 2, or 3)[2]
Arizona Department of Transportation Resolution of Abandonment No. 2010-03-A-023							
Y127	East Main Canal	Highway 95 in San Luis	N32°29'58.60"	W114°47'09.30"	City of San Luis	City of San Luis	3
Yuma County Water Users' Association License 017-95-001							
Y128	Yuma Main Drain	Juan Sanchez Boulevard	N32°29'39.25"	W114°47'11.25"	City of San Luis	City of San Luis	3

[1] **Bridge Inventory Nos.** are for Reclamation's Yuma Area Office use only.

[2] **Bridge Type Descriptions**:

Type 1 Bridge

Any Reclamation-owned bridge that is located on a public road or on a privately maintained road open to public travel. Inspection of Type 1 bridges is conducted in accordance with the National Bridge Inspection Standards (NBIS). Type 1 bridges are usually scheduled for NBIS inspections once every 2 years. Inspections require load rating certification, inspection by a qualified bridge inspector, inspection report, and submittal of inspection data to the Federal Highway Administration annually for inclusion in the National Bridge Inventory database.

Type 2 Bridge

Any Reclamation-owned bridge that is not located on a public road [i.e., general public access to the road/bridge is restricted by some physical device(s) or barrier(s), or through the use of prohibitive signs].

Type 3 Bridge

Any bridge that crosses a Reclamation facility and is owned by an entity other than Reclamation (i.e., other governmental agencies, water user organizations, private individuals, etc.). Inspection of Type 3 bridges are conducted in accordance with the NBIS. Type 3 bridges are usually scheduled for NBIS inspections once every 2 years. Inspections require load rating certification, inspection by a qualified bridge inspector, inspection report, and submittal of inspection data to the Federal Highway Administration annually for inclusion in the National Bridge Inventory database.

Enclosure 2

Standard Form (SF) 299 – Application for Transportation and Utility Systems and Facilities on Federal Lands

SF299 is available electronically at http://www.gsa.gov/portal/forms/download/117318

A hard copy of the form follows.

STANDARD FORM 299 (05/2009)
Prescribed by DOI/USDA/DOT
P.L. 96-487 and Federal
Register Notice 5-22-95

APPLICATION FOR TRANSPORTATION AND UTILITY SYSTEMS AND FACILITIES ON FEDERAL LANDS

FORM APPROVED
OMB Control Number: 05960082
Expiration Date: 1/31/2017

FOR AGENCY USE ONLY

Application Number

Date Filed

NOTE: Before completing and filing the application, the applicant should completely review this package and schedule a preapplication meeting with representatives of the agency responsible for processing the application. Each agency may have specific and unique requirements to be met in preparing and processing the application. Many times, with the help of the agency representative, the application can be completed at the preapplication meeting.

1. Name and address of applicant *(include zip code)*

2. Name, title, and address of authorized agent if different from item 1 *(include zip code)*

3. Telephone (area code)

Applicant

Authorized Agent

4. As applicant are you? *(check one)*

a. ☐ Individual
b. ☐ Corporation*
c. ☐ Partnership/Association*
d. ☐ State Government/State Agency
e. ☐ Local Government
f. ☐ Federal Agency

** If checked, complete supplemental page*

5. Specify what application is for: *(check one)*

a. ☐ New authorization
b. ☐ Renewing existing authorization No.
c. ☐ Amend existing authorization No.
d. ☐ Assign existing authorization No.
e. ☐ Existing use for which no authorization has been received *
f. ☐ Other*

** If checked, provide details under item 7*

6. If an individual, or partnership are you a citizen(s) of the United States? ☐ Yes ☐ No

7. Project description (describe in detail): (a) Type of system or facility, *(e.g., canal, pipeline, road);* (b) related structures and facilities; (c) physical specifications *(Length, width, grading, etc.)*; (d) term of years needed: (e) time of year of use or operation; (f) Volume or amount of product to be transported; (g) duration and timing of construction; and (h) temporary work areas needed for construction *(Attach additional sheets, if additional space is needed.)*

8. Attach a map covering area and show location of project proposal

9. State or Local government approval: ☐ Attached ☐ Applied for ☐ Not Required

10. Nonreturnable application fee: ☐ Attached ☐ Not required

11. Does project cross international boundary or affect international waterways? ☐ Yes ☐ No *(if "yes," indicate on map)*

12. Give statement of your technical and financial capability to construct, operate, maintain, and terminate system for which authorization is being requested.

13a. Describe other reasonable alternative routes and modes considered.

b. Why were these alternatives not selected?

c. Give explanation as t o why it is necessary to cross Federal Lands.

14. List authorizations and pending applications filed for similar projects which may provide information to the authorizing agency. *(Specify number, date, code, or name)*

15. Provide statement of need for project, including the economic feasibility and items such as: (a) cost of proposal (construction, operation, and maintenance); (b) estimated cost of next best alternative; and (c) expected public benefits.

16. Describe probable effects on the population in the area, including the social and economic aspects, and the rural lifestyles.

17. Describe likely environmental effects that the proposed project will have on: (a) air quality; (b) visual impact; (c) surface and ground water quality and quantity; (d) the control or structural change on any stream or other body of water; (e) existing noise levels; and (f) the surface of the land, including vegetation, permafrost, soil, and soil stability.

18. Describe the probable effects that the proposed project will have on (a) populations of fish, plantlife, wildlife, and marine life, including threatened and endangered species; and (b) marine mammals, including hunting, capturing, collecting, or killing these animals.

19. State whether any hazardous material, as defined in this paragraph, will be used, produced, transported or stored on or within the right-of-way or any of the right-of-way facilities, or used in the construction, operation, maintenance or termination of the right-of-way or any of its facilities. "Hazardous material" means any substance, pollutant or contaminant that is listed as hazardous under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended, 42 U.S.C. 9601 et seq., and its regulations. The definition of hazardous substances under CERCLA includes any "hazardous waste" as defined in the Resource Conservation and Recovery Act of 1976 (RCRA), as amended, 42 U.S.C. 6901 et seq., and its regulations. The term hazardous materials also includes any nuclear or byproduct material as defined by the Atomic Energy Act of 1954, as amended, 42 U.S.C. 2011 et seq. The term does not include petroleum, including crude oil or any fraction thereof that is not otherwise specifically listed or designated as a hazardous substance under CERCIA Section 101(14), 42 U.S.C. 9601(14), nor does the term include natural gas.

20. Name all the Department(s)/Agency(ies) where this application is being filed.

I HEREBY CERTIFY, That I am of legal age and authorized to do business in the State and that I have personally examined the information contained in the application and believe that the information submitted is correct to the best of my knowledge.

Signature of Applicant	Date

Title 18, U.S.C. Section 1001, makes it a crime for any person knowingly and willfully to make to any department or agency of the United States any false, fictitious, or fraudulent statements or representations as to any matter within its jurisdiction.

GENERAL INFORMATION
ALASKA NATIONAL INTEREST LANDS

This application will be used when applying for a right-of-way, permit, license, lease, or certificate for the use of Federal lands which lie within conservation system units and National Recreation or Conservation Areas as defined in the Alaska National Interest lands Conservation Act. Conservation system units include the National Park System, National Wildlife Refuge System, National Wild and Scenic Rivers System, National Trails System, National Wilderness Preservation System, and National Forest Monuments.

Transportation and utility systems and facility uses for which the application may be used are:

1. Canals, ditches, flumes, laterals, pipes, pipelines, tunnels, and other systems for the transportation of water.

2. Pipelines and other systems for the transportation of liquids other than water, including oil, natural gas, synthetic liquid and gaseous fuels, and any refined product produced therefrom.

3. Pipelines, slurry and emulsion systems, and conveyor belts for transportation of solid materials.

4. Systems for the transmission and distribution of electric energy.

5. Systems for transmission or reception of radio, television, telephone, telegraph, and other electronic signals, and other means of communications.

6. Improved right-of-way for snow machines, air cushion vehicles, and all-terrain vehicles.

7. Roads, highways, railroads, tunnels, tramways, airports, landing strips, docks, and other systems of general transportation.

This application must be filed simultaneously with each Federal department or agency requiring authorization to establish and operate your proposal.

In Alaska, the following agencies will help the applicant file an application and identify the other agencies the applicant should contact and possibly file with:

Department of Agriculture
Regional Forester, Forest Service (USFS)
Federal Office Building,
P.O. Box 21628
Juneau, Alaska 99802-1628
Telephone: (907) 586-7847 *(or a local Forest Service Office)*

Department of the Interior
Bureau of Indian Affairs (BIA)
Juneau Area Office
Federal Building Annex
9109 Mendenhall Mall Road, Suite 5
Juneau, Alaska 99802
Telephone: (907) 586-7177

Department of the Interior
Bureau of Land Management
222 West 7th Avenue
P.O. Box 13
Anchorage, Alaska 99513-7599
Telephone: (907) 271-5477 (or a local BLM Office)

U.S. Fish & Wildlife Service (FWS)
Office of the Regional Director
1011 East Tudor Road
Anchorage, Alaska 99503
Telephone: (907) 786-3440

National Park Service (NPA)
Alaska Regional Office, 2225
Gambell St., Rm. 107
Anchorage, Alaska 99502-2892
Telephone: (907) 786-3440

Note - Filings with any Interior agency may be filed with any office noted above or with the Office of the Secretary of the Interior, Regional Environmental Office, P.O. Box 120, 1675 C Street, Anchorage, Alaska 9513.

Department of Transportation
Federal Aviation Administration
Alaska Region AAL-4, 222 West 7th Ave., Box 14
Anchorage, Alaska 99513-7587
Telephone: (907) 271-5285

NOTE - The Department of Transportation has established the above central filing point for agencies within that Department. Affected agencies are: Federal Aviation Administration (FAA), Coast Guard (USCG), Federal Highway Administration (FHWA), Federal Railroad Administration (FRA).

OTHER THAN ALASKA NATIONAL INTEREST LANDS

Use of this form is not limited to National Interest Conservation Lands of Alaska.

Individual department/agencies may authorize the use of this form by applicants for transportation and utility systems and facilities on other Federal lands outside those areas described above.

For proposals located outside of Alaska, applications will be filed at the local agency office or at a location specified by the responsible Federal agency.

SPECIFIC INSTRUCTIONS
(Items not listed are self-explanatory)

7 Attach preliminary site and facility construction plans. The responsible agency will provide instructions whenever specific plans are required.

8 Generally, the map must show the section(s), township(s), and range(s) within which the project is to be located. Show the proposed location of the project on the map as accurately as possible. Some agencies require detailed survey maps. The responsible agency will provide additional instructions.

9 , 10, and 12 The responsible agency will provide additional instructions.

13 Providing information on alternate routes and modes in as much detail as possible, discussing why certain routes or modes were rejected and why it is necessary to cross Federal lands will assist the agency(ies) in processing your application and reaching a final decision. Include only reasonable alternate routes and modes as related to current technology and economics.

14 The responsible agency will provide instructions.

15 Generally, a simple statement of the purpose of the proposal will be sufficient. However, major proposals located in critical or sensitive areas may require a full analysis with additional specific information. The responsible agency will provide additional instructions.

16 through 19 Providing this information is as much detail as possible will assist the Federal agency(ies) in processing the application and reaching a decision. When completing these items, you should use a sound judgment in furnishing relevant information. For example, if the project is not near a stream or other body of water, do not address this subject. The responsible agency will provide additional instructions.

Application must be signed by the applicant or applicant's authorized representative.

EFFECT OF NOT PROVIDING INFORMATION: Disclosure of the information is voluntary. If all the information is not provided, the application may be rejected.

DATA COLLECTION STATEMENT

The Federal agencies collect this information from applicants requesting right-of-way, permit, license, lease, or certification for the use of Federal lands. The Federal agencies use this information to evaluate the applicant's proposal. The public is obligated to submit this form if they wish to obtain permission to use Federal lands.

SUPPLEMENTAL

NOTE: The responsible agency(ies) will provide instructions	CHECK APPROPRIATE BLOCK	
I - PRIVATE CORPORATIONS	ATTACHED	FILED*
a. Articles of Incorporation	☐	☐
b. Corporation Bylaws	☐	☐
c. A certification from the State showing the corporation is in good standing and is entitled to operate within the State	☐	☐
d Copy of resolution authorizing filing	☐	☐
e. The name and address of each shareholder owning 3 percent or more of the shares, together with the number and percentage of any class of voting shares of the entity which such shareholder is authorized to vote and the name and address of each affiliate of the entity together with, in the case of an affiliate controlled by the entity, the number of shares and the percentage of any class of voting stock of that affiliate owned, directly or indirectly, by that entity, and in the case of an affiliate which controls that entity, the number of shares and the percentage of any class of voting stock of that entity owned, directly or indirectly, by the affiliate.	☐	☐
f. If application is for an oil or gas pipeline, describe any related right- of-way or temporary use permit applications, and identify previous applications.	☐	☐
g. If application is for an oil and gas pipeline, identify all Federal lands by agency impacted by proposal.	☐	☐
II - PUBLIC CORPORATIONS		
a. Copy of law forming corporation	☐	☐
b. Proof of organization	☐	☐
c. Copy of Bylaws	☐	☐
d. Copy of resolution authorizing filing	☐	☐
e. If application is for an oil or gas pipeline, provide information required by item "I - f" and "I - g" above.	☐	☐
III - PARTNERSHIP OR OTHER UNINCORPORATED ENTITY		
a. Articles of association, if any	☐	☐
b. If one partner is authorized to sign, resolution authorizing action is	☐	☐
c. Name and address of each participant, partner, association, or other	☐	☐
d. If application is for an oil or gas pipeline, provide information required by item "I - f" and "I - g" above.	☐	☐

*If the required information is already filed with the agency processing this application and is current, check block entitled "Filed." Provide the file identification information *(e.g., number, date, code, name)*. If not on file or current, attach the requested information.

NOTICES

Note: This applies to the Department of Agriculture/Forest Service (FS)

This information is needed by the Forest Service to evaluate the requests to use National Forest System lands and manage those lands to protect natural resources, administer the use, and ensure public health and safety. This information is required to obtain or retain a benefit. The authority for that requirement is provided by the Organic Act of 1897 and the Federal Land Policy and Management Act of 1976, which authorize the secretary of Agriculture to promulgate rules and regulations for authorizing and managing National Forest System lands. These statutes, along with the Term Permit Act, National Forest Ski Area Permit Act, Granger-Thye Act, Mineral Leasing Act, Alaska Term Permit Act, Act of September 3, 1954, Wilderness Act, National Forest Roads and Trails Act, Act of November 16, 1973, Archeological Resources Protection Act, and Alaska National Interest Lands Conservation Act, authorize the Secretary of Agriculture to issue authorizations or the use and occupancy of National Forest System lands. The Secretary of Agriculture's regulations at 36 CFR Part 251, Subpart B, establish procedures for issuing those authorizations.

BURDEN AND NONDISCRIMINATION STATEMENTS

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0596-0082. The time required to complete this information collection is estimated to average 8 hours hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, age, disability, and where applicable, sex, marital status, familial status, parental status, religion, sexual orientation, genetic information, political beliefs, reprisal, or because all or part of an individual's income is derived from any public assistance. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at 202-720- 2600 (voice and TDD).

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call toll free (866) 632-9992 (voice). TDD users can contact USDA through local relay or the Federal relay at (800) 877-8339 (TDD) or (866) 377-8642 (relay voice). USDA is an equal opportunity provider and employer.

The Privacy Act of 1974 (5 U.S.C. 552a) and the Freedom of Information Act (5 U.S.C. 552) govern the confidentiality to be provided for information received by the Forest Service.

LICENSE NO. **017-95-001**

YUMA COUNTY WATER USERS' ASSOCIATION
P.O. BOX 5775
YUMA, AZ 85366-5775

LICENSE FOR ENCROACHMENTS AND CONSTRUCTION, INSTALLATION, OPERATION AND MAINTENANCE OF FACILITIES

LICENSEE: **CITY OF SAN LUIS**

SERIAL NO(S): **N/A** DIVISION: **N/A**

LOCATION: **USBR MAIN DRAIN RIGHTS-OF-WAY AT COUNTY 23RD STREET IN SECTIONS, 1, 2, 11 AND 12, TOWNSHIP 11 SOUTH, RANGE 25 WEST, GSRBM**

1. Authority. Pursuant to the provisions of United States Department of the Interior, Bureau of Reclamation, Public Notice No. 77 dated February 12, 1960 (entitled "Public Notice Announcing Procedures for Processing Water Right Applications and Certain Other Contracts", the Yuma County Water Users' Association (Licensor) licenses the above named Licensee to construct, install, operate and maintain facilities encroaching upon rights-of-way of the United States forming a part of the Valley Division of the Yuma Project, a reclamation project constructed under the laws of the United States.

2. Description of Encroachment. The encroachment shall be constructed and operated only under the terms and conditions of this license and is specifically described as follows:

a. **CONSTRUCTION AND MAINTENANCE OF A BRIDGE AND ROADWAY, INCLUDING SIDEWALKS AND GUARDRAILS, ACROSS THE RIGHTS-OF-WAY OF THE USBR MAIN DRAIN AT COUNTY 23RD STREET (G STREET).**

b. Any violation of this paragraph shall, at the option of the Licensor, constitute grounds for immediate termination of the license without further notice. Upon an election to terminate, any facilities constructed by the Licensee shall be removed in the manner provided in paragraph 11 of this license.

c. Nothing in this paragraph prohibits the Licensee from utilizing the services of a person or entity not a party the this License for the purpose of constructing the encroachment herein contemplated.

6. Licensee's Liability. The Licensee shall be liable for all damages to the property of the United States, the Licensor, or any third party or parties caused by reason of the exercise of the Licensee of any right conferred by this license.

7. Hold Harmless Agreement. To the maximum extent permitted by law, the Licensee agrees to hold forever harmless, indemnify and defend the Licensor and the United States Government, together with all of their respective officers, employees, successors and assigns from any and all claims related to or any way connected with the construction, operation or maintenance of the facilities described in this license. The Licensee's obligation hereunder includes, but is not limited to, the obligation to pay the Licensor attorney fees and costs incurred in connection with any claim without regard to whether such claim results in litigation.

8. Duration of License. This license shall continue in effect so long as the Licensor determines, in its sole discretion, that the same is expedient and is not detrimental or incompatible with the proper care, operation and maintenance of the Valley Division and its works.

9. Additional Approval.

a. This license and consent to encroachment are subject to the approval of:

Area Manager, Yuma Area Office
United States Bureau of Reclamation
P.O. Box D
Yuma, AZ 85366

and the Licensee shall take no action nor commence any activities hereunder until such consent is approved as provided in this paragraph.

b. A copy of this license with all attachments shall be mailed by the Licensor to the Area Manager at the above address on the next working day after the date it is fully executed by the Licensee and the Licensor. The license shall be deemed approved by the Area Manager unless the same is disapproved in writing (with a copy to the Licensor) within twenty (20) working days after the date it is fully executed.

termination of this license without further notice. Upon such termination, all encroaching facilities constructed hereunder shall be removed in the manner provided in paragraph 11 of this license.

13. Plans and Specifications: Construction. All structures constructed under this license shall be erected in accordance with plans and specifications approved in advance by the Licensor as herein provided and shall be erected in such a manner as not to obstruct in any manner the flow of water in the canals, laterals or drain ditches of the United States of the Licensor or to interfere in any manner whatsoever with the construction, operation and maintenance of any part of the project by the Licensor or the United States.

14. Specifications and Conditions.

a. The encroachment and the erection of structures of facilities under the terms of this license shall be in accordance with the plans, specifications and conditions described below:

1) **PLANS PREPARED BY NICKLAUS ENGINEERING ENTITLED "G STREET/MAIN DRAIN BRIDGE," DATED 12/26/95, SHEETS 1 THRU 19.**

2) **PLACEMENT FOR RIP RAP SHALL BE SUCH AS TO ADEQUATELY PROTECT THE BANKS OF THE MAIN DRAIN FROM EROSION AND SUCH AS TO NOT OBSTRUCT FLOWS IN THE MAIN DRAIN, AS DETERMINED BY INSPECTION BY THE ASSOCIATION.**

3) **SHEET PILING SHALL BE EXTENDED INTO THE BANKS TO ABOVE THE HIGH WATER LINE.**

All of the foregoing plans, specifications and conditions are made a part of this license and are subject to the prior approval of the Licensor.

b. Any proposed variation in construction or operation of encroaching facilities from approved plans and specifications must be approved in writing by the Licensor and the Licensee before construction or operation. If any proposed variation is, in the opinion of the Licensor substantial in nature, the same must also be approved by the USBR in the manner provided in paragraph 9.

15. Increased Operation and Maintenance Expense.

a. If the construction and placement of facilities by the Licensee under the terms of this license increases the costs to the Licensor, or its successors, of operation and maintenance functions on the right-of-way herein described, it is agreed that the amount of any such increase shall be paid by the Licensee.

Dated : 2/7/96

Approved:

By _____
Manager, YUMA COUNTY WATER
USERS' ASSOCIATION

Copy to: Area Manager
Yuma Area Office
United States Bureau of Reclamation
P.O. Box D
Yuma, AZ 85366

Arizona Department of Transportation
Intermodal Transportation Division
Right of Way Group
INTEROFFICE MEMO

To PAUL PATANE Yuma District Engineer Mail Drop # Y-200	Date: April 14, 2010
From: SHERI GARRIGUS Right of Way Titles Resolution/Disposal Unit	Subject: Recorded Resolution of Abandonment

RE: RESOLUTION OF ABANDONMENT
PROJECT: F-063-1-724 / 095YU.667H441601R
HIGHWAY: SAN LUIS – YUMA - QUARTZSITE
SECTION: San Luis – Gadsden (County 23rd St. – County 22nd St.)

Attached is your copy of a Recorded Resolution of Abandonment that affects your District.

Resolution 2010-03-A-023, dated March 19, 2010, recorded April 1, 2010, in DOCUMENT # 2010-08182, will abandon a portion of U.S. 95 to the City of San Luis for a continued public transportation use.

cc: Gerry Ramirez, ADOT, Yuma District

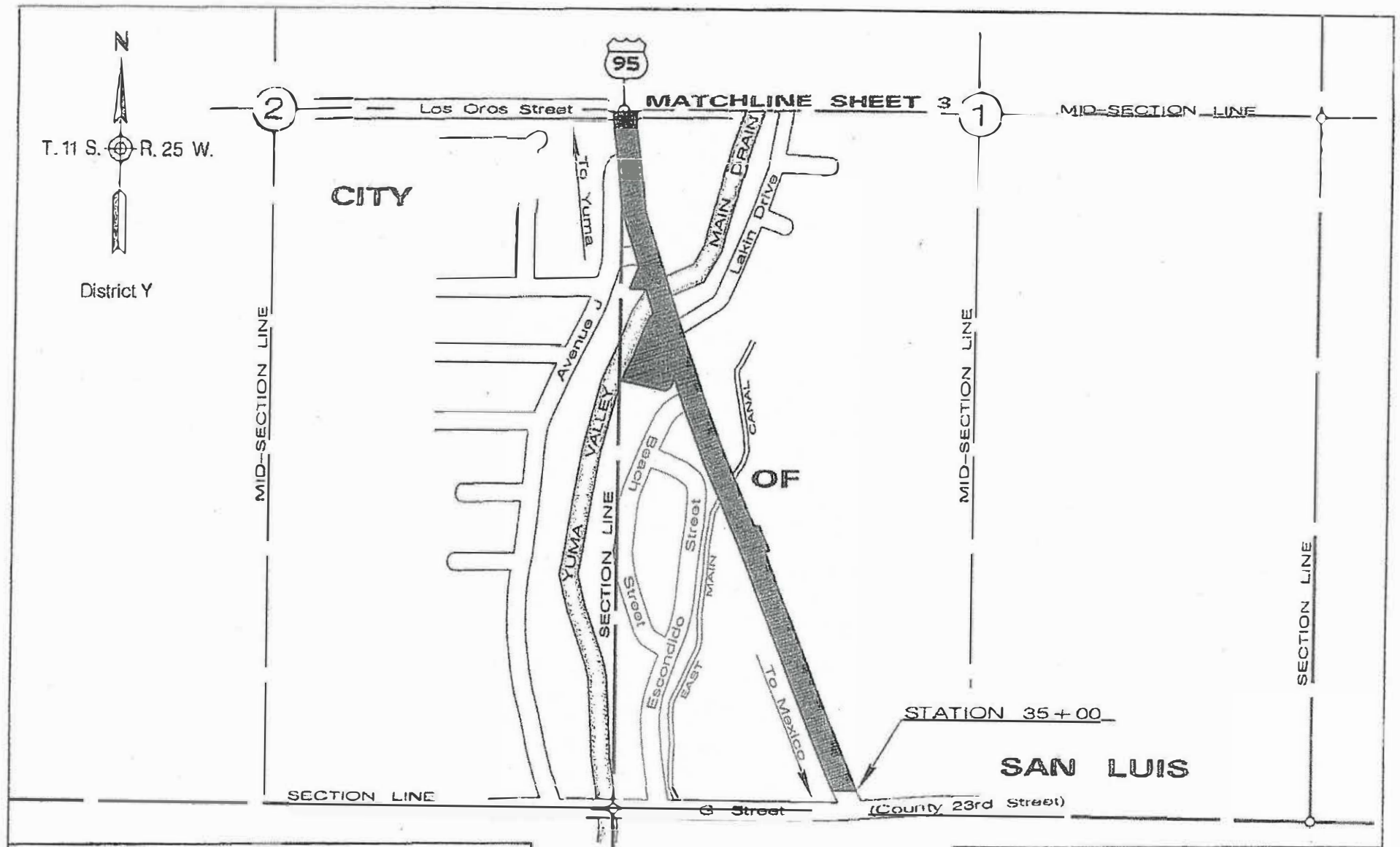
Attachment

March 19, 2010

RES. NO. 2010-03-A-023
PROJECT: F-063-1-724 / 095YU.667H441601R
HIGHWAY: SAN LUIS - YUMA - QUARTZSITE
SECTION: San Luis - Gadsden (County 23rd St. - County 22nd St.)
ROUTE NO.: U.S. Route 95
ENG. DIST.: Yuma
COUNTY: Yuma

RESOLVED that the abandonment becomes effective upon recordation in the Office of the County Recorder in accordance with Arizona Revised Statute Section 28-7213; be it further

RESOLVED that the Director provide written notice to the City of San Luis evidencing the abandonment of the State's interest.



A LEGIBLE COPY CAN BE OBTAINED FROM THE
ARIZONA DEPARTMENT OF TRANSPORTATION
STATE ENGINEER'S OFFICE
RIGHT OF WAY GROUP
205 SOUTH 17TH AVENUE
PHOENIX, ARIZONA 85007
MAIL DROP 612E

AREA OF ABANDONMENT

APPENDIX "A"

095 YU .667 H4416 01R
F-063-1-724
SAN LUIS - YUMA - QUARTZSITE HWY
San Luis-Gadsden
(County 23rd St - County 22nd St)
Yuma County
MARCH 19, 2010 SHEET 2 OF 3

EXHIBIT B
CONTRACT NO. 20-07-34-L2033
PAGE 16 OF 18

March 19, 2010

RES. NO. 2010-03-A-023
PROJECT: F-063-1-724 / 095YU.667H441601R
HIGHWAY: SAN LUIS - YUMA - QUARTZSITE
SECTION: San Luis - Gadsden (County 23rd St. - County 22nd St.)
ROUTE NO.: U.S. Route 95
ENG. DIST.: Yuma
COUNTY: Yuma

REPORT AND RECOMMENDATION

TO THE HONORABLE ARIZONA TRANSPORTATION BOARD:

The Intermodal Transportation Division has made a thorough investigation concerning the abandonment of a portion of right of way acquired for U.S Route 95 within the above referenced project.

This portion was previously established as a State Route by Arizona Highway Commission Resolution dated May 19th, and 20th, 1936, pages 586 and 624 of the Official Minutes; Resolution dated May 26, 1936, page 634 of the Official Minutes established this route as a State Highway; Resolutions dated October 25, 1946, page 43 and August 1, 1947, page 208 relocated and altered a portion thereof; thereafter Arizona Department of Transportation Board Resolution 98-05-A-014, dated May 15, 1998, established additional right of way for improvements thereof.

A portion of the previously acquired right of way is no longer needed for state transportation purposes. The City of San Luis has agreed to accept jurisdiction of the right of way for a continued public transportation use by waiving the Advance Four-Year Notice of Abandonment and pavement quality report in accordance with Arizona Revised Statutes Section 28-7209. Accordingly, I recommend that the State's interest in the portion of right of way be abandoned.

The portion of right of way to be abandoned is depicted in Appendix "A" and delineated on the maps and plans on file in the office of the State Engineer, Intermodal Transportation Division, Phoenix, Arizona, entitled "Right of Way Plans, SAN LUIS - YUMA - QUARTZSITE Highway, Project F-063-1-724 / 095YU.667H441601R."

March 19, 2010

RES. NO. 2010-03-A-023
PROJECT: F-063-1-724 / 095YU.667H441601R
HIGHWAY: SAN LUIS - YUMA - QUARTZSITE
SECTION: San Luis - Gadsden (County 23rd St. - County 22nd St.)
ROUTE NO.: U.S. Route 95
ENG. DIST.: Yuma
COUNTY: Yuma

CERTIFICATION

I, JOHN S. HALIKOWSKI, Director of the Arizona Department of Transportation, do hereby certify that the foregoing is a true and correct copy from the minutes of the Transportation Board made in official session on March 19, 2010.

IN WITNESS WHEREOF I have hereunto set my hand and the official seal of the Transportation Board on March 19, 2010.

JOHN S. HALIKOWSKI, Director
Arizona Department of Transportation

Acronyms and Abbreviations

AASHTO	American Association of State Highway and Transportation Official
AOE	authorized operating entity
AWWA	American Water Works Association
CFR	Code of Federal Regulations
CPS	cathodic protection system
DOT	Department of Transportation
HDD	horizontal directional drilling
kV	kilovolt(s)
MERL	Materials Engineering and Research Laboratory
O&M	operations and maintenance
Reclamation	Bureau of Reclamation
ROW	right-of-way
WB-67	67-foot wheelbase

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EXHIBIT C
CONTRACT NO. 20-07-34-L2033

1.0 PURPOSE

These are general guidelines for Bureau of Reclamation (Reclamation) offices to follow when reviewing the engineering and operations and maintenance (O&M) factors in outside entity requests for authorization to cross (encroach upon) Reclamation lands that contain project features such as levees, canals, pipelines, or other water conveyance facilities owned or administered by Reclamation. These guidelines include a general overview of the permitting process administered by Reclamation Lands Groups for allowing a particular use on lands where Reclamation holds a fee or an easement right-of-way interest. These engineering and construction recommendations are minimum guidelines for engineers to use in reviewing and evaluating these portions of the applications.

2.0 GENERAL PERMIT INFORMATION

Applicants requesting to cross any Reclamation land, facility, or water body must obtain a written land use authorization from Reclamation. Requirements for obtaining a use authorization to cross Reclamation project land and water surfaces are in the Code of Federal Regulations (CFR) at 43 CFR 429 and Reclamation Manual LND 08-01. The applicant must complete the *Standard Form (SF) 299*, **"Application for Transportation and Utility Systems and Facilities on Federal Lands,"** or similar forms in use at the local Reclamation office. The form can be obtained by contacting the involved Reclamation office, or it can be accessed electronically at Reclamation's Web site at: <http://www.usbr.gov/pmts/lands>.

Applicants can contact their local Reclamation office to discuss their proposed use before filing an application for a use authorization.

3.0 ENGINEERING AND O&M REVIEW CONSIDERATIONS

3.1 Introduction

Technical review of the crossing evaluates impacts on any existing Reclamation facility and **does not determine the adequacy of the crossing design for the applicant's intended purpose.**

The use authorization or consent document specifies criteria which, if followed, would not be deemed unreasonable interference. These review guidelines are strictly limited to those criteria which:

- Protect Reclamation's facility and/or appurtenant facility from damage
- Ensure unrestricted flow and quality of water in Reclamation's facility
- Do not diminish the ability to perform O&M of Reclamation's facility, including access
- Prevent any burden of liability

These guidelines are provided as recommendations that apply to most Reclamation facilities. Each Reclamation office and/or authorized operating entity (AOE) should apply these guidelines using **sound engineering judgment** that best applies to their facilities and existing conditions. Additional Reclamation guidelines for specific locations (e.g., Central Arizona Project Reach 11 Basin Guidelines) may also apply and may be provided to applicants when necessary. These guidelines are minimums, and local conditions may be more stringent depending on the direct impacts to facilities and lands. AOEs may have additional requirements.

Uses that may be deemed reasonable within Reclamation pipeline easements include greenbelts, asphalt roadways, flexible pavement parking lots, transverse curbs and gutters, and sidewalks. Canals and pipelines may have overhead power and telephone lines (but not their supporting poles), transverse fences with gated openings (no walls), and similar surface and overhead structures.

3.2 General

The following individual items should be addressed by the applicant and evaluated by Reclamation and/or AOE as they may affect the Reclamation facility's engineering and O&M aspects. If unusual conditions are proposed for the encroaching structure or unusual field conditions within a Reclamation facility right-of-way (ROW) are encountered, Reclamation reserves the right to impose more stringent criteria than prescribed in these guidelines.

1. Structures that should not be constructed on Reclamation pipeline or canal ROW (whether fee owned or easement) include foundations, buildings, garages, carports, trailers, street light standards, supports for large signs, walls, longitudinal fences (except security/safety fences), power or telephone poles, and similar surface structures.

2. Prior to construction, a joint inspection should be conducted and the condition of existing facilities documented. Reclamation's ROW should be restored to pre-existing conditions following completion of work.

3. When applications are requesting public use of trails and maintenance roads adjacent to or crossing Reclamation canals, these facilities should be fenced for safety to separate them from open canal water, except when Reclamation's ROW is used as a greenbelt and the applicant accepts legal hazard responsibility. Trails and maintenance roads should be fenced on an as-needed basis whenever such fencing is warranted for public safety, restricted access, security, etc. If a fence is allowed within Reclamation's ROW, Reclamation should approve the fence materials. Any gates allowed within Reclamation's ROW should be at least 16 feet wide. Reclamation will be provided with full access through any fences or gates.

4. Prior to construction of any structure that encroaches within a Reclamation pipeline or canal ROW, a "pothole excavation" should be made to determine the locations of any existing Reclamation and non-Reclamation facilities and their appurtenant features that may be affected. Potholing is the practice of digging test holes to expose underground utilities to determine the horizontal and vertical location of the utility.

   All work within 18 inches of the facility should be done using hand-held tools only. The excavation should be made by or in the presence of Reclamation and/or AOE personnel. The presence of a Reclamation and/or AOE inspector may be required throughout the excavation process, but this presence in no way relieves the applicant or their contractor of responsibility.

   The resultant elevation information should be delineated on the profile view and labeled as:

   POTHOLED ELEVATION XX.X
   Surface Elevation XX.X

   The pothole excavation should be filled in, or a safety fence installed, prior to departing the site each day.

5. If Reclamation facilities need to be modified to avoid adverse impacts from the applicant's crossing facility, the applicant should be responsible for the cost of such modifications.

6. A temporary permit may be required for visual inspections, ground and aerial surveys,[1] or potholing that requires physical entrance onto a Reclamation facility. **A use authorization or consent document issued by Reclamation and/or AOE should be obtained prior to entering or crossing Reclamation's ROW for any activity.**

7. Applications should include a project description, calculations, specifications, and detailed construction plans showing plan views, profiles and sections, and grading plans of proposed work within or adjacent to Reclamation's ROW. Plans should show an easily recognizable boundary (tied to a known corner) and Reclamation's ROW and Reclamation stationing or mile post designation.

   All Reclamation facilities should be shown and labeled (e.g., "Centerline of xx-inch Reclamation Pipeline," "Reclamation Communication and Control Cable," etc.) The type and weight of the construction equipment crossing Reclamation pipelines, roads, and bridges as well as the crossing locations should be included. Additional information, as identified in following individual specific feature sections of these guidelines, should also be included with the application for review.

   Any engineering or land survey drawing should contain the appropriate registered engineer's or land surveyor's stamp and signature. A construction schedule outlining the anticipated duration of the construction should be submitted. A minimum of two[2] copies of the application (including calculations, specifications, and plans) should be submitted to Reclamation and/or AOE for review and approval.

8. For crossings of all Reclamation facilities, Reclamation and/or AOE personnel familiar with the facilities (including cathodic protection systems) will obtain and provide copies of existing files showing information about existing buried facilities (center of pipeline, depth of cover, size of pipe, class of pipe, etc.) to the applicant.

9. Existing Reclamation facilities (e.g., canal lining, canal check structure, turnout structure, etc.) and appurtenances (e.g., existing blow-offs, air valves, vents, manholes, and/or cathodic protection test stations) and existing non-Reclamation facilities on Reclamation's ROW (e.g., petroleum pipelines, natural gas pipelines, communications lines, powerlines, water lines, sewer lines, storm drain lines, etc.) **should be protected** in place prior to and during construction.

---

[1] Aerial surveys require placing on-the-ground survey control markers.
[2] Revise per local Reclamation office and/or AOE practice.

The applicant and/or their contractor may be liable for all damages to Reclamation facilities and appurtenances as a result of construction and for any other damages or losses suffered by Reclamation or its water contractors, including power, irrigation, municipal and industrial water supply, and communication losses.

10. Trench excavation should comply with the most current Occupational Safety and Health Administration standards or Reclamation Health and Safety Standards, whichever are more stringent. Trench backfill should be placed in 4- to 6-inch lifts if hand compacted or no more than 8-inch lifts if power compacted. Trench backfill within Reclamation's ROW should be compacted to 95 percent relative compaction (ASTM D 698, Standard Proctor) (or 90 percent of ASTM D 1557). Mechanical compaction using heavy equipment (greater than 2,000 pounds) should not be used within 18 inches of the Reclamation pipeline. Flowable fill (or controlled low strength material) should be substituted for compacted pipe embedment under canals and may be used when crossing pipelines.

11. Erosion control measures, including re-vegetation, should be implemented after completing construction.

12. If existing drainage features are to be modified during construction, detailed drawings showing the proposed drainage replacement/ restoration should be submitted with the application for review and approval. The applicant is responsible for the care and handling of storm water runoff both during and after construction.

13. The applicant should not divert surface runoff[3] toward Reclamation canal or canal embankments. The 100-year storm[4] surface runoff should use detention basins outside of Reclamation's ROW. Lined drainage channels should be designed to transfer flow from the detention basins to the existing cross drainage facilities that drained the original area. Also refer to "4.4 Storm Water Cross Drainage."

14. Proposed temporary or permanent modifications to the existing cover over Reclamation pipelines should be subject to review and approval by Reclamation and/or AOE. Design parameters for roadway, parking lot, and driveway crossings over the pipe should also be subject to review and approval by Reclamation and/or AOE.

[3] Subdivision or commercial development on the uphill side of canals that pave large areas and have large roof areas will greatly increase peak storm runoff—most city development requires retention basins. Applicants should provide the same retention basins that are required for similar development projects.

[4] Revise per Reclamation field office for specific canal if a higher storm frequency is required.

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15. When a Reclamation pipeline system being crossed has pipe with an "A" cover pipe designation (less than 5 feet of earth), the applicant is to analyze the crossing to show "A" pipe load carrying capability exists to meet their carrying requirements or replace the "A" pipe with pipe of sufficient load carrying capability.

16. Reclamation's ongoing O&M activities should not be disrupted during construction. The primary or secondary operating road should be kept available for Reclamation and/or AOE use at all times.

17. Detectable warning tape may be required over below-ground utilities. Refer to "3.3 Detectable Warning Tape."

18. The points where the proposed utilities enter and exit Reclamation's ROW should be plainly and permanently marked by sign posts extending 5 feet above grade. Applicants should provide sign posts directly above their utilities and at all angle points within Reclamation's ROW. The distance between adjacent sign posts should not exceed 500 feet. Sign posts should contain the name of owner/operator, contents of the pipeline, utility identification, and emergency contact telephone number. Sign posts for angle points that lie within roads or canals should be offset and have a reference noted. The locations of the sign posts should be shown on the plans.

19. Following completion of work, applicants should provide as-built drawings of their facilities on Reclamation's ROW. Reclamation as-built drawings are to be updated by the appropriate Reclamation office and/or AOE to reflect the crossing. As-built drawings may be maintained by the AOE, but should remain accessible to Reclamation upon request.

3.3 Detectable Warning Tape

Detectable warning tape may be required over below-ground utilities situated within Reclamation's ROW and should be a minimum of 18 inches above the utility and between 18 and 30 inches below the ground surface. Warning tapes should conform to the following specifications:

a. For potable water lines, the warning tape should be a 3-inch-wide blue detectable tape imprinted with **"CAUTION BURIED POTABLE WATER LINE."**

b. For nonpotable water lines, the warning tape should be a 3-inch-wide purple detectable tape imprinted with **"CAUTION BURIED NONPOTABLE WATER LINE."**

c. For sewer and storm drain lines, the warning tape should be a 3-inch-wide green detectable tape imprinted with **"CAUTION BURIED (type) LINE."**

d. For gas, oil, and steam chemical lines, the warning tape should be a 3-inch-wide yellow detectable tape imprinted with **"CAUTION BURIED (type) LINE."**

e. For telecommunications, telephone, and television conduit(s), the warning tape should be a 3-inch-wide orange detectable tape imprinted with **"CAUTION BURIED (type) CONDUIT."**

f. For electrical, street lighting, and traffic signal conduit(s), the warning tape should be a 3-inch-wide red detectable tape imprinted with **"CAUTION BURIED (type) CONDUIT."**

4.0 Specific Feature Review Guidelines

4.1 Bridges

1. New bridge crossings (vehicular, pedestrian, and utility) should be perpendicular (between 70 and 90 degrees) to the centerline of the water conveyance facility and at locations approved by Reclamation and/or the AOE. Exceptions to the policy may be considered on an individual basis.

2. Public use bridges in urban areas should be spaced no closer together than 1/3 mile (about 4 blocks or 1,700 feet) apart. This is to ensure O&M operations are not overly restricted.

3. Bridge crossings should be of free span design. Consideration of any anticipated (known or ongoing) canal subsidence issues, anticipated raising of the canal lining, or anticipated increases in the canal's high water level should be made. The minimum vertical clearance between the bottom of the superstructure and the top of the canal lining should be 3 feet. For unlined canals, the vertical clearance may be measured to the high water level. If this minimum clearance is reduced by subsidence or by future Reclamation modifications to the canal lining, the minimum clearance should be re-established at the applicant's expense. The minimum horizontal clearance from the face of the abutment to the top of the canal lining should be 5 feet. For unlined canals, the horizontal clearance may be measured to the high water level.

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These clearances are suggested to minimize impact on the canal section during construction and future inspections and O&M. Applicants may request to re-construct a canal section if Reclamation's operations are impacted by close construction during periods when the canal is normally unwatered. If so, vertical clearances may be reduced to 1 foot and horizontal clearance to 3 feet.

4. Canal O&M roads should intersect public roads at bridges at right angles for proper visibility. This may require the applicant to acquire additional ROW for use if the existing canal ROW is not sufficient. American Association of State Highway and Transportation Official (AASHTO) criteria for sight distances at the intersection of O&M roads and roadways at new bridges should be met to allow O&M vehicles to cross them safely.

5. Driving piles at concrete-lined canals should not be permitted. Any abutment foundation support piles, at concrete-lined canals, should be drilled and cast-in-place.

   At a minimum, the applicant's drilling and piling plan should include:

   - Drilling methods and equipment
   - Methods for preserving existing foundation material
   - Methods and equipment to determine the presence of quick soil conditions or scouring and caving
   - The proposed method for casing installation and removal if casings are used
   - Methods and equipment for accurately determining the depth of concrete and actual or theoretical volume placed

   At a minimum, the applicant's contingency plan should include:

   - Means to repair in a certain time
   - Minimum flows after event
   - Review of geotechnical conditions surrounding the pile locations
   - Assessment of how the proposed mitigations will address geotechnical conditions
   - Methods for restoring foundation material

- A list of material, equipment, and personnel with qualifications to be used during mitigation work

- A seal from a Professional Engineer on all relevant plans and drawings

6. The submitted plan drawings for the bridge should contain the following information:

    a. Superstructure, abutments, railings, embankments, and drainage, including details and sections

    b. Type of materials (concrete, steel, timber, etc.) used for different members

    c. Details of cast-in-place foundation piles, if any, on both sides of the canal

    d. The elevation of the bottom of the superstructure and the clearance between the top of the canal lining (or high water level if unlined canal) to the superstructure or bottom of deck slab, whichever is lowest

    e. Design loadings

    f. Design standards on which the bridge is based (AASHTO, etc.)

7. The calculations and specifications for the bridge should be submitted to Reclamation and/or AOE for review.

8. The right lane turn radius from the new road onto a Reclamation operating road should comply with the provisions of a 67-foot wheelbase[5] (WB-67) truck turning template in the AASHTO manual on Geometric Design of Highway and Streets.

9. Details of any proposed utilities to be attached to an existing bridge include:

    a. Anchor bolt locations should not intercept the critical reinforcing steel of the bridge.

[5] The field office should adjust these provisions according to anticipated needs.

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b. Utilities should be placed and anchored under bridge decks and through utility openings, if they are present. The utility should be placed off center in the utility opening, if possible, to allow for future utility additions.

c. If an expansion joint is used in the pipeline, the joint should be placed near the bridge deck expansion joint.

d. Holes through bridge concrete or abutment and retaining walls for passage of utilities should be allowed by core drilling. The annular space between the utility and core hole surface should be completely filled with an elastomeric sealant to prevent loss of material or water piping from behind the wingwalls and abutments.

e. Submit calculations showing the effects of the weights of the proposed utilities on the load carrying capacity of the bridge for Reclamation review.

f. Intermediate supports for the utility should withstand the same seismic load considerations as the bridge.

g. Load limit signs should be placed adjacent to the bridge, as required under AASHTO criteria.

h. Beam guardrails should be installed at bridges and bridge approaches, as required under AASHTO criteria.

10. The applicant will be responsible for changes to Reclamation existing ROW; bridge O&M approach roads; existing fencing, gates, and signs; and the addition of new fencing, O&M gates, cattle guards, signs, etc.

4.2 Landscaping

1. No landscaping or other changes in ground surfaces within Reclamation pipeline and canal/lateral ROW should be made without advance written permission of Reclamation through the application process. Landscaping changes may (1) limit, prevent, or hamper O&M access; (2) increase the costs of operations and maintenance of the facility; (3) impact facility reliability; or (4) create a public nuisance or liability issue.

2. Open space with natural hiking trails and walkways may be permitted if vehicle access to Reclamation pipeline and appurtenant facilities for patrol and maintenance is provided.

3. The following may apply within Reclamation's ROW:

    a. The easement may be used as a greenbelt upon Reclamation approval.

    b. Ground cover and shrubs are permitted upon Reclamation approval.

    c. Trees and vines should not be allowed. See Appendix B of *Review of Operation and Maintenance Program Field Examination Guidelines* (reproduced as appendix B at the end of these guidelines).

4. All temporary or permanent changes in ground surfaces within Reclamation pipeline and canal ROW are considered encroaching structures and are handled as such. Earthfills and cuts on adjacent property should not encroach onto Reclamation pipeline and canal ROW. Excavations of adjacent property (even property not within Reclamation's purview) within the projection of the Reclamation embankment line may impact embankment stability and should be evaluated.

5. Permanent landscaping structures should not be allowed within the exterior limits of a Reclamation linear facility ROW (fee owned or easement).

6. Pressurized lawn and park sprinkler irrigation lines (3-inch maximum size) and isolation valves within Reclamation easements that run parallel to a Reclamation pipeline should be installed at least 15 feet from the edge of the Reclamation pipeline.

    Irrigating lawns and flower beds along canal embankments should not overwater the area or threaten the embankment stability.

4.3 Roadway Crossing

Note: This type of encroachment also includes parking areas and recreational trails.

1. The applicant should submit a grading plan as part of the application.

2. If the roadway crosses a Reclamation pipeline system that has a cover pipe designation of "A," refer to "3.2 General."

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3. If the applicant intends to modify existing drainage features during construction, detailed drawings showing the proposed drainage replacement/restoration should be submitted with the application for review and approval. (Refer to "3.2 General.")

4. If the proposed roadway includes a bridge crossing over a Reclamation canal or pipeline, Reclamation and/or AOE should review and approve the vertical clearance and location of the abutments. (Refer to "4.1 Bridges.")

5. Streets, roads, or parking areas crossing Reclamation pipeline easements are permissible. All streets, roads, and parking surfaces are to be asphalt or other flexible pavement. Depressed curbs or driveways should be provided for Reclamation vehicular access when new roads cross Reclamation pipelines or canals.

6. Roadway ditch drainage should not be allowed to flow into the canal. Drainage should be retained and released in a controlled way to maintain peak discharges that are less than any peak historical runoff rate before these modifications. Applicants should direct drainage to an original sub-basin cross drainage culvert or overchute. (Refer to "3.2 General" and "4.4 Storm Water Cross Drainage.")

7. If existing roadway embankments are to be widened, the work should be conducted in accordance with the provisions of construction in the applicable State Department of Transportation (DOT) Standard Specifications.

4.4 Storm Water Cross Drainage

1. Upslope development impacts historic natural drainage volumes and peak flow rates. Development re-grades and revises drainage sub-basins. Revised ground cover from constructing roads, parking areas, and buildings may result in the need to change the cross drainage features (culverts and/or overchutes) along Reclamation canals.

2. A hydrologic study should accompany all plans that modify the existing drainage across and/or along Reclamation facilities. The study or report should show the proposed flows of the canal and the associated crossings. The drainage study or report should show that the downstream system can accept the flows without creating any flooding to properties adjacent to or downstream of the canal.

3. All drainage crossings, whether existing or proposed, should carry the peak runoff of a 100-year event while preventing any storm water from entering the canal and/or ponding against the canal embankment.

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4. Urban runoff should not be allowed to enter into, or drain onto, Reclamation's land. All flows generated outside Reclamation's ROW should enter the storm drain system prior to entering Reclamation's ROW. Piped connections are preferred, but concrete-lined channels may be acceptable upon Reclamation's review.

5. The new crossing under a canal should be designed with 3 feet vertical clearance from the top of the cross drainage structure to the bottom of the canal (or liner). The structure should extend completely across Reclamation's ROW.

6. New overcrossings of the canal should have 2 feet of vertical clearance from the top of the liner and 2 feet of horizontal clearance from the support abutments to the outside edge of the canal lining. The O&M road crossing of the cross drainage structure should be structurally capable of withstanding highway-legal vehicle loadings and provide at least 1 foot of cover in the roadway.

7. Pipe crossing barriers should be installed on all pipe overcrossings.

8. All drainage flow should be discharged to a downstream storm drainage system owned, operated, and maintained by a public agency (such as a city or county) or into areas such as channels, roadways, parks, wetland basins, or other non-private lands that can accept the concentrated flows from the drainage crossing.

9. All drainage from upland property should be collected by the applicant's installed system of curbs and inlets within their property and discharged into a non-Reclamation public agency's drainage system.

10. New drainage system designs will not use ponding against the existing canal embankment for temporary detention of storm runoff that will not immediately pass through existing or new crossings.

    Proposed permanent detention facilities adjacent to Reclamation's property should include engineered fill beyond the canal ROW to provide, at a minimum, a fill-width maintenance access roadway between the canal property and the basin. The applicant shall submit a geotechnical report verifying that the canal embankments can perform as detention basin embankments. The design should provide for sufficient freeboard to contain the 100-year event within the proposed basin adjacent to Reclamation's property and shall have adequate protection from seepage and erosion.

    The ownership and related O&M of the embankments shall be the responsibility of the applicant requesting the crossing.

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11. When grading operations upstream of existing canal drainage crossings are scheduled to take longer than a normal construction season to complete, temporary basins shall be installed. These temporary basins should be designed to detain the 100-year event, capture silt from the disturbed area, and meter the flows across the existing drain crossings without spilling flows into the canal.

12. Unless Reclamation specifies otherwise, the applicant should remove or plug and abandon existing drainage crossings that are not used by the development unless they are shown to provide an additional measure of safety for the canal by reducing the likelihood of spill into the canal caused by extreme runoff flows. Otherwise, these crossings should remain in place for Reclamation's benefit and will not require ownership transfer to a public agency.

    These crossings must discharge into the non-Reclamation public agency's storm drainage systems or into areas such as channels, roadways, parks, wetland basins, or other nonprivate lands that can accept the concentrated flows from the drainage crossing in the case of an extreme runoff event.

    Grading in Reclamation property should be preserved or revised to direct extreme runoff flows into these unused drainage crossings without allowing said flows to enter into the canal until the crossings reach their capacity.

4.5 Subdivision

Urban developments are reaching Reclamation's lands and ROWs. These are general guidelines for accommodating development in subdivisions (refer to "3.2 General" and "4.4 Storm Water Cross Drainage").

1. Permanent structures should not be permitted within Reclamation fee-owned linear ROWs.

2. Open space with natural hiking trails and vegetation may be allowable.

3. Where subdivision development is adjacent to a canal, fencing should include these characteristics:

    a. Temporary chain link fences must be installed prior to removing any portion of existing fences.

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b. Upon completion of grading for drainage and other work, fencing should be installed along the subdivision's boundary length of the adjacent ROW plus 150 feet beyond the development's property boundary. The fence should be per project standards and at the applicant's expense.

c. The new fence should be located 1 foot outside of Reclamation's ROW. The fence location should be shown on the improvement plans.

4. Use of Reclamation pipeline easements as part of residential subdivision lots should not be allowed. Pipeline easements may be included within the subdivision greenbelt or similar use areas.

5. Drawings should include all proposed improvements (i.e., streets, utilities, landscaping, etc.) within, and adjacent to, Reclamation's ROW.

6. Trees or vines should not be allowed within a Reclamation pipeline or canal ROW. See Appendix B of *Review and Operation and Maintenance Program Field Examination Guidelines* (reproduced as appendix B at the end of these guidelines).

7. Streets, roads, or parking areas using Reclamation easements may be permissible. All streets, roads, and parking surfaces should be asphalt or other flexible pavement. Depressed curbs or driveways should be provided for Reclamation vehicular access when new roads cross Reclamation pipelines or canals.

8. Where fencing is proposed within Reclamation easements, a minimum 16-foot-wide gate should be provided for Reclamation access.

9. Pipelines containing sewage, oil, gasoline, natural gas, or hazardous materials should only cross perpendicular (between 70 and 90 degrees) to the Reclamation pipeline or canal and be installed with the necessary safety measures and separation clearance as required in "4.6 Utility Crossing."

10. Electroliers, posts, etc., should be installed at the maximum distance possible from the edge of the pipeline or canal.

11. If crossing a Reclamation pipeline system that has "A" cover pipe designation, refer to recommendations in "3.2 General."

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4.6 Utility Crossing

Note: All pipelines, electrical, and communication lines and conduits are referred to as "utilities" in these guidelines.

4.6.1 Casings

The Reclamation Materials Engineering and Research Laboratory's (MERL) position is to avoid using casing pipes around metallic carrier pipelines (steel, ductile iron, cast iron, reinforced concrete, pretensioned concrete cylinder, etc.) whenever possible. The experience of the corrosion community in general is that these casings often cause corrosion-control problems. Furthermore, dielectric (plastic, fiberglass, etc.) casings, or even dielectrically coated casings, should not be used. They can shield the carrier pipe from receiving cathodic protection current.

Cathodic protection to a buried metallic pipeline is more trouble free and more certain without a casing pipe. MERL recommends relying on effective corrosion control measures on the carrier pipeline rather than relying on a casing pipe (which may shield cathodic protection current) to direct a leak away from Reclamation property.

4.6.2 Overhead Line Crossing

1. Overhead wires across Reclamation pipeline and canal ROWs should be at least 32 feet above all ground levels in the Reclamation ROW. For electrical powerlines of 69 kilovolts (kV) or higher voltage, the minimum clearance should be 40 feet plus 0.25 inch per kV of line-to-line voltage above 450 kV. In any case, the minimum clearance is to be that determined to be needed with an ambient temperature of 120 degrees Fahrenheit.

2. Reclamation has the following requirements for overhead crossings:

    a. Poles or towers should not be allowed within Reclamation's ROW.

    b. Overhead electrical and communication lines should cross perpendicular (between 70 and 90 degrees) to the centerline of the Reclamation facility.

    c. If necessary, fence grounding is to be provided for existing fence lines, especially under power transmission lines.

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3. A marker warning sign should be provided that shows the clearance and electrical line voltage. The warning sign should face oncoming traffic and state, "**DANGER, HIGH VOLTAGE OVERHEAD.**"

4.6.3 Utility Crossing Reclamation's Canal

Utility crossings include open ditch laterals, subsurface and surface drains, levees, and similar facilities.

General Requirements:

1. Utilities crossing Reclamation canals should be designed to cross perpendicular (between 70 and 90 degrees).

2. Pier construction in the canal for new utility crossing(s) should not be allowed. New utility crossings should be free span design.

3. Open cut crossings of Reclamation canals and ditches, when allowed, should require replacing linings to re-establish the original construction style and materials (i.e., disturbed concrete lining panels should be removed in their entirety and replaced, membrane lining and earth or concrete protective cover should be re-constructed, gravel and canal under-drainage systems should be re-established to full working order, etc.) Proposals should be submitted for approval with the crossing permit application.

4. For trench excavation and backfill requirements, refer to "3.2 General."

5. Boring and jacking of a utility through canal embankments or protective levees should not be permitted. Boring and jacking of a utility should be constructed through the embankment foundation materials. Applicants should make special design and construction considerations with bored crossings under canals containing water during construction. Among these should be using proper bentonite slurry to seal the annulus space between the utility conduit and the boring cavity from canal seepage. Refer to appendix A for more details to be considered.

   The applicant's drilling plan should cover:

   a. Drilling methods and equipment

   b. Methods for preserving existing foundation material

   c. Methods and equipment to determine the presence of quick soil conditions or scouring and caving

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d. Proposed method for casing installation and removal if casings are used

e. Methods and equipment for accurately determining the depth of concrete and actual or theoretical volume placed

The applicant's contingency plan should cover:

a. Means to repair in a certain time

b. Minimum flows after event

c. Review of geotechnical conditions surrounding the pile locations

d. Assessment of how the proposed mitigations will address geotechnical conditions

e. Methods for restoring foundation material

f. List of material, equipment, and personnel with qualifications to be used during mitigation work

g. A seal from a Professional Engineer on all relevant plans and drawings

6. When horizontal directional drilling (HDD) or other trenchless methods are used, canal seepage conditions may be aggravated by the collapse of the canal foundation material into the annular void between the bore and pipe. Penetration through the top stratum of fine-grained materials may concentrate seepage at those locations. Pipe installed with trenchless methods should proceed only after completion of a comprehensive evaluation of the following:

(a) Comprehensive understanding of the subsurface soil and groundwater conditions to a minimum depth of 20 feet below the lowest pipe elevation

(b) Locations of the HDD pipe penetration entry and exit

(c) Construction procedure

(d) Allowable uplift pressures

(e) Onsite quality control and quality assurance monitoring during construction operation

(f) Grouting of the pipe annulus

(g) Backfilling of any excavated areas

(h) Repair and reinstatement of the construction staging areas

A geotechnical report should be submitted with the application for review prior to approval of the proposed utility crossing.

Directional drilling under a canal may be considered if a minimum clearance of 25 feet to the bottom of the canal lining is maintained for utilities with less than a 24-inch outside diameter. Larger utility crossings should be considered on an individual basis and may require additional clearance from the bottom of the canal lining.

7. Cut and cover constructed utilities under Reclamation canals should have a minimum cover of 36 inches when within Reclamation's ROWs. Bored construction utilities should have a minimum of 3 diameters cover.

8. Reclamation's ongoing O&M activities should not be disrupted during crossing construction. The primary or secondary operating road should be kept available for Reclamation use at all times.

9. Canal embankments should be re-built or repaired with materials and standards equal to or better than the existing embankments.

10. Drawings should be stamped and signed by a Professional Engineer and contain the following information:

    a. Canal milepost or station at each proposed crossing, utility size and location, and type of utility or material transported

    b. Maximum utility operating pressure, type of pipe, joints, wall thickness, maximum test pressure, and description of test procedures

    c. Type of sleeve/casing (when allowed) including diameter, joints, and wall thickness

    d. For utilities attached to a bridge or an overchute, details showing the structure name, superstructure, abutments, embankments, protective dikes, method of attachment, spacing of utility supports on the structure, location of other attached utilities, and structural calculations

e. Protective coatings and corrosion control measures

f. Method of handling pipeline expansion and contraction

g. Location of nearest shutoff valve on each side of the crossing

h. Location and details of thrust restraint

i. Design code(s) used for the utility crossing

j. Location, including depth, of the buried pipeline communication and control cables

k. Other existing utility easements in the immediate vicinity

Hazardous Material Carrier Requirements:

1. Pipelines carrying hazardous material or pollutants (e.g., oils, gasoline, sewage, contaminated waters, and nonpotable waters) should be designed for a reduced risk of failure in the portion within Reclamation's ROW. The design should require either:

   a. Designing the crossing pipeline with an additional 50 percent working pressure factor

   or

   b. Using secondary containment (casing pipe) for all hazardous material pipelines

2. To minimize the amount of any hazardous material entering the canal, Reclamation may require the installation of a block (gate) valve and or a check valve on each side of the canal between the ROW boundary and the embankment. When selecting the type of the valves, take into the account the flow direction and the terrain.

3. A final hazardous material spill contingency plan and an emergency response plan should be approved by Reclamation prior to start of construction.

4. A monitoring program and/or Supervisory Control and Data Acquisition System alarm may be required depending on the hazardous material transported. This applies to all "overcrossings" and "undercrossings" when the hydraulic grade line is within 60 inches of the canal liner or when local geology would promote this requirement.

Attaching Utilities to Bridges and Overchutes:

Note: Reclamation does not guarantee the long-term availability of bridges or overchutes as support devices for utility crossings because they may require structural modifications or alterations to accommodate widening, repairs, subsidence offsets, etc., to such an extent that service may be interrupted or stopped. Reclamation may determine the bridge is no longer required and may remove it. In that event, the owner/operator of each utility attached to a bridge or an overchute may be required to re-locate or permanently remove their utility at their own expense.

Specific details for attaching utilities to bridges are:

a. Utilities should not be placed on the bridge deck.

b. Anchor bolt locations should not intercept the critical reinforcing steel of the bridge.

c. Utilities should be placed and anchored under bridge decks between girders and through utility openings, if they are present. The utility should be placed off center in the utility opening, if possible, to allow for future utility additions.

d. If an expansion joint is used in the pipeline, it should be placed near the bridge deck expansion joint.

e. Holes through bridge concrete or abutment and retaining walls for passage of utilities may be allowed and should be core drilled. The annular space between the utility and core hole surface should be completely filled with an elastomeric sealant to prevent loss of material or water piping from behind the wingwalls and abutments.

f. Calculations showing the effects of the weights of the proposed utilities on the load carrying capacity of the bridge should be submitted for Reclamation review.

g. Intermediate supports for the utility should withstand the seismic conditions of the bridge.

4.6.4 Utility Crossing Reclamation's Underground Pipelines

1. The applicant should submit the procedures, excavation plans, schedules, as well as type and weight of the construction equipment to be used for crossing the Reclamation pipeline.

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2. High voltage, direct current powerlines should not be permitted to encroach on the Reclamation pipeline ROW, except in unusual circumstances and with proper cathodic protection considerations.

3. For proposed metallic pipelines, refer to "5.0 Cathodic Protection Requirements."

4. For utilities crossing above or under the Reclamation pipeline, the vertical clearance between the utility and Reclamation pipeline should be a minimum of 12 inches.

5. The location of the Reclamation pipeline and the communication and control cables throughout the area of the proposed construction should be shown on the plans. Prior to Reclamation and/or AOE issuing a use authorization or consent document, the pipeline and the cable(s) should be located and exposed by potholing. The pothole locations should be shown on the drawings. The pothole elevations should be referenced to Reclamation stationing or milepost. (Refer to "3.2 General.")

6. Drawings should contain the following information:

    a. Reclamation milepost or station at each proposed crossing, pipeline size and location, and type of utility or material transported.

    b. Maximum utility operating pressure, type of pipe and joints, maximum test pressure and description of test procedures, wall thickness, and utility pipe classification.

    c. Type of sleeve/casing pipe (when allowed) including diameter, joints, and wall thickness.

    d. Protective coatings and corrosion control measures.

    e. Location of nearest shutoff valve on each side of the crossing.

    f. Location and details of thrust restraint.

    g. Design code(s) used for utility crossing.

    h. Location, including depth of the Reclamation pipeline and the communication and control cables.

    i. Other existing utility easements in the immediate vicinity.

7. Detectable warning tape may be required over trenched utilities. (Refer to "3.3 Detectable Warning Tape.")

8. For trench excavation and backfill requirements, refer to "3.2 General."

9. Embankments should not be permitted within Reclamation's ROW where underground pipeline exists.

4.6.5 Utility Crossing Under Reclamation's Roadways

1. The applicant should supply typical cross sections that show existing ground surface elevations, utility trench invert elevations, and utility details.

2. For trench excavation and backfill requirements, refer to "3.2 General."

3. Conduits with diameters up to 24 inches should be bored and jacked underneath pavements. Larger conduits may be considered on an individual basis. Pavement or road surfaces should not be cut unless an acceptable detour, if required, is approved. The cover over the conduit(s) when within Reclamation's ROWs should be a minimum of 36 inches. (Refer to "3.2 General.")

4. Unless otherwise approved, the applicant should replace existing Reclamation roads and parking surfaces that are removed or damaged by the applicant's construction activities in accordance with provisions in the latest edition of the applicable State DOT Standard Specifications.

5. If existing road embankments are to be widened, the work should be conducted in accordance with the provisions of embankment construction in the applicable State DOT Standard Specifications.

6. Detectable warning tape may be required over buried utilities. (Refer to "3.3 Detectable Warning Tape.")

5.0 CATHODIC PROTECTION REQUIREMENTS

5.1 Cathodically Protected Metallic Pipelines

Unless approved in writing by Reclamation, metallic pipelines or those containing metallic reinforcement (e.g., reinforced concrete) installed within Reclamation's ROW should have a suitable bonded dielectric coating (see "5.2 Protective Coatings for Corrosion Control") and be cathodically protected. Impressed current cathodic protection rectifiers and deep-well anode systems should not be

permitted within Reclamation facilities without prior approval from MERL's Corrosion Technology Group. All submittals should include details of the cathodic protection system (CPS) and its appurtenances.

1. All existing Reclamation cathodic protection test stations, cables running to these stations, rectifiers, anode beds, and any other appurtenances should be located prior to any grading or excavation. The test stations should be staked and flagged. The test stations, cables running to these stations, any anode beds, etc., should be suitably enclosed or protected during construction to prevent damage. No re-location or modification of the test stations, cables, anode beds, etc., is allowed without prior approval from MERL's Corrosion Technology Group.

2. Generally, the CPS to the proposed pipeline should be the sacrificial anode type unless the proposed installation continues an existing pipeline that uses impressed current type of cathodic protection.

3. A means of monitoring the effectiveness of the CPS on the proposed pipeline should be provided within Reclamation's ROWs. The number of anodes and test stations will differ with each project. Test stations should be located at every anode bed connection and should not be more than 1,000 feet apart. A test station should also be located where any metallic pipeline crosses over or under a metallic Reclamation pipeline, metallic fence, other metallic structure embedded in the ground, or comes within 20 feet of a Reclamation structure on or embedded in the ground. Both the proposed cathodically protected pipeline and the Reclamation pipeline should be monitored regularly using these test stations. Monitoring results should be reported to MERL's Corrosion Technology Group. In addition, the owner of the proposed crossing pipeline should investigate and mitigate any adverse potential shift caused by the proposed pipeline on the Reclamation pipeline. Owners of proposed crossing pipelines should return Reclamation pipelines to their original electrochemical potentials or to more benign potentials. Mitigation measures should be approved by MERL's Corrosion Technology Group. The effectiveness of mitigation measures should be confirmed in the presence of a Reclamation representative following installation.

   For those pipelines under DOT regulation, the application and monitoring of the CPS should conform to Title 49 CFR, Part 195, any special provisions of this guideline, and the provisions of NACE International RP 0169, in that order. For other pipelines, any special provisions of this guideline should take precedence, followed by the provisions of NACE RP 0169.

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5.2 Protective Coatings for Corrosion Control

1. *Atmospheric Exposed Pipe*

   The coating should be a high build modified aluminum epoxy mastic primer and top coated with a high build aliphatic urethane. The type of coating should be listed in the submitted plans and specifications. Information should include the surface preparation and the thickness of the coating to be applied.

2. *Buried Pipe*

   The type of coating may vary from project to project due to geology and soil corrosivity and should be considered on an individual basis. The type of coating should be listed in the submitted plans and specifications. Information should include the surface preparation and the thickness of the coating to be applied.

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REFERENCES

Application for Transportation and Utility Systems and Facilities on Federal Lands, <http://www.ntia.doc.gov/FROWsite/SF-299_2006.pdf>.

Application for Use of Reclamation Project Land and Water Surfaces, <http://www.usbr.gov/pmts/lands/>.

Bureau of Reclamation Right-of-Use Application, <http://www.usbr.gov/pmts/lands/FINAL7-2540-5-06ExpDate03312009.pdf>.

California Department of Water Resources - Encroachment Permit Guidelines.

Central Arizona Project, Reach 11 Guidelines.

GP Region Billings MT – Standard Crossing & Clearance Requirements, Utility Lines and Cables, drawing 40-600-51. The office also uses a Preliminary Project Description Form and a Special Use Permit.

NACE, International RP 0169, "Standard Recommended Practice – Control of External Corrosion on Underground or Submerged Metallic Piping Systems."

PN Region Burley ID – Overhead and underground crossing clearances.

Policy on Geometric Design of Highway and Streets, American Association of State Highway and Transportation Officials (AASHTO), Fifth Edition, 2004.

Reclamation, 2005. Preliminary drawing 103-D-1700 that provides general requirements for installation of crossings, June 2005.

Reclamation Manual, Directive and Standards LND 08-01, Land Use Authorizations, <http://www.usbr.gov/recman/lnd/lnd08-01.pdf>.

Title 29 CFR, Part 195.

U.S. Army Corps of Engineers – Engineering and Design, Design and Construction of Levees EM 1110-2-1913, 30 Apr 2000, CECW-EG Washington, DC 20314-1000.

GLOSSARY

Bored and jacked – This terminology is a general way of referring to a family of trenchless methods.

Bridge, class A – Vehicular bridge used by the public. May or may not be owned by the Bureau of Reclamation.

Consent Document Permit – Permit required across fee-owned lands.

Detention basin – An artificial flow control structure used to contain flood water for a limited period of a time, thereby providing protection for areas downstream. Detention basins provide a way to reduce storm peak flows, while retention basins hold water for an extended period of time. These basins are generally a part of a larger engineered flood water management system.

Electroliers – A branching frame, often of ornamental design, used to support electric illuminating lamps.

Pothole excavation – See potholing.

Potholing – The practice of digging test holes to expose underground utilities (e.g., cables) to determine the horizontal and vertical location of these utilities.

Trenchless methods – Procedures for installing pipe without using traditional trench cut and cover methods. These trenchless methods may be referred to as bore and jack, tunneling, horizontal directional drilling, and microtunneling, among others.

Water conveyance facility – Canal, ditch, pipeline, drain, levee, open or closed laterals, and similar facilities and their associated appurtenant features.

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Appendix A

General Requirements for Installing Bored and Jacked Pipe Undercrossings

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Bored and Jacked Under the Canal – This terminology is a general way of referring to a family of trenchless technologies. Similar guidance to the requirements listed below should be followed no matter what method is used for installation.

1. Installing a lone carrier pipe (without casing) is encouraged. Refer to "4.6 Utility Crossing," and "4.6.1 Casings" for information on cautions of using casings around metallic carrier pipe.

2. Plans must show carrier/casing pipe type, diameter, and thickness. Casing pipes should be steel pipe (American Water Works Association [AWWA] C-200) and have 1/4-inch minimum wall thickness. Applicants should provide the type of carrier pipe and appropriate bell dimensions for said carrier pipe to verify annular clearances.

3. When installing pipe while the canal is unwatered, a minimum of 3 pipe diameters or 60 inches of clearance (whichever is greater) between the top of the pipe and the bottom of the canal must be maintained. However, 72 inches or more clearance is recommended.

4. Provide a minimum of 3 inches of clearance between the carrier and casing pipes at all points (including bells).

5. A bulkhead or effective sealing device should be provided at both ends of each casing pipe to seal the annular space between the two pipes. Vent pipe should be included to allow ventilation and reduce the risk of condensation buildup and flooding.

6. As a result of the installation process, an annular void is usually created around the outside of the casing pipe. Provisions should be made to pressure grout or effectively seal (e.g., bentonite slurry) this void space.

7. Requirements below are provided to establish minimums for determination of the length of pipe to be installed. It is strongly recommended that pipes be installed perpendicular (between 70 and 90 degrees) to the canal alignment. Regardless, the pipe must extend completely through the Bureau of Reclamation's (Reclamation) right-of-way (ROW). Theses minimums do not relieve the applicant's engineer from performing an onsite investigation or other work to determine local conditions that may require additional pipe length.

   Jacking pit configuration, location, and length of pipe to be installed should be based on the following parameters:

   a. One operating road shall remain open to vehicular traffic at all times.

b. The minimum operating road embankment top width to be maintained during construction should be either 14 feet wide, the width of the existing embankment, or as required by Reclamation.

c. As a minimum, jacking pit excavations should not be within:

(1) A line drawn from the outside edge of the operating road embankment extended downward and away from the canal at a slope of 3/4 horizontal to 1 vertical.

(2) A line drawn from the outside edge of the top of the concrete lining extended downward and away from the canal at a slope of 1 horizontal to 1 vertical.

d. To contain the slurry during installation, jacking pits should be constructed so that natural ground or a compacted dike is entirely around the pit to an elevation at least 1 foot above the top of the canal lining.

e. All excavations should be in compliance with Occupation Safety and Health Administration regulations and Reclamation's Health and Safety Standards.

f. If the contractor elects to install shoring in the jacking pits, all shoring designs should be prepared by a Professional Engineer knowledgeable in said type of work. A copy of the shoring designs should be submitted to Reclamation.

8. Jacking pits should be backfilled with native material and mechanically compacted to 95 percent of the maximum dry density per ASTM D-698.

9. The contractors should be responsible for any damage to the canal section during the construction of a crossing, and the contractor shall repair the damage at their own expense.

10. If an emergency situation develops during construction, the contractor should immediately notify appropriate contacts with Reclamation. Reclamation must approve further work at that point.

11. The minimum distance between two jacked pipes should be 10 feet.

12. Any pressure lines installed within Reclamation's ROW must have adequate thrust restraint at bends and valves. Specified design pressures and thrust restraint calculations shall be provided to Reclamation to confirm the design configuration.

Appendix B

Guidelines – Removal of Trees and Other Vegetative Growth from Earth Dams, Dikes, and Conveyance Features

Excerpted from: Review of Operation and Maintenance Program Field Examination Guidelines

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APPENDIX B

GUIDELINES
REMOVAL OF TREES AND OTHER VEGETATIVE GROWTH FROM EARTH DAMS, DIKES, AND CONVEYANCE FEATURES*

Growth of trees and other significant vegetation on or adjacent to earth dams, dikes, and conveyance features, should be prevented from becoming established for the following reasons:

1. To allow proper surveillance and inspection of the structures and adjacent areas for seepage, cracking, sinkholes, settlement, deflection, and other signs of distress.
2. To allow adequate access for normal and emergency Operation and Maintenance (O&M) activities.
3. To prevent damage to the structures due to root growth, such as shortened seepage paths through embankments; voids in embankments from decayed roots or toppled trees; expansion of cracks or joints of concrete walls, canal lining, or pipes; and plugging of perforated or open-jointed drainage pipes.
4. To discourage animal/rodent activity (by eliminating their food source and habitat), thereby preventing voids within embankments and possible shortened seepage paths.
5. To allow adequate flow-carrying capability of water conveyance channels (e.g., spillway inlet and outlet channels; open canals, laterals, and drains).

The growth of trees and potentially detrimental vegetation should be prevented during its early stages as part of the operating office or entity's normal O&M program. Early control is generally the most cost effective means of avoiding potential adverse effects on these structures from their continued growth. Control efforts may consist of applying herbicides, spraying, cutting, and/or removing the trees or undesirable vegetation.

Suggested clearance zones (areas of control) adjacent to these structures are provided within these guidelines. Concerted efforts should be made to maintain these clearance zones. However, site-specific conditions, such as landscaping, accessibility, erosion susceptibility of material in the area, type of abutment material, original construction clearance zone, right-of-way easement, etc., may influence the necessity or success of these control efforts.

Should trees and/or other significant vegetation become established, proper O&M of earth embankment dams, dikes, and conveyance features, may require their discriminate removal. During the Review of Operation and Maintenance examination for the facility or system, the examiners should use these guidelines, along with their experience and professional judgment, to evaluate the need for removal of such established growth.

If trees and other significant growth are identified by the examination team in locations delineated by these guidelines, a determination should be made regarding their need for removal. If the identified vegetation is deemed to be in location such that its existence is not considered to be detrimental and therefore does not require removal, sufficient justification should be provided during the examination and included within the associated report to support that determination.

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* Enclosure to memorandum dated April 26, 1989, from Manager, Project Operation Services Staff, to all Regional Directors, Subject: Revised Guidelines — *Removal of Trees and Other Vegetative Growth From Earth Dams, Dikes, and Conveyance Features.*

When, in the opinion of an Review of Operation and Maintenance examination team, such established growth requires removal, specific followup procedures should be addressed as part of the examination. Such procedures may include the need for right-of-way easement determination; the need for an assessment for potential environmental impacts (any impact assessments should be coordinated with designated regional or project office environmental staff); whether removal of the root system is necessary and to what extent; the method of removal and recompaction of material within the void created; and the need for any erosion stabilization measures.

National Environmental Policy Act compliance is required relative to such tree and vegetation removal. Additionally, the application of herbicides should comply with applicable provisions of the Endangered Species Act. The determination of appropriate procedures to be followed in assessing potential environmental impacts and mitigation (including those to wildlife and its habitat) will be the responsibility of each regional and/or project office. This will include the preparation of an appropriate National Environmental Policy Act document and an assessment of the need for mitigation prior to the onset of removal activities. Appropriate National Environmental Policy Act compliance may include a Categorical Exclusion Checklist, an environmental assessment followed by a Finding of No Significant Impact, or an Environmental Impact Statement.

The following guidelines and associated clearance zones should be used for all Reclamation earth dams, dikes, and conveyance features. They are not considered "policy;" rather, they are guides which should be used with reasonable judgment and practicality.

1. Trees and detrimental vegetative growth should be prevented from becoming established on the surface of all earth dam, dike, and conveyance feature embankments. A small amount of shallow-rooted vegetation may be acceptable to aid in erosion protection and slope stabilization. Mowing of grass and other small vegetation is desirable and may be necessary to allow proper surveillance of the surfaces and observation of animal/rodent activity.

2. A clearance zone of 25 feet beyond each contact (groins and toe) of earth dam embankments and dikes should be maintained of all trees and detrimental vegetation. Similarly, a clearance zone of 15 feet should be maintained beyond the outside toe of all fill sections/embankments for open canals and laterals. These clearance zones may need to be extended for seepage areas or other conditions where proper surveillance or access may be warranted.

3. Earth dam, dike, and conveyance feature (open canal and lateral) embankments have large tree growth or stumps from previously cut trees on or near them should be evaluated, usually in conjunction with an Review of Operation and Maintenance examination, for any necessary future action, (i.e., monitor, excavation and backfill, rebuild, etc.). Generally, sizable old root systems of large trees should be grubbed out and the embankment replaced and compacted to prevent the development of piping action or erosion. Likewise, any sizable voids resulting from animal/rodent burrowing activity should be filled and compacted. Seeding may be necessary for protection from surface erosion.

4. Spillway inlet and outlet channels, outlet works discharge channels, and other open conveyance channels (open canals, laterals, and drains) should be free of vegetative growth that could significantly impede water flow or reduce design capacity.

5. A clearance zone of 25 feet adjacent to all concrete structures associated with such facilities should be maintained of all trees and detrimental vegetative growth to prevent damage from root growth, to allow proper surveillance, and to allow adequate O&M access.

6. Associated cut slopes adjacent to open canals and laterals should be kept clear of vegetation which, if toppled and/or uprooted, could affect operations or O&M access.

7. For pipe conveyance systems (such as siphons, aqueducts, discharge lines, perforated or open-jointed drains, etc.), to provide O&M access and to prevent root encroachment, a clearance zone should be maintained 15 feet from each side of the pipeline. However, in some cases, farming of annual crops over pipelines may be permissible.

* * * * * *

LICENSE NO. **017-95-001**

YUMA COUNTY WATER USERS' ASSOCIATION
P.O. BOX 5775
YUMA, AZ 85366-5775

LICENSE FOR ENCROACHMENTS AND CONSTRUCTION, INSTALLATION, OPERATION AND MAINTENANCE OF FACILITIES

LICENSEE: **CITY OF SAN LUIS**

SERIAL NO(S): **N/A** DIVISION: **N/A**

LOCATION: **USBR MAIN DRAIN RIGHTS-OF-WAY AT COUNTY 23RD STREET IN SECTIONS, 1, 2, 11 AND 12, TOWNSHIP 11 SOUTH, RANGE 25 WEST, GSRBM**

1. Authority. Pursuant to the provisions of United States Department of the Interior, Bureau of Reclamation, Public Notice No. 77 dated February 12, 1960 (entitled "Public Notice Announcing Procedures for Processing Water Right Applications and Certain Other Contracts", the Yuma County Water Users' Association (Licensor) licenses the above named Licensee to construct, install, operate and maintain facilities encroaching upon rights-of-way of the United States forming a part of the Valley Division of the Yuma Project, a reclamation project constructed under the laws of the United States.

2. Description of Encroachment. The encroachment shall be constructed and operated only under the terms and conditions of this license and is specifically described as follows:

a. **CONSTRUCTION AND MAINTENANCE OF A BRIDGE AND ROADWAY, INCLUDING SIDEWALKS AND GUARDRAILS, ACROSS THE RIGHTS-OF-WAY OF THE USBR MAIN DRAIN AT COUNTY 23RD STREET (G STREET).**

3. Nature of Right Conferred: Rights of Licensor.

a. The encroachment and consent to construct contained in this license relate only to the rights of the Licensor by virtue of its contractual relationship with the United States Department of Interior, Bureau of Reclamation (USBR) for the maintenance and operation of Federal facilities constituting the Valley Division of the Yuma Project. The lands to which this license pertains are not owned by the Licensor. Nothing in this license constitutes a representation by the Licensor of any authority to grant a right-of-way across any property owned or controlled by any person other than the Licensor.

b. Any right granted to the Licensee hereunder shall be inferior to the right of the Licensor to operate and maintain project irrigation facilities and to reconstruct, repair or improve any works within said rights-of-way without the consent of the Licensee and without liability for damages caused by any non-negligent act of the Licensor to any facilities or property owned or controlled by the License.

c. Except in the case of emergencies, and when deemed appropriate by the Licensor, the Licensor will provide the Licensee with notice of its intent to construct, repair or improve any works within the portion of the right-of-way wherein the Licensee is encroaching. Notwithstanding the foregoing sentence, the Licensor shall give the Licensee prior notice of its intention to perform any work which will require the closing of a public thoroughfare under the Licensee's jurisdiction, or the interruption of utility services operated or controlled by the Licensee.

d. Notification may be either written or oral and shall be given by the Licensor as soon as practicable. The failure of the Licensor to give the Licensee notice in any case shall not subject the Licensor to any liability whatsoever.

4. Administrative Fee. Upon submission of this license to the Licensor, the Licensee agrees to pay the Licensor an administrative fee in the amount of $250.00. Of this amount, $200.00 is non-refundable and shall be retained by the Licensor as compensation for costs incurred in processing and administering this license. The remaining $50.00 shall be paid to the USBR as compensation for their costs incurred pursuant to paragraph 9. In the event this license is not forwarded to the USBR for approval, the $50.00 shall be refunded to the Licensee.

5. Assignments and Sublicenses.

a. The Licensee may not, without the prior written consent of the Licensor, assign or otherwise transfer any right created by this license. The Licensee shall not authorize or permit others to utilize any facilities or structures or right-of-way area which are the subject matter of this license in any way not expressly authorized by this license in writing or by the Licensor.

b. Any violation of this paragraph shall, at the option of the Licensor, constitute grounds for immediate termination of the license without further notice. Upon an election to terminate, any facilities constructed by the Licensee shall be removed in the manner provided in paragraph 11 of this license.

c. Nothing in this paragraph prohibits the Licensee from utilizing the services of a person or entity not a party the this License for the purpose of constructing the encroachment herein contemplated.

6. Licensee's Liability. The Licensee shall be liable for all damages to the property of the United States, the Licensor, or any third party or parties caused by reason of the exercise of the Licensee of any right conferred by this license.

7. Hold Harmless Agreement. To the maximum extent permitted by law, the Licensee agrees to hold forever harmless, indemnify and defend the Licensor and the United States Government, together with all of their respective officers, employees, successors and assigns from any and all claims related to or any way connected with the construction, operation or maintenance of the facilities described in this license. The Licensee's obligation hereunder includes, but is not limited to, the obligation to pay the Licensor attorney fees and costs incurred in connection with any claim without regard to whether such claim results in litigation.

8. Duration of License. This license shall continue in effect so long as the Licensor determines, in its sole discretion, that the same is expedient and is not detrimental or incompatible with the proper care, operation and maintenance of the Valley Division and its works.

9. Additional Approval.

a. This license and consent to encroachment are subject to the approval of:

Area Manager, Yuma Area Office
United States Bureau of Reclamation
P.O. Box D
Yuma, AZ 85366

and the Licensee shall take no action nor commence any activities hereunder until such consent is approved as provided in this paragraph.

b. A copy of this license with all attachments shall be mailed by the Licensor to the Area Manager at the above address on the next working day after the date it is fully executed by the Licensee and the Licensor. The license shall be deemed approved by the Area Manager unless the same is disapproved in writing (with a copy to the Licensor) within twenty (20) working days after the date it is fully executed.

10. Notification of Commencement of Work. The Licensee agrees to provide the Licensor with two (2) working days notification prior to the actual encroachment and commencement of work. Failure to provide said notification can be sufficient cause to terminate this license and require the removal of facilities in the manner provided in paragraph 11 of this license.

11. Termination.

a. This license and consent to encroach are subject to termination by the Licensor or the United States on thirty (30) days notice all as provided in Public Notice No. 77. The Licensor agrees, however, that, except in the case of emergencies or in cases where the Licensor is requested or directed by the United States to exercise the aforesaid termination provision, this license shall not be terminated on less than six (6) months prior written notice to the Licensee.

b. In the event this license is terminated, the Licensee agrees to remove all encroachments constructed hereunder within one hundred eighty (180) days after the date of the notice of termination and agrees to return the rights-of-way affected by this license to their original condition (or in a condition acceptable to the Licensor) at its sole expense and at no expense to the Licensor or the United States.

c. If the Licensee fails to remove its encroaching facilities as provided above, the Licensor may, without liability for damages to the Licensee, remove such facilities without further notice. The License agrees to pay the Licensor the reasonable cost of the removal of its facilities and the cost of restoring the rights-of-way to their original condition. Payment shall be made by the Licensee to the Licensor within thirty (30) days after the receipt of a statement of costs from the Licensor.

12. Consent to Encroachment: Extent of Consent.

a. The Licensor, for itself and on behalf of the United States, consents to the Licensee's encroachment upon Federal rights-of-way as described in this license and its attachments.

b. Nothing in this license constitutes a grant or other disposition of any land or interest in land which is owned or otherwise occupied by the United States. The Licensee shall not authorize or permit encroachment of any kind by persons not partied to this license or permit the planting of trees upon the encroachment area or otherwise utilize the encroachment area in any manner which may, in the opinion of the Licensor, endanger or interfere with the proper use and operation of any works or property of the United States or the Licensor.

c. Any violation of this paragraph shall constitute grounds for immediate

termination of this license without further notice. Upon such termination, all encroaching facilities constructed hereunder shall be removed in the manner provided in paragraph 11 of this license.

13. Plans and Specifications: Construction. All structures constructed under this license shall be erected in accordance with plans and specifications approved in advance by the Licensor as herein provided and shall be erected in such a manner as not to obstruct in any manner the flow of water in the canals, laterals or drain ditches of the United States of the Licensor or to interfere in any manner whatsoever with the construction, operation and maintenance of any part of the project by the Licensor or the United States.

14. Specifications and Conditions.

a. The encroachment and the erection of structures of facilities under the terms of this license shall be in accordance with the plans, specifications and conditions described below:

1) **PLANS PREPARED BY NICKLAUS ENGINEERING ENTITLED "G STREET/MAIN DRAIN BRIDGE," DATED 12/26/95, SHEETS 1 THRU 19.**

2) **PLACEMENT FOR RIP RAP SHALL BE SUCH AS TO ADEQUATELY PROTECT THE BANKS OF THE MAIN DRAIN FROM EROSION AND SUCH AS TO NOT OBSTRUCT FLOWS IN THE MAIN DRAIN, AS DETERMINED BY INSPECTION BY THE ASSOCIATION.**

3) **SHEET PILING SHALL BE EXTENDED INTO THE BANKS TO ABOVE THE HIGH WATER LINE.**

All of the foregoing plans, specifications and conditions are made a part of this license and are subject to the prior approval of the Licensor.

b. Any proposed variation in construction or operation of encroaching facilities from approved plans and specifications must be approved in writing by the Licensor and the Licensee before construction or operation. If any proposed variation is, in the opinion of the Licensor substantial in nature, the same must also be approved by the USBR in the manner provided in paragraph 9.

15. Increased Operation and Maintenance Expense.

a. If the construction and placement of facilities by the Licensee under the terms of this license increases the costs to the Licensor, or its successors, of operation and maintenance functions on the right-of-way herein described, it is agreed that the amount of any such increase shall be paid by the Licensee.

b. Payments under the terms of this paragraph shall be made monthly, or at such other time or times as the Licensor may elect, and shall be made on the basis of statements furnished by the Licensor to the Licensee describing with reasonable particularity the nature and extent of all charges claimed.

c. The amount of any increased operation and maintenance charges payable by the Licensee under this paragraph shall be determined by the Licensor. Any dispute between the Licensor and the Licensee as to the appropriateness or amount of any increased operations and maintenance charge claimed by the Licensor shall be resolved by the Area Manager, Yuma Area Office, USBR. The determination of the Area Manager shall be conclusive upon both parties, unless either party determines to bring a cause of action to resolve the dispute.

16. Attorney Fees. If either party commences a legal action to enforce any term or condition of this license, it is understood and agreed that the prevailing party in any such litigation shall be entitled to recover a reasonable sum as and for attorney fees, said sum to be fixed by the Court. The provisions of this paragraph are supplemental to the provisions of paragraph 7.

17. Covenant Against Contingent Fees.

a. The Licensee warrants that no person or agency has been employed or retained to solicit or secure this license upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial agencies maintained by the Licensee for the purpose of securing business.

b. Any breach of the provisions of this paragraph shall, at the option of the Licensor, constitute grounds to terminate this license without further notice and without liability for damages of any type.

c. In the event of a termination under the provisions of this paragraph, the Licensee agrees to remove all encroaching facilities in the manner provided in paragraph 11 of this license.

Licensee:

Dated: January 26, 1996

By _____ Victor M. Stevens

Its City Manager

Representing:

City of San Luis

P.O. Box "S"

San Luis, AZ 85349

(Address)

(Licensee sign 3 copies)

Dated : 2/7/96

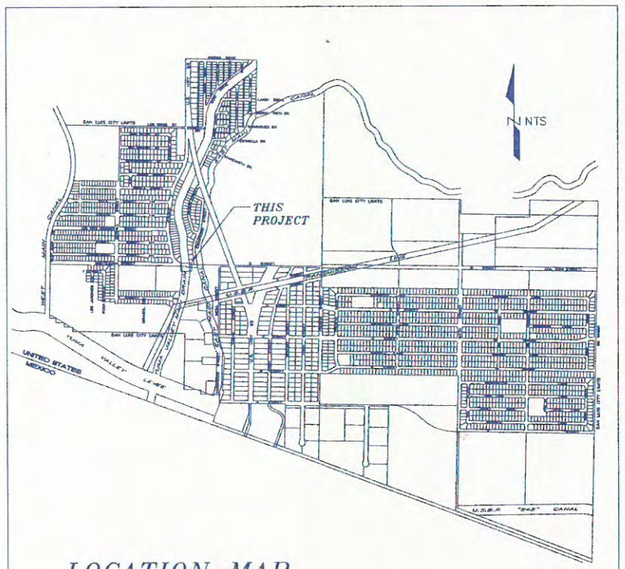
Approved:

By _____
Manager, YUMA COUNTY WATER
USERS' ASSOCIATION

Copy to: Area Manager
Yuma Area Office
United States Bureau of Reclamation
P.O. Box D
Yuma, AZ 85366

CITY OF SAN LUIS, ARIZONA

"G" STREET/MAIN DRAIN BRIDGE



LOCATION MAP

MAYOR–MIGUEL A. "MIKE" LOPEZ

VICE MAYOR–JOSEFINA RODRIGUEZ

COUNCIL MEMBERS–

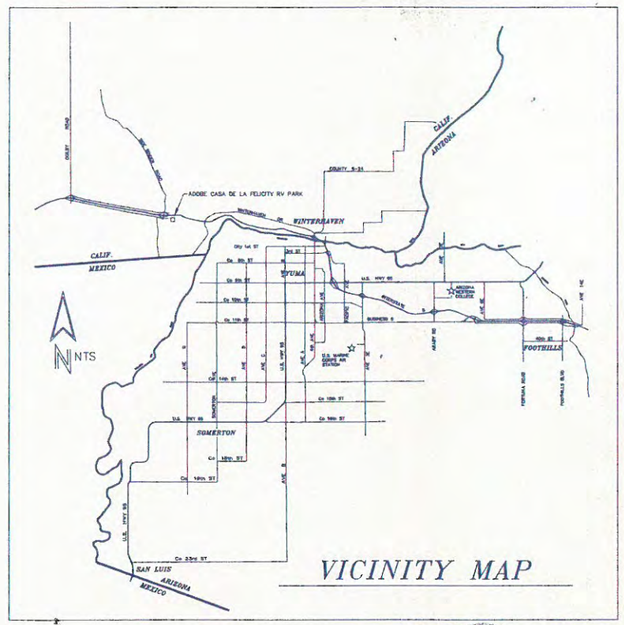
JUAN S. ESPINOZA
LETICIA COURET
ESTELLA S. LUNA
LUIS R. CASTRO
ISMAEL BUENO

CITY MANAGER–VICTOR STEVENS

CITY ATTORNEY–ROBERT CLARKE

DIRECTOR OF PUBLIC WORKS–DAVID FORD

CITY ENGINEER–NICKLAUS ENGINEERING, INC.



VICINITY MAP

SHEET INDEX

1. TITLE, LOCATION MAP, VICINITY MAP AND SHEET INDEX
2. DEMOLITION PLAN
3. SITE GRADING PLAN
4. ROAD AND SEWER MAIN PROFILE
5. ROAD AND WATER MAIN PROFILE
6. ROAD AND TELEPHONE CONDUIT PROFILE
7. ELECTRICAL SITE PLAN, ONE LINE DIAGRAM DETAIL AND SECTION
8. SHEET PILE WALL PLAN AND ELEVATION
9. GUARDRAIL AND RIP RAP PLAN AND DETAILS
10. DETAILS
11. DETAILS
12. BRIDGE GENERAL PLAN
13. FOUNDATION DATA
14. FOUNDATION PLANS & DETAILS
15. ABUTMENT 1 PLAN & ELEVATION & SECTIONS
16. ABUTMENT 2 PLAN & ELEVATION & SECTIONS
17. DECK PLAN & DETAILS
18. PRESTRESS GIRDER DETAILS
19. DIAPHRAM DETAILS

RECEIVED
FEB 07 1996
Yuma County Water Users Assn

YUMA COUNTY WATER USERS' ASSOCIATION		
Reviewed	Date	By
Water Dept	2-8-96	[illegible]
Engineers		
Real Estate	2/7/96	RBM

12754
THOMAS EDWARD
WILSON
12-26-95

APPROVALS:

APPROVED BY:

Mayor _____ Date _____

ATTEST:

CITY Manager _____ Date _____

PREPARED BY:

NICKLAUS engineering
1851 West 24th. STREET P.O. BOX 6029
YUMA, ARIZONA 85364 (602) 344-8374

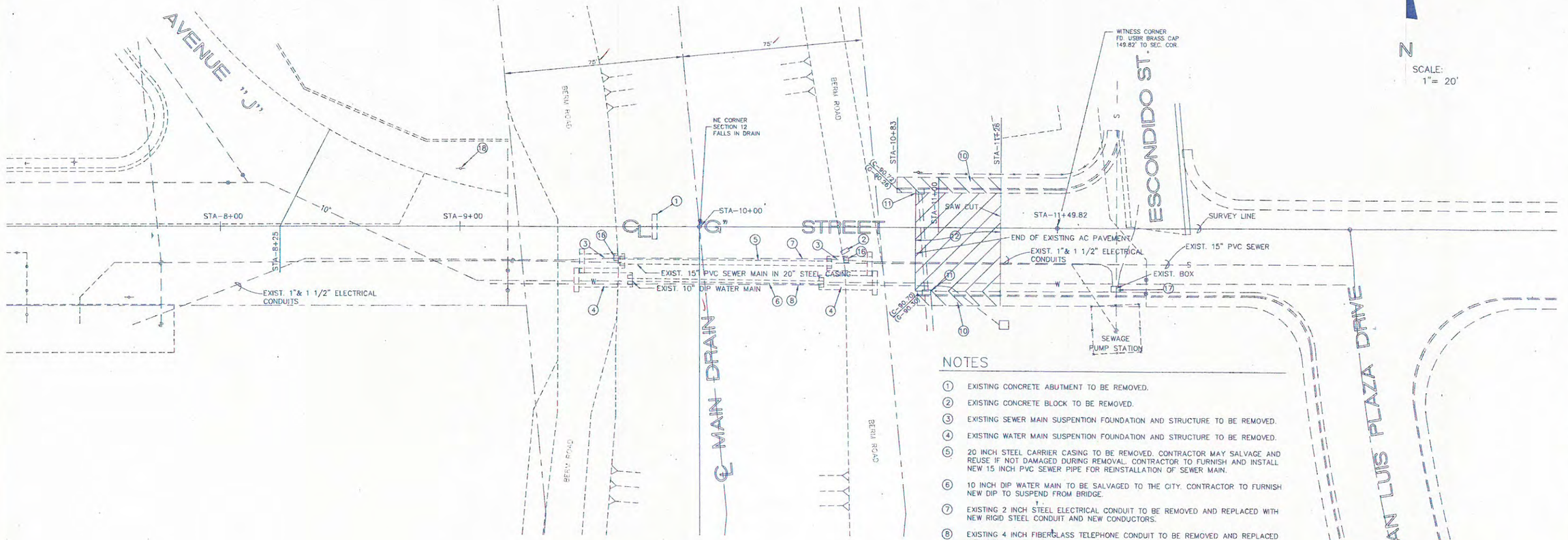
#11

SHEET 1 OF 19

MAIN DRAIN 4042

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C:\ACAD\DRAWINGS\95061 Thu Dec 21 15:57:06 1995 Plotted by Robert

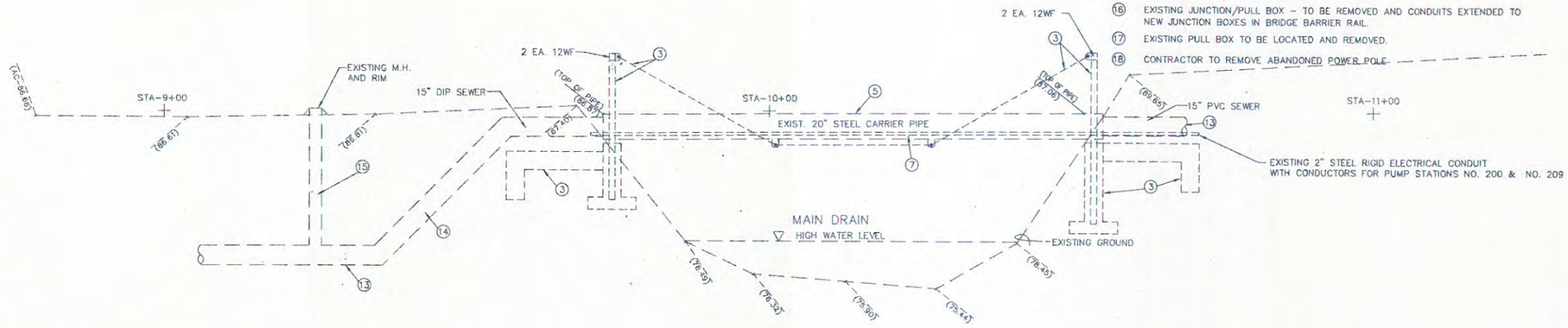


DEMOLITION PLAN

SCALE: 1"=20'

NOTES

1. EXISTING CONCRETE ABUTMENT TO BE REMOVED.
2. EXISTING CONCRETE BLOCK TO BE REMOVED.
3. EXISTING SEWER MAIN SUSPENTION FOUNDATION AND STRUCTURE TO BE REMOVED.
4. EXISTING WATER MAIN SUSPENTION FOUNDATION AND STRUCTURE TO BE REMOVED.
5. 20 INCH STEEL CARRIER CASING TO BE REMOVED. CONTRACTOR MAY SALVAGE AND REUSE IF NOT DAMAGED DURING REMOVAL. CONTRACTOR TO FURNISH AND INSTALL NEW 15 INCH PVC SEWER PIPE FOR REINSTALLATION OF SEWER MAIN.
6. 10 INCH DIP WATER MAIN TO BE SALVAGED TO THE CITY. CONTRACTOR TO FURNISH NEW DIP TO SUSPEND FROM BRIDGE.
7. EXISTING 2 INCH STEEL ELECTRICAL CONDUIT TO BE REMOVED AND REPLACED WITH NEW RIGID STEEL CONDUIT AND NEW CONDUCTORS.
8. EXISTING 4 INCH FIBERGLASS TELEPHONE CONDUIT TO BE REMOVED AND REPLACED WITH NEW 4 INCH SCH. 40 STEEL CONDUIT SUSPENDED FROM BRIDGE.
9. CONTRACTOR TO PROVIDE AND MAINTAIN TEMPORARY BY-PASS FOR 15 INCH SEWER MAIN, 10 INCH WATER MAIN AND 2 INCH ELECTRICAL CONDUIT WITH CONDUCTORS WHILE BRIDGE IS BEING CONSTRUCTED. CONTRUCTOR TO RECONNECT WATER, SEWER AND ELECTRICAL TO NEW BRIDGE CROSSINGS WHEN COMPLETED.
10. REMOVED EXISTING CURB GUTTER AND SIDEWALK.
11. REMOVED EXISTING CATCH BASIN AND CURB INLET AND CONSTRUCT NEW CATCH BASIN AND CURB INLET TO NEW GRADES.
12. REMOVE EXISTING AC PAVEMENT.
13. REMOVE EXISTING 15" PVC SEWER MAIN STA. 9+22 TO 10+80.
14. REMOVE EXISTING 15" DIP & PVC SEWER MAIN FROM STATION 9+22 TO 9+72.
15. REMOVE EXISTING 4' DIA MANHOLE TO BASE AND REPLACE WITH NEW EPOXY OR PLASTIC LINED 4' DIA DROP MANHOLE.
16. EXISTING JUNCTION/PULL BOX – TO BE REMOVED AND CONDUITS EXTENDED TO NEW JUNCTION BOXES IN BRIDGE BARRIER RAIL.
17. EXISTING PULL BOX TO BE LOCATED AND REMOVED.
18. CONTRACTOR TO REMOVE ABANDONED POWER POLE.



15" SEWER SUSPENSION STRUCTURE ELEVATION

HORIZ: 1"=10'
VERT: 1"=4'

(10" DIP WATER MAIN SUSPENTION STRUCTURE SIMILAR)

CERTIFICATE NO. 12754 THOMAS EDWARD WILSON 12-31-95 REGISTERED

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C:\ACAD\DRAWINGS\95056SHM1 Thu Dec 21 16:09:52 1995 Plotted By Robert

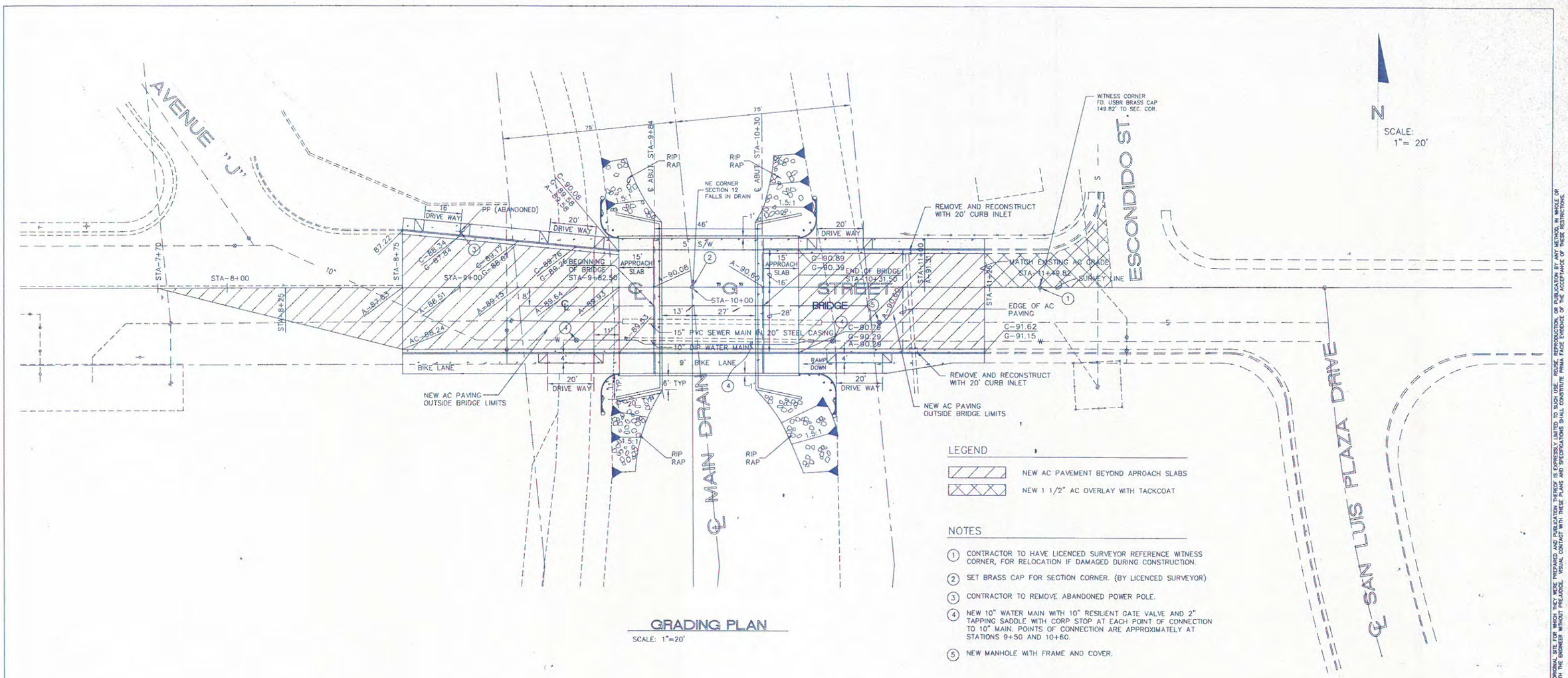
CITY OF SAN LUIS

DEMOLITION PLAN
'G' STREET/ MAIN DRAIN BRIDGE

SCALE:	AS SHOWN
DATE:	OCT. 1995
DES. BY:	T.E.W.
DRAWN BY:	A.A./RGA
SURVEYED BY:	
JOB. No.:	95-056
FILE No.:	XIV-D-20

NICKLAUS engineering
1851 West 24th. STREET P.O. BOX 6029
YUMA, ARIZONA 85364 (520) 344-8374

SHEET 2 OF 19



GRADING PLAN

SCALE: 1"=20'

LEGEND

- NEW AC PAVEMENT BEYOND APROACH SLABS
- NEW 1 1/2" AC OVERLAY WITH TACKCOAT

NOTES

1. CONTRACTOR TO HAVE LICENCED SURVEYOR REFERENCE WITNESS CORNER, FOR RELOCATION IF DAMAGED DURING CONSTRUCTION.
2. SET BRASS CAP FOR SECTION CORNER. (BY LICENCED SURVEYOR)
3. CONTRACTOR TO REMOVE ABANDONED POWER POLE.
4. NEW 10" WATER MAIN WITH 10" RESILIENT GATE VALVE AND 2" TAPPING SADDLE WITH CORP STOP AT EACH POINT OF CONNECTION TO 10" MAIN. POINTS OF CONNECTION ARE APPROXIMATELY AT STATIONS 9+50 AND 10+60.
5. NEW MANHOLE WITH FRAME AND COVER.

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12754
THOMAS EDWARD WILSON
12-26-95
Thomas E. Wilson

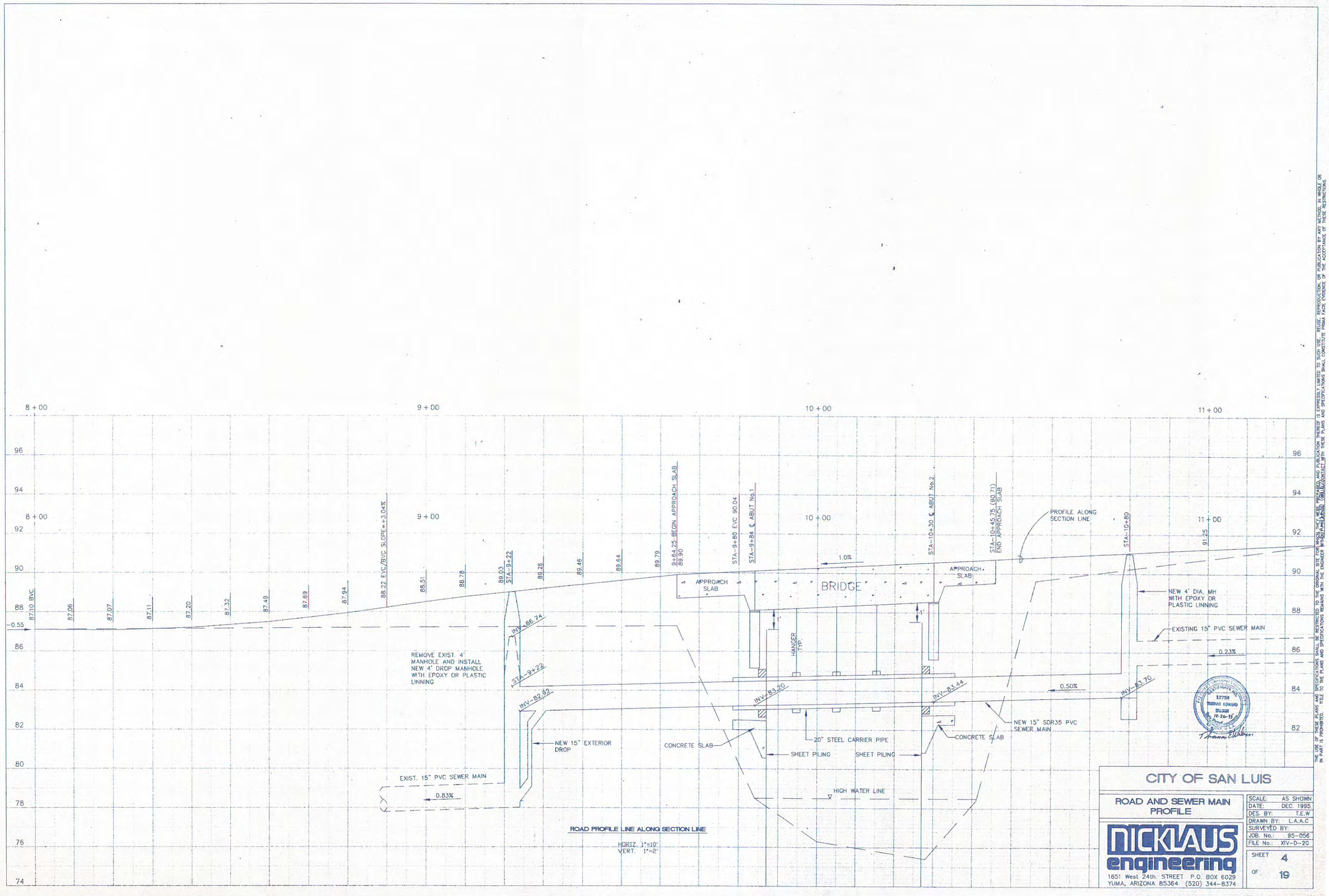
CITY OF SAN LUIS

SITE GRADING PLAN
"Q" STREET/ MAIN DRAIN BRIDGE

SCALE:	AS SHOWN
DATE:	OCT. 1995
DES. BY:	T.E.W.
DRAWN BY:	A.A./RGA
SURVEYED BY:	
JOB No.:	95-056
FILE No.:	XIV-D-20
SHEET	3
OF	19

NICKLAUS engineering
1851 West 24th. STREET P.O. BOX 6029
YUMA, ARIZONA 85364 (520) 344-8374

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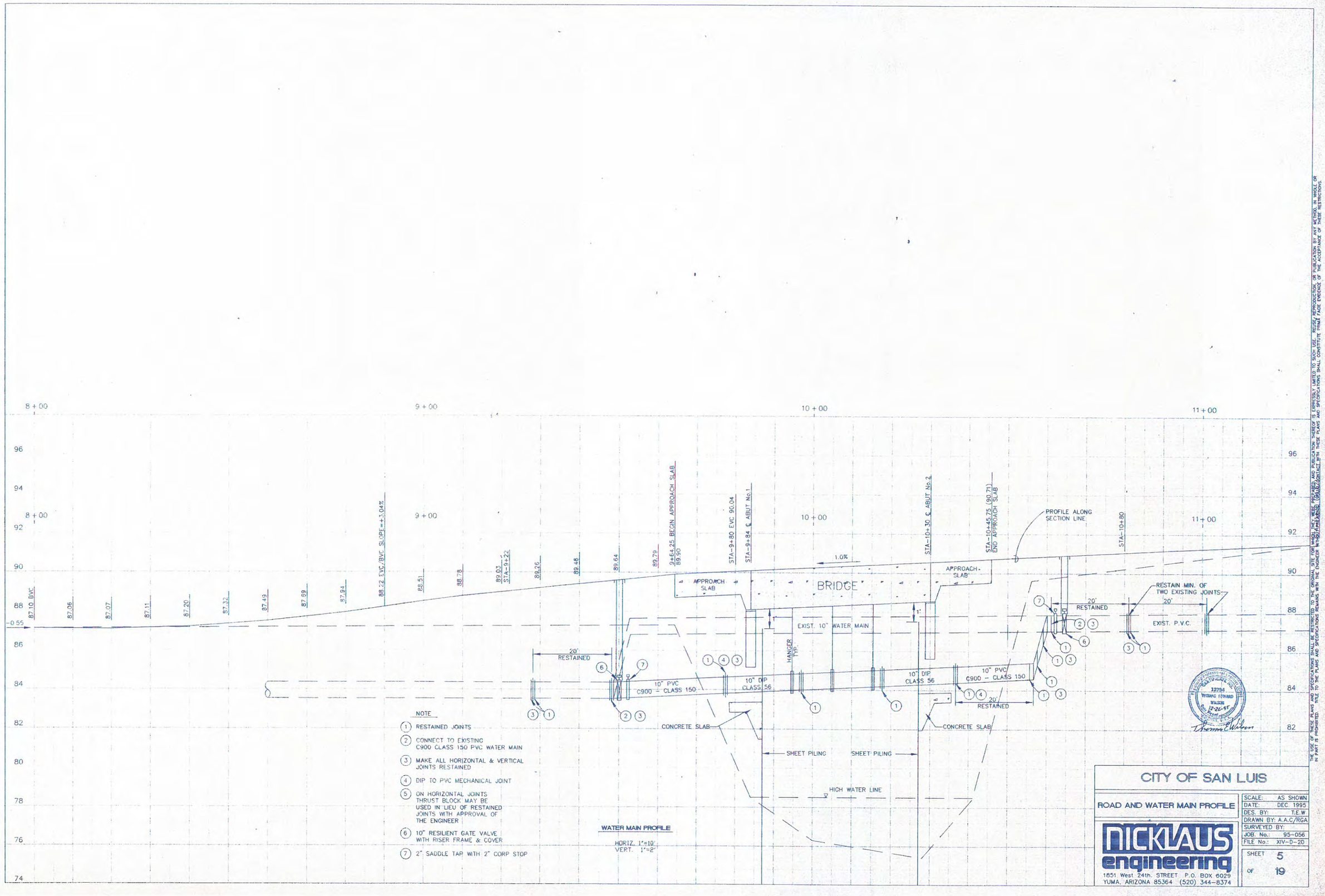
THE USE OF THESE PLANS AND SPECIFICATIONS SHALL BE RESTRICTED TO THE ORIGINAL SITE FOR WHICH THEY WERE PREPARED AND PUBLICATION THEREOF IS EXPRESSLY LIMITED TO SUCH USE. REUSE, REPRODUCTION, OR PUBLICATION BY ANY METHOD, IN WHOLE OR IN PART, IS PROHIBITED. TITLE TO THE PLANS AND SPECIFICATIONS REMAINS WITH THE ENGINEER WHO PREPARED THEM. ANY REUSE WITHOUT WRITTEN VERIFICATION OR ADAPTATION BY THE ENGINEER FOR THE SPECIFIC PURPOSE INTENDED WILL BE AT USER'S SOLE RISK AND WITHOUT LIABILITY OR LEGAL EXPOSURE TO THE ENGINEER. USER SHALL INDEMNIFY AND HOLD HARMLESS THE ENGINEER AGAINST ALL CLAIMS, DAMAGES, LOSSES AND EXPENSES INCLUDING ATTORNEY'S FEES ARISING OUT OF OR RESULTING THEREFROM. ANY MODIFICATION BY USER SHALL CONSTITUTE PRIMA FACIE EVIDENCE OF THESE RESTRICTIONS.

CITY OF SAN LUIS

ROAD AND SEWER MAIN PROFILE

SCALE:	AS SHOWN
DATE:	DEC. 1995
DES. BY:	T.E.W
DRAWN BY:	L.A.A.C
SURVEYED BY:	
JOB. No.:	95-056
FILE No.:	XIV-D-20
SHEET	4
OF	19

NICKLAUS engineering
1851 West 24th. STREET P.O. BOX 6029
YUMA, ARIZONA 85364 (520) 344-8374



NOTE

1. RESTAINED JOINTS
2. CONNECT TO EXISTING C900 CLASS 150 PVC WATER MAIN
3. MAKE ALL HORIZONTAL & VERTICAL JOINTS RESTAINED
4. DIP TO PVC MECHANICAL JOINT
5. ON HORIZONTAL JOINTS THRUST BLOCK MAY BE USED IN LIEU OF RESTAINED JOINTS WITH APPROVAL OF THE ENGINEER
6. 10" RESILIENT GATE VALVE WITH RISER FRAME & COVER
7. 2" SADDLE TAP WITH 2" CORP STOP

WATER MAIN PROFILE

HORIZ. 1"=10'
VERT. 1"=2'

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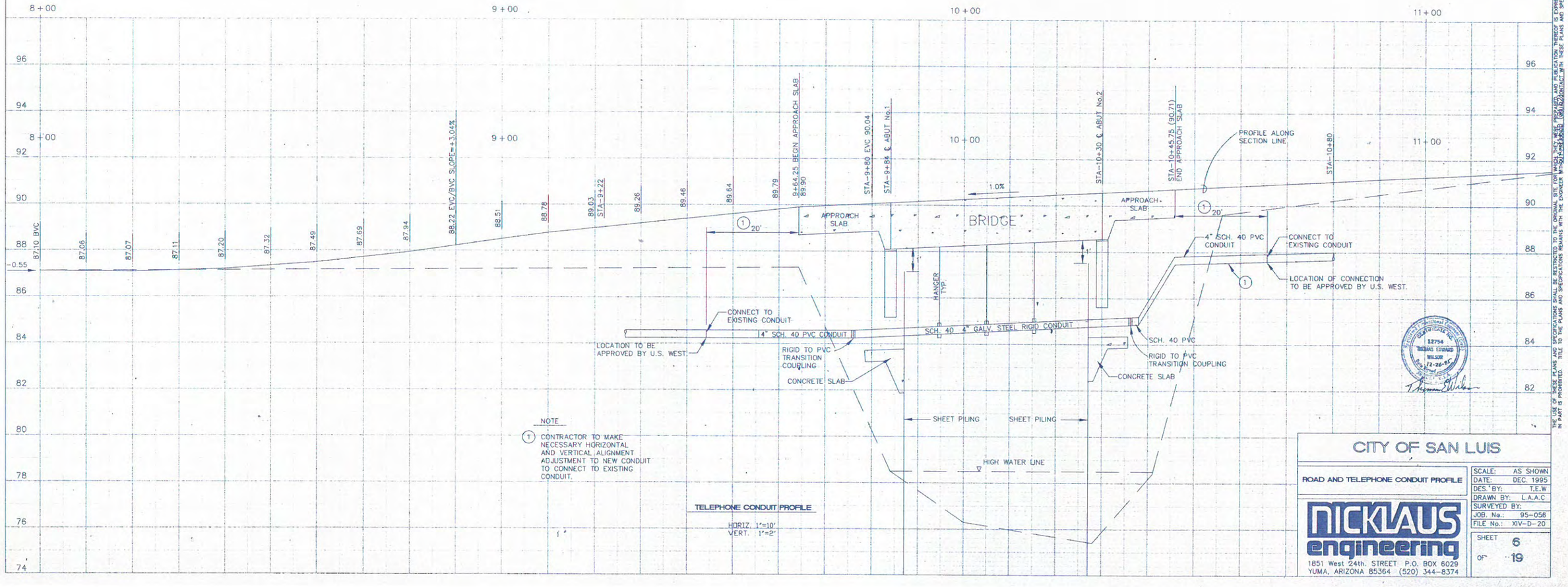
CITY OF SAN LUIS

ROAD AND WATER MAIN PROFILE

SCALE:	AS SHOWN
DATE:	DEC. 1995
DES. BY:	T.E.W
DRAWN BY:	A.A.C/RGA
SURVEYED BY:	
JOB. No.:	95-056
FILE No.:	XIV-D-20
SHEET	5
OF	19

NICKLAUS engineering
1651 West 24th. STREET P.O. BOX 6029
YUMA, ARIZONA 85364 (520) 344-8374

C:\ACAD\DRAWINGS\PVIEW12 Tue Dec 26 10:42:14 1995 Plotted by Robert



NOTE

(T) CONTRACTOR TO MAKE NECESSARY HORIZONTAL AND VERTICAL ALIGNMENT ADJUSTMENT TO NEW CONDUIT TO CONNECT TO EXISTING CONDUIT.

TELEPHONE CONDUIT PROFILE

HORIZ. 1"=10'
VERT. 1"=2'

CITY OF SAN LUIS

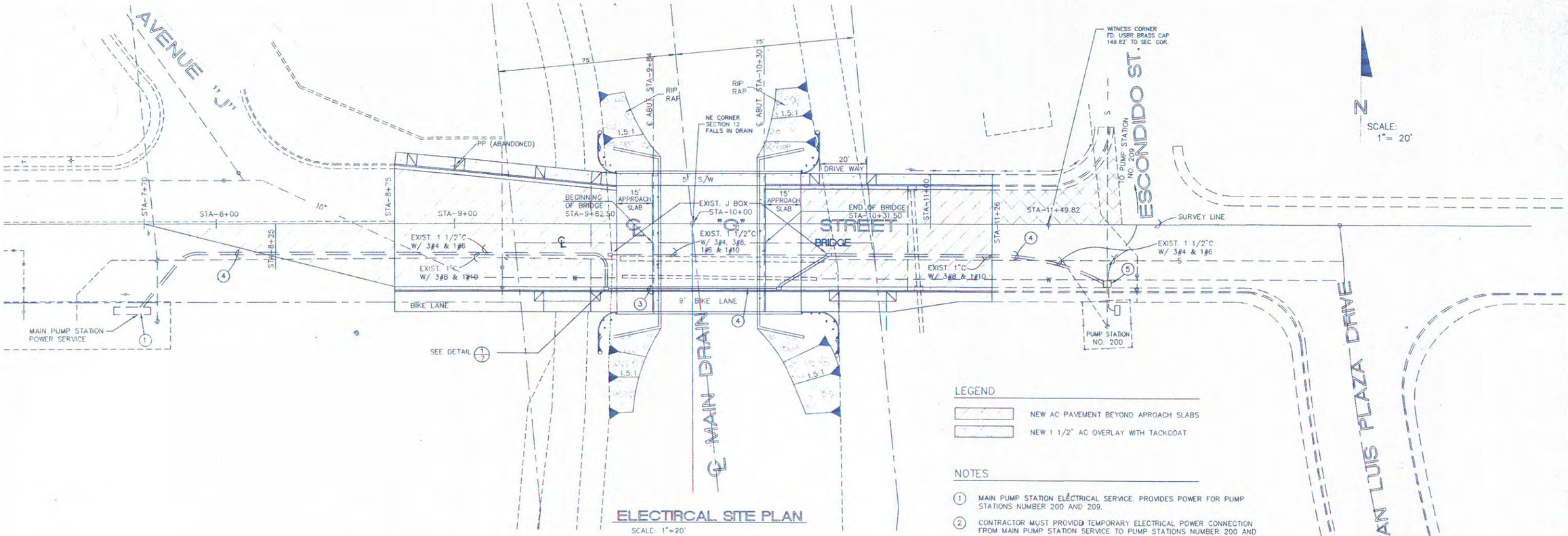
ROAD AND TELEPHONE CONDUIT PROFILE

SCALE:	AS SHOWN
DATE:	DEC. 1995
DES. BY:	T.E.W
DRAWN BY:	L.A.A.C
SURVEYED BY:	
JOB. No.:	95-056
FILE No.:	XIV-D-20
SHEET	6
OF	19

NICKLAUS engineering
1851 West 24th. STREET P.O. BOX 6029
YUMA, ARIZONA 85364 (520) 344-8374

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ELECTIRCAL SITE PLAN

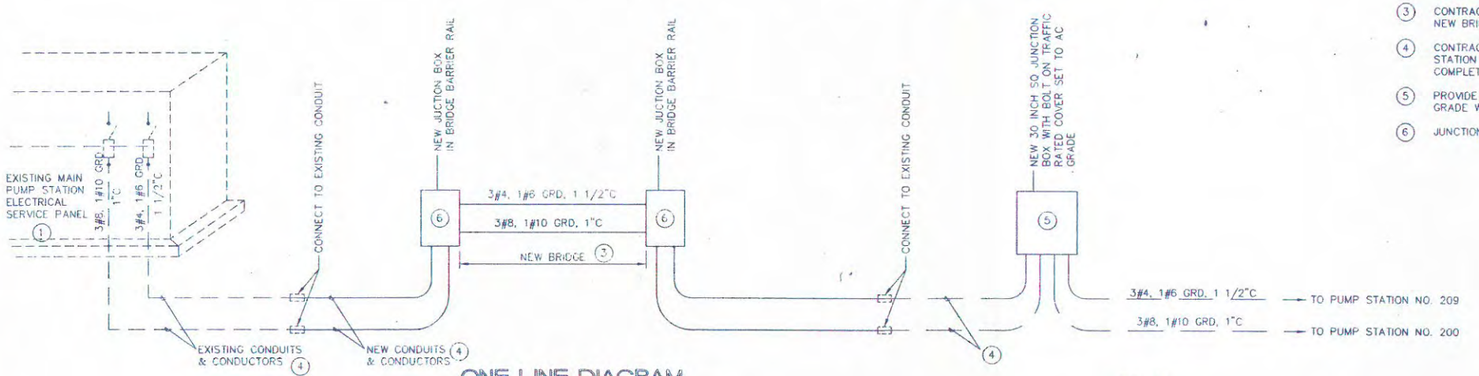
SCALE: 1"=20'

LEGEND

- NEW AC PAVEMENT BEYOND APROACH SLABS
- NEW 1 1/2" AC OVERLAY WITH TACKCOAT

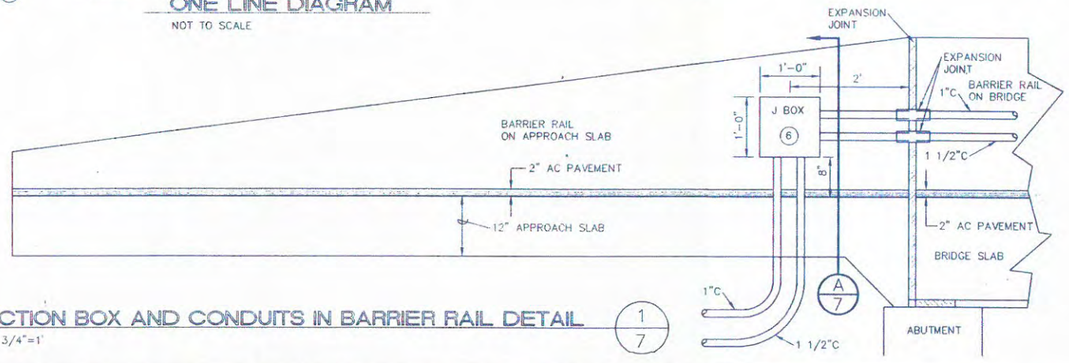
NOTES

1. MAIN PUMP STATION ELECTRICAL SERVICE. PROVIDES POWER FOR PUMP STATIONS NUMBER 200 AND 209.
2. CONTRACTOR MUST PROVIDE TEMPORARY ELECTRICAL POWER CONNECTION FROM MAIN PUMP STATION SERVICE TO PUMP STATIONS NUMBER 200 AND 209 DURING CONTRUCTION.
3. CONTRACTOR TO PROVIDE PERMANENT CONDUITS AND CONDUCTORS ACROSS NEW BRIDGE FOR PUMP STATION NO. 200 AND 209.
4. CONTRACTOR TO FURNISH AND INSTALL NEW CONDUCTORS FROM MAIN PUMP STATION PANEL TO JUNCTION BOX NORTH OF PUMP STATION NO. 200 UP ON COMPLETION OF THE BRIDGE PROJECT. SEE ONE LINE DRAWING.
5. PROVIDE NEW PULL BOX WITH BOLT DOWN COVER SET TO EXISTING ASPHALT GRADE WITH 12" CONCRETE COLLAR.
6. JUNCTION BOX WITH WEATHER TIGHT BOLT ON COVER.



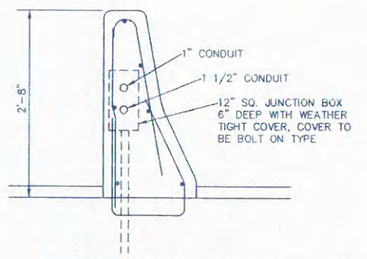
ONE LINE DIAGRAM

NOT TO SCALE



JUNCTION BOX AND CONDUITS IN BARRIER RAIL DETAIL (1/7)

SCALE: 3/4"=1'



BARRIER RAIL SECTION (A/7)

NOT TO SCALE

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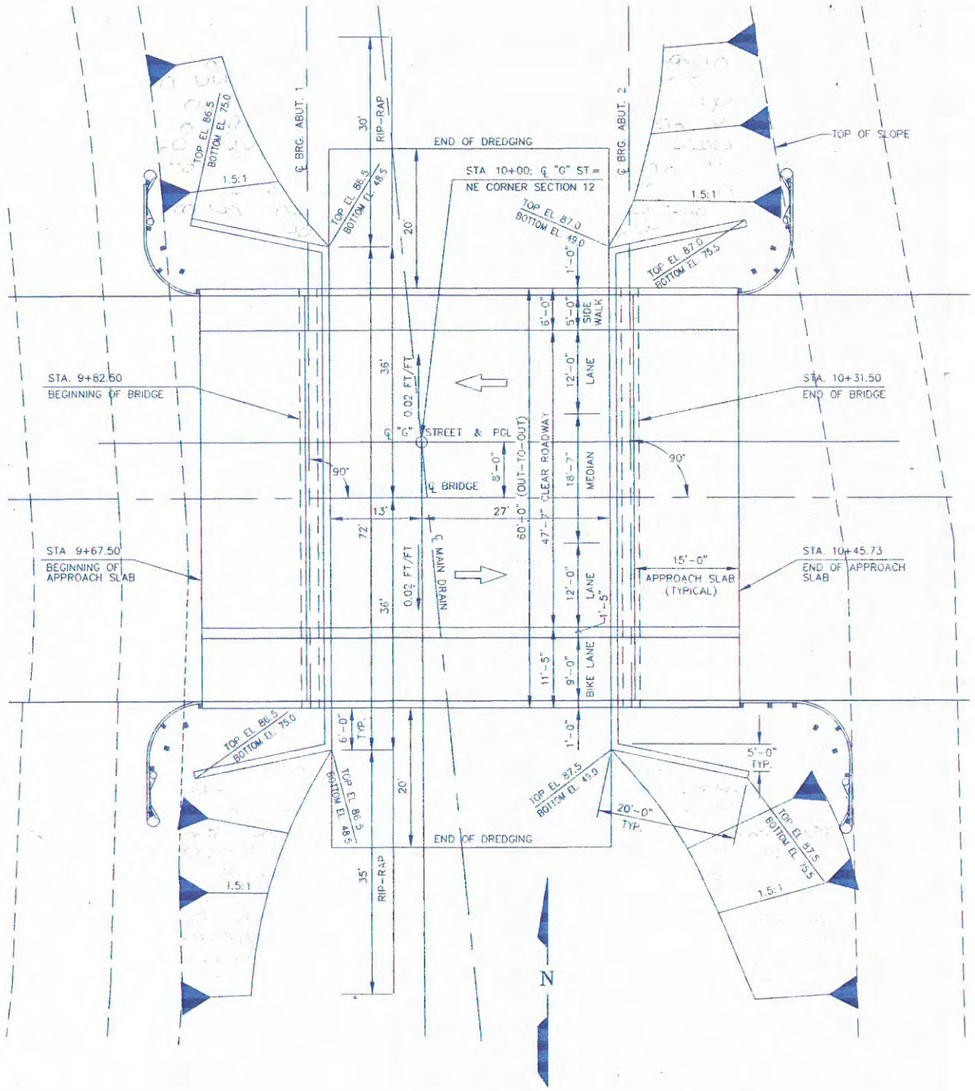
CITY OF SAN LUIS

ELECTRICAL SITE PLAN
ONE LINE DIAGRAM, DETAIL AND SECTION

SCALE:	AS SHOWN
DATE:	OCT. 1995
DES. BY:	T.E.W.
DRAWN BY:	A.A./RGA
SURVEYED BY:	
JOB. No.:	95-056
FILE No.:	XIV-D-20
SHEET	7
OF	19

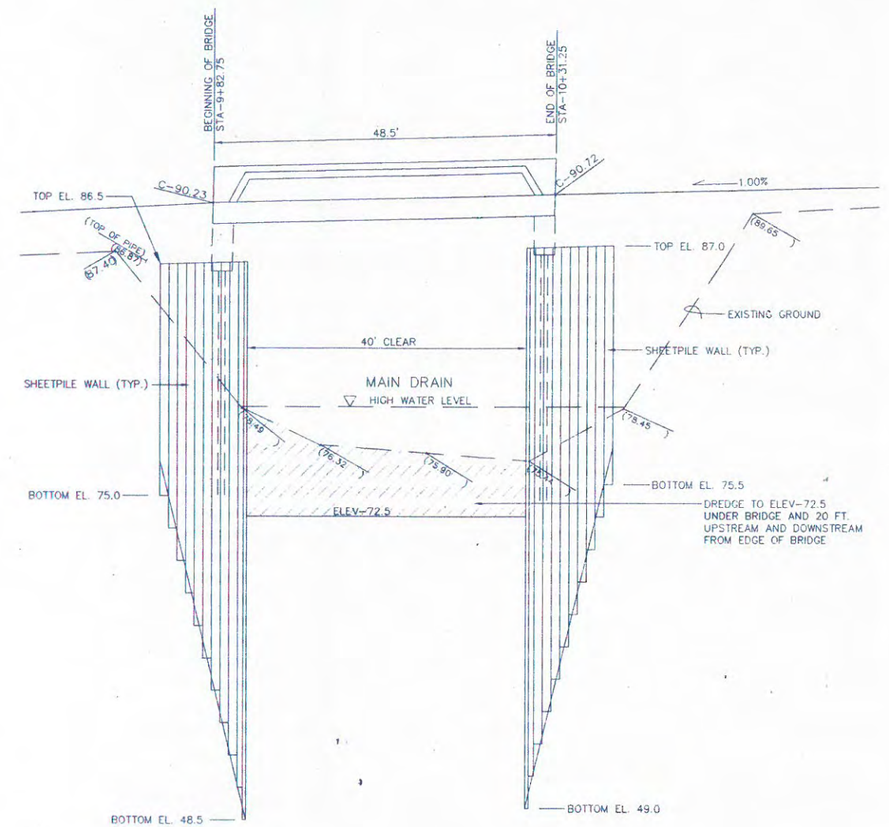
NICKLAUS engineering
1651 West 24th. STREET P.O. BOX 6029
YUMA, ARIZONA 85364 (520) 344-8374

C:\ACAD\DRAWINGS\95056D1 Tue Dec 26 10:50:41 1995 Plotted by Robert



SHEET PILE WALL PLAN

SCALE: 1"=10'



SHEET PILE WALL ELEVATION

NTS

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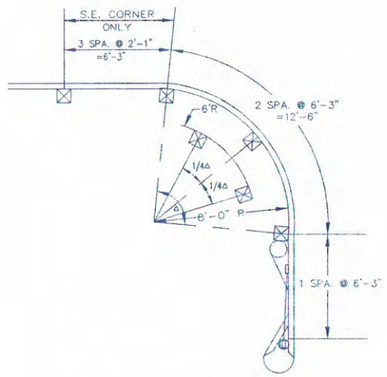
C:\ACAD\DRAWINGS\SG056053 Tue Dec 26 10:56:03 1995 Plotted by Robert

CITY OF SAN LUIS

SHEET PILE WALL
PLAN AND ELEVATION

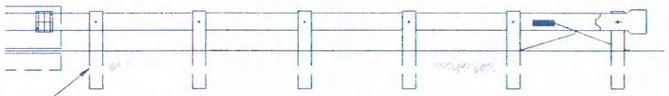
SCALE:	AS SHOWN
DATE:	SEPT. 1995
DES. BY:	T.E.W.
DRAWN BY:	A.A./RGA
SURVEYED BY:	
JOB. No.:	95-056
FILE No.:	XIV-D-20
SHEET	8
OF	19

NICKLAUS engineering
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YUMA, ARIZONA 85364 (520) 344-8374



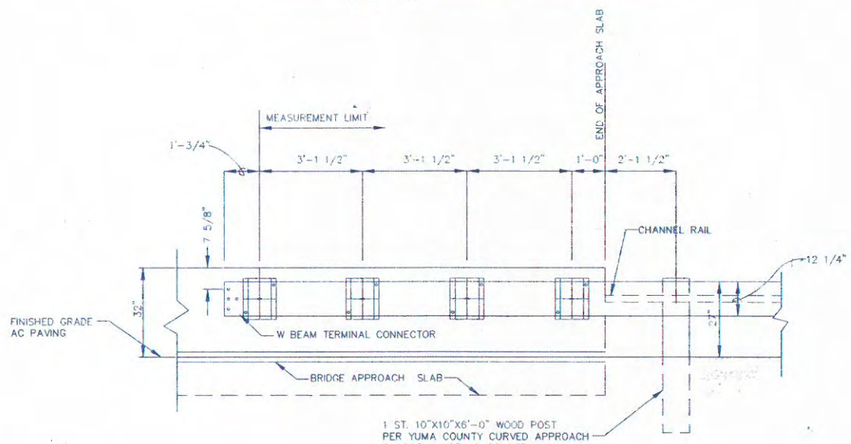
PLAN VIEW

SCALE: 1"=4'



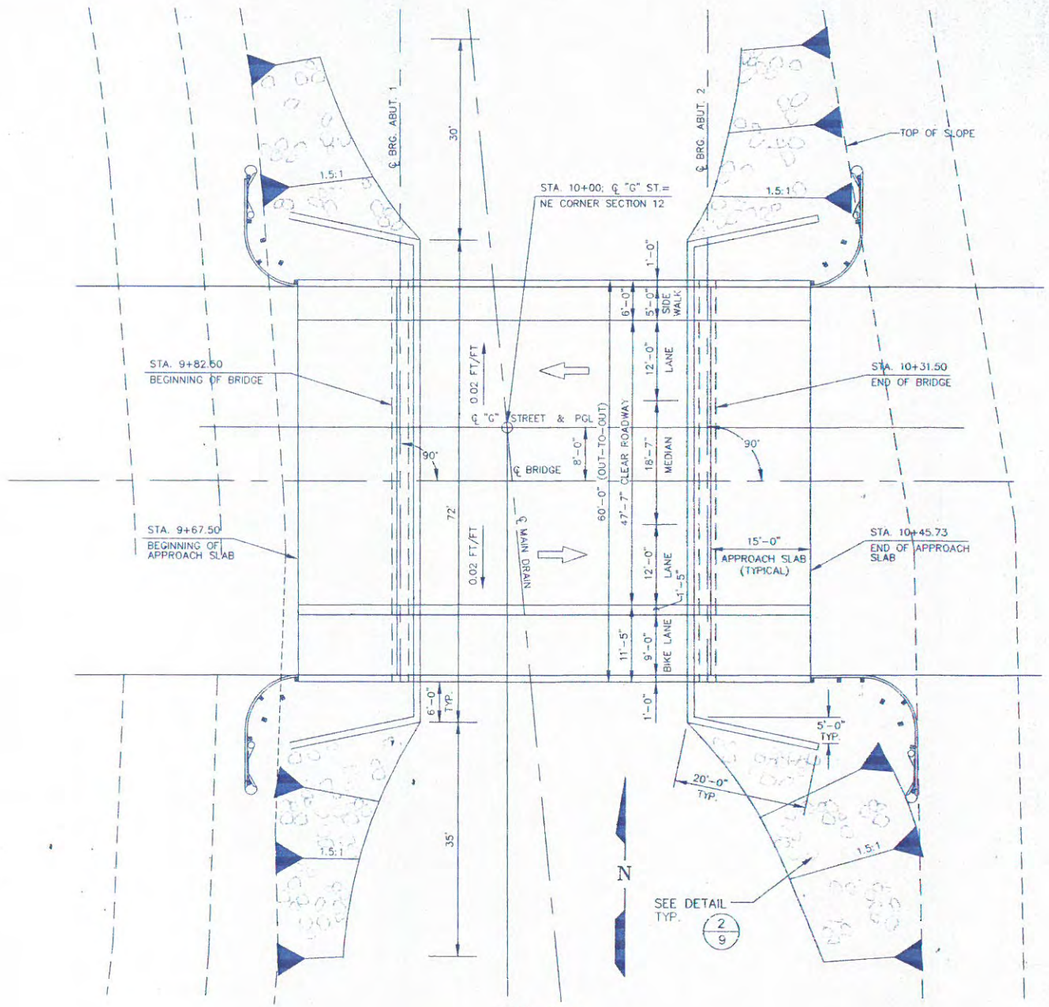
ELEVATION VIEW

SCALE: 1"=10'



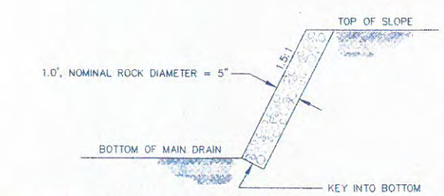
GUARD RAIL TRANSITION

SCALE: 1"=10'



PLAN

SCALE: 1"=10'



TYPICAL ROCK SLOPE PROTECTION DETAIL

NOT TO SCALE

2/9

12754 THOMAS EDWARD WILSON 12-26-95

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C:\ACAD\DRAWINGS\0560S1 Tue Dec 26 10:59:15 1995 Plotted by Andrea

CITY OF SAN LUIS

GUARD RAIL AND RIP RAP PLAN AND DETAILS

SCALE:	AS SHOWN
DATE:	SEPT. 1995
DES. BY:	T.E.W.
DRAWN BY:	A.A./RGA
SURVEYED BY:	
JOB. No.:	95-056
FILE No.:	XIV-D-20
SHEET	9
OF	19

NICKLAUS engineering
1651 West 24th. STREET P.O. BOX 6029
YUMA, ARIZONA 85364 (520) 344-8374

GENERAL NOTES

Construction Specifications – Arizona Department of Transportation Standard Specifications for Road and Bridge Construction, 1990.

Design Specifications – AASHTO Standard Specifications for Highway Bridges, 15th Edition (1992), with 1993 and 1994 Interim Specifications.

Dead Load – Dead Load includes allowance of 25 pounds per square foot for future wearing surfaces.

Loading Class – HS20-44 with no reduction in load intensity for superstructure for multiple lane loadings.

All concrete shall be class "S" unless otherwise noted.

Seismic Performance Category D (Acc = 0.40g).

Reinforcing steel shall conform to ASTM Specifications A615, except bars which are to be welded shall conform to ASTM A706. All reinforcing shall be furnished as grade 60.

All bend dimensions for reinforcing steel shall be out-to-out of bars. All placement dimensions for reinforcing steel shall be to center of bars unless noted otherwise.

Standard hook dimensions shall be used unless noted otherwise.

All reinforcing steel shall have 2" clear cover unless noted otherwise.

Stresses:

Concrete
Superstructure except barriers.....f'c = 5,000 psi
Driven Piles.....f'c = 4,000 psi
All other class "S" Concrete.....f'c = 3,000 psi

Steel
Grade 60 reinforcing steel.....fs = 24,000 psi
Prestressing steel.....f's = 270,000 psi
(1/2 dia. 7-wire Low Relaxation Strand)

Chamfer all exposed corners 3/4" as per Std. B-19.10 unless otherwise noted.

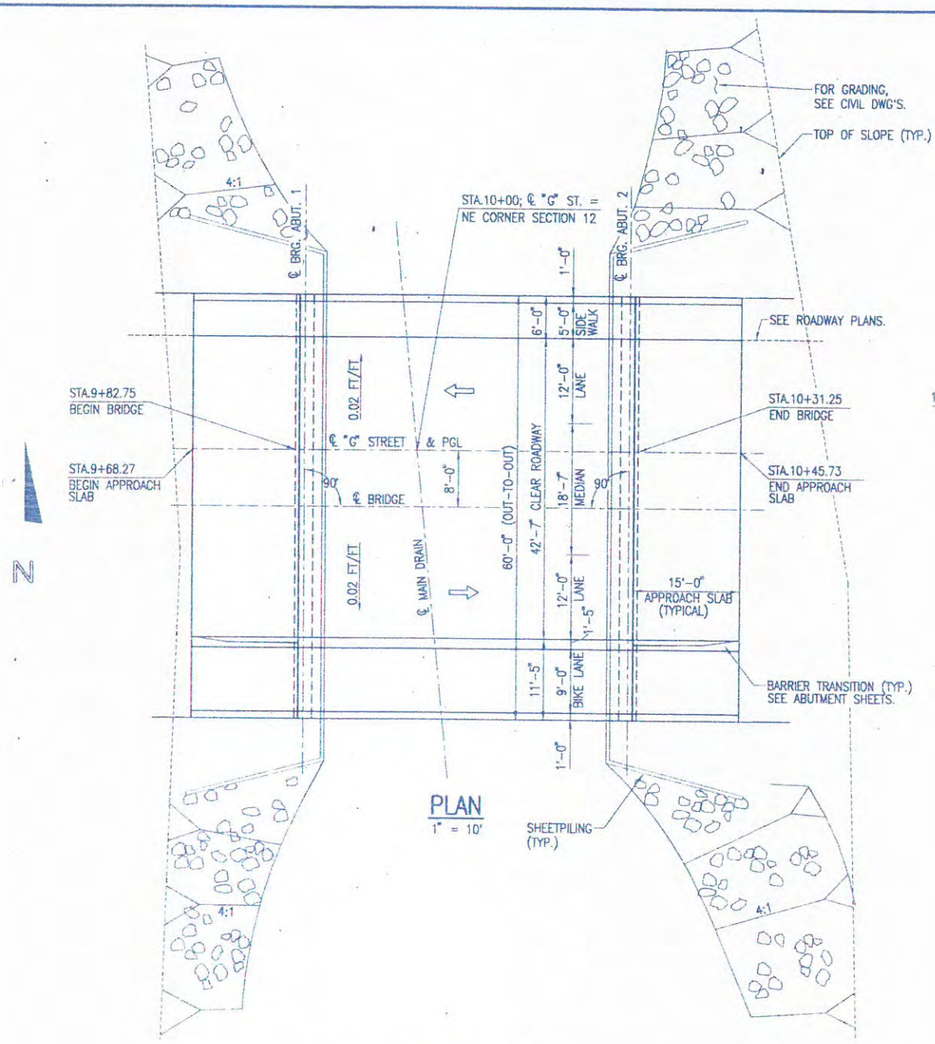
Dimensions shall not be scaled from drawings.

Inventory Rating (Working Stresses Method) HS 20

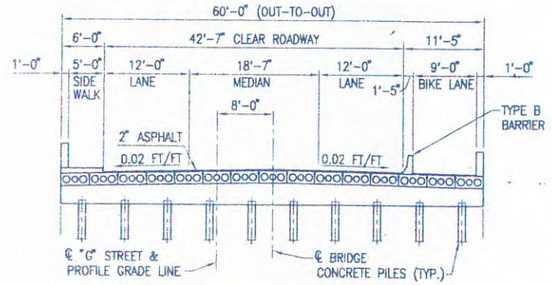
Operating Rating (Working Stress Method) HS 25.6

A.D.O.T. Structures Section Standards, 1992 Edition.

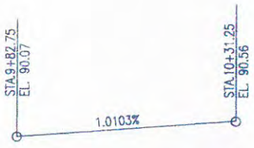
B-19.10
B-19.30
B-19.40
B-20.10
B-21.18



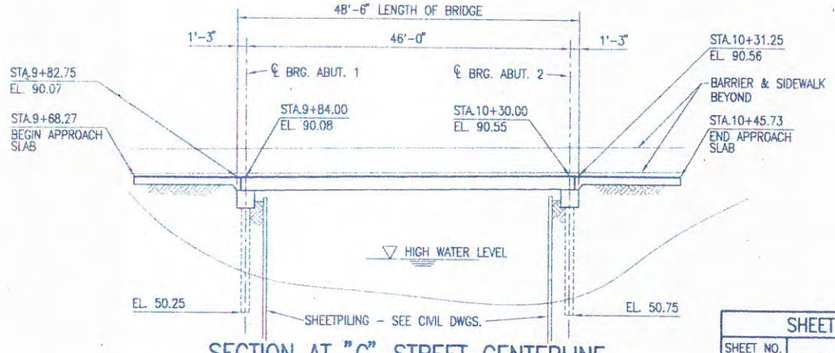
PLAN
1" = 10'



TYPICAL SECTION
(LOOKING UPSTATION)
1" = 10'



PROFILE GRADE
NO SCALE



SECTION AT "G" STREET CENTERLINE
NOTE: ALL STATIONS & ELEVATIONS ARE ON ℄ "G" STREET (TOP OF ASPHALT SURFACE)
1" = 10'

APPROXIMATE QUANTITIES

ITEM	STRUCTURAL EXCAVATION	STRUCTURE BACKFILL	CLASS "S" CONCRETE 3,000 p.s.i.	REINFORCEMENT STEEL	PRECAST VOIDED SLABS	C.I.P. CONCRETE PILES
UNIT	C. Y.	C. Y.	C. Y.	LBS.	NO.	LIN. FT.
ABUTMENT #1	20	70	15	1885		350
ABUTMENT #2	20	70	15	1885		350
SUPERSTRUCTURE					15	
APPROACH SLABS			71	10560		
SIDEWALK & BARRIERS			41	4990		
TOTAL	40	140	142	19320	15	700
AS-BUILT TOTAL						

SHEET INDEX	
SHEET NO.	TITLE
12	GENERAL PLAN, SECTION & NOTES
13	FOUNDATION DATA
14	FOUNDATION PLAN & DETAILS
15	ABUTMENT 1 – PLAN, ELEVATION
16	ABUTMENT 2 – PLAN, ELEVATION
17	DECK PLAN & DETAILS
18	PRESTRESSED GIRDER DETAILS
19	DIAPHRAGM DETAILS

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28212
MARK J. LANDA
11/24/96
REGISTERED PROFESSIONAL ENGINEER
CERTIFICATE NO.
ARIZONA U.S.A.

CITY OF SAN LUIS

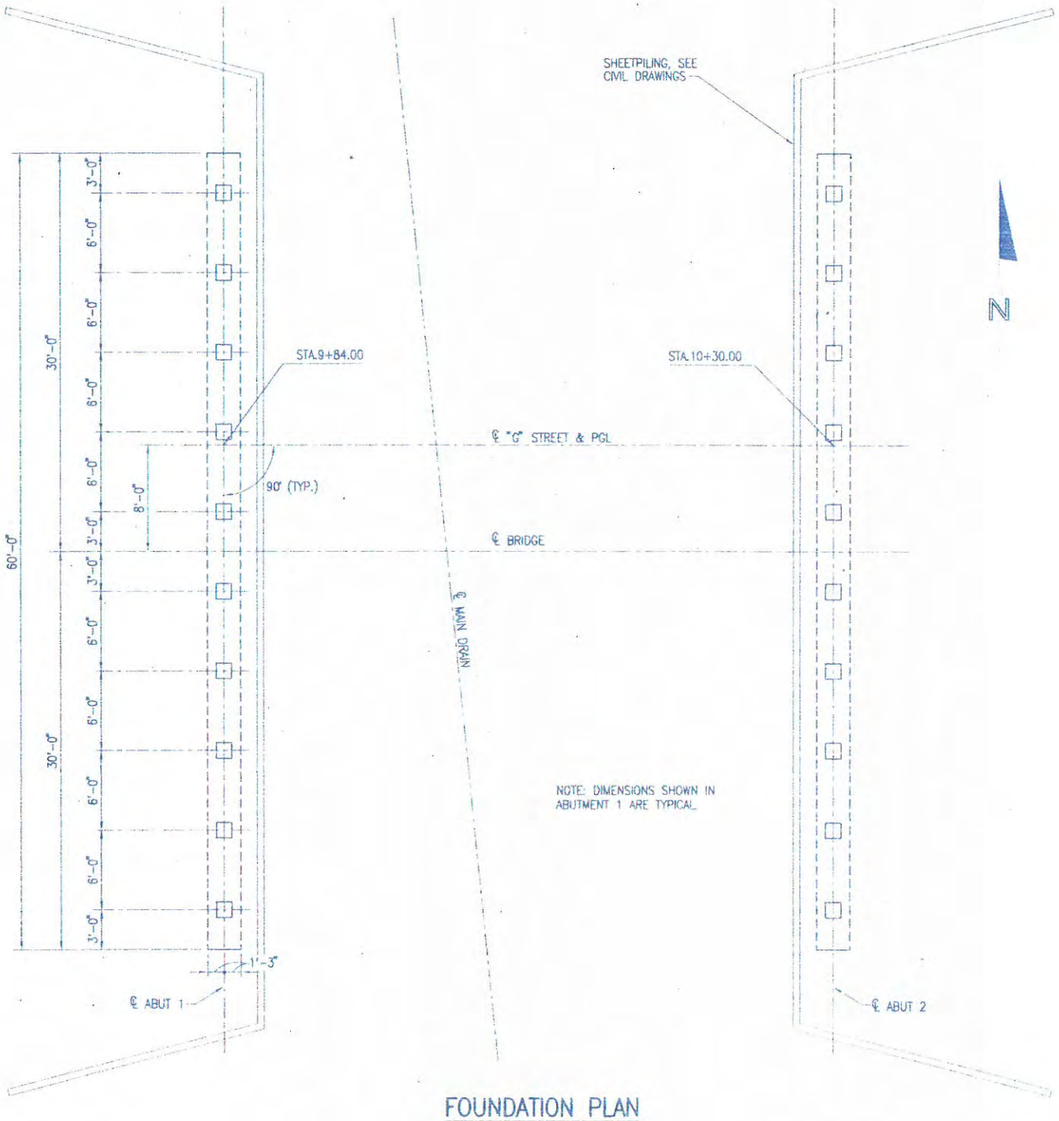
GENERAL PLAN, SECTION & NOTES
"G" STREET/ MAIN DRAIN BRIDGE

NICKLAUS engineering
1851 West 24th. STREET P.O. BOX 6029
YUMA, ARIZONA 85364 (520) 344-8374

SCALE:	AS SHOWN
DATE:	1/23/96
DES. BY:	C. G.
DRAWN BY:	RYAN A.
SURVEYED BY:	
JOB. No.:	LA95-185
FILE No.:	-

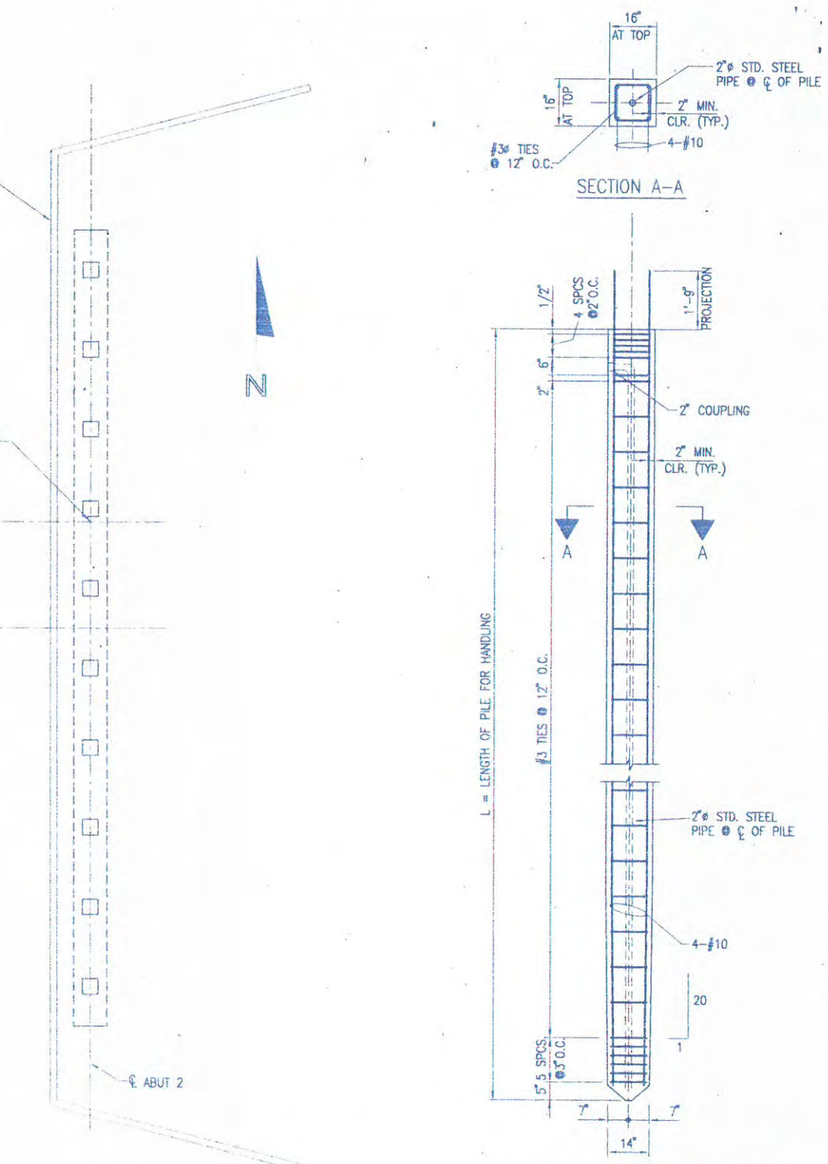
SHEET
OF 12 - 19

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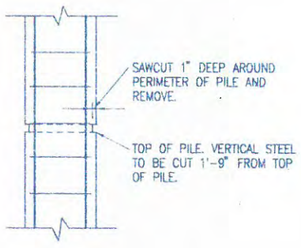
NOTE: DIMENSIONS SHOWN IN ABUTMENT 1 ARE TYPICAL.

FOUNDATION PLAN
3/16" = 1'-0"



PRECAST CONCRETE PILES
1/2" = 1'-0"

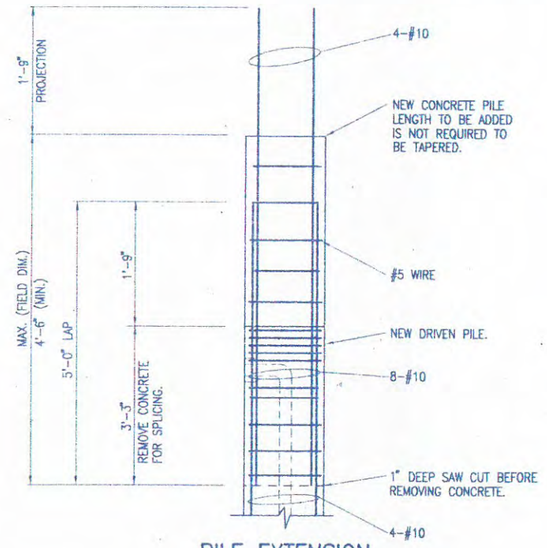
ELEVATION	A	B	C
ABUT #1	89.0	45.25	50.25
ABUT #2	89.4	45.75	50.75



PILE SHORTENING
1" = 1'-0"

PILE NOTES:

1. PILES SHALL BE PRECAST CONCRETE (f'c = 4,000 P.S.I.) WITH A POINT DIMENSION OF 14" AND TAPERED TO 16" AT THE TOP.
2. PILE TIPS SHALL BE REINFORCED WITH AN APPROVED CAST STEEL PILE POINT.
3. MINIMUM BEARING SHALL BE 50 TONS.
4. PRECAST PILES SHALL BE CAST 2'-0" LONGER THAN NET REQUIRED LENGTH, OR APPROVED DRIVING HEAD PROVIDED. AFTER DRIVING TO A DEPTH SATISFACTORY TO THE ENGINEER, THE EXCESS LENGTH SHALL BE TRIMMED OFF TO 3" ABOVE THE BOTTOM OF THE FOOTING AND THE PILE EDGES BEVELED. VERTICAL REINF. SHALL BE CUT OFF TO PROVIDE 1'-6" EMBEDMENT. IF EXTENDED PILE IS TO BE DRIVEN FURTHER, THE LONGITUDINAL STEEL SHALL BE LAPPED 40 DIAMETERS FOR THE SPLICE. CONCRETE FOR PRECAST PILES SHALL BE CLASS S, INTERNALLY VIBRATED.
5. FOR PRECAST PILE PICK-UP INFORMATION, SEE A.D.O.T. STANDARD STRUCTURES DRAWING B-20-10.
6. FILLS SHALL BE BUILT TO ELEVATION A. FILLS SHALL BE COMPACTED (PER A.D.O.T. STANDARD SPECIFICATIONS) BEFORE PILES ARE JETTED AND DRIVEN. EXCAVATION FOR ABUTMENT CONCRETE SHALL BE MADE BEFORE PILES ARE IN PLACE.
7. PILES ARE TO BE JETTED TO ELEVATION B BY ALTERNATE RAISING AND DROPPING PILE DURING CONTINUOUS JETTING.
8. A WATER PUMP SHALL BE USED THAT PRODUCES 400 GAL./MIN. WITH 400 P.S.I.
9. THE REMAINING PENETRATION OF THE PILE TO FINAL TIP ELEVATION OF C SHALL BE OBTAINED BY THE USE OF A GRAVITY HAMMER. THE HAMMER SHALL BE CAPABLE OF PRODUCING 8,000 FT./LBS. OF FORCE TO THE PILE UNTIL TIP ELEVATION IS REACHED.
10. CONTRACTOR SHALL SUBMIT TO ENGINEER PRIOR TO COMMENCING WORK, THE EQUIPMENT TO BE USED IN JETTING AND DRIVING PILES. APPROVAL MUST BE SECURED BEFORE WORK IS BEGUN.



PILE EXTENSION
1" = 1'-0"

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Consulting Structural Engineers

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CITY OF SAN LUIS

FOUNDATION PLAN & DETAILS
"G" STREET/ MAIN DRAIN BRIDGE

SCALE:	AS SHOWN
DATE:	1/23/96
DES. BY:	C. G.
DRAWN BY:	RYAN A.
SURVEYED BY:	
JOB. No.:	LA95-185
FILE No.:	-

NICKLAUS engineering
1851 West 24th. STREET P.O. BOX 6029
YUMA, ARIZONA 85364 (520) 344-8374

SHEET
OF 14 - 19

LICENSE NO. **015-97-002**

YUMA COUNTY WATER USERS' ASSOCIATION
P.O. BOX 5775
YUMA, AZ 85366-5775

LICENSE FOR ENCROACHMENTS AND CONSTRUCTION, INSTALLATION, OPERATION AND MAINTENANCE OF FACILITIES

LICENSEE: **ARIZONA DEPARTMENT OF TRANSPORTATION**

SERIAL NO(S): **VARIOUS** DIVISION: **N/A**

LOCATION: **USBR RIGHTS-OF-WAYS FOR THE INGRAHAM LATERAL IN SECTIONS 23 AND 24, T.10S.,R.25W., THE PARVIN LATERAL IN SECTION 25, T.10S.,R.25W., THE LARKIN LATERAL IN SECTION 35, T.10S.,R.25W., THE SOUTH DRAIN IN SECTIONS 35 AND 36, T.10S.,R.25W., THE BARKLEY LATERAL IN SECTIONS 1 AND 2, T.11S., R.25W., THE MICHAEL LATERAL IN SECTION 2, T.11S., R.25W., THE EAST MAIN CANAL AND THE MAIN DRAIN IN SECTION 1, T.11S., R.25W, AND THE 34.5 KV TRANSMISSION LINE IN SECTION 12, T.11S., R.25W..**

1. Authority. Pursuant to the provisions of United States Department of the Interior, Bureau of Reclamation, Public Notice No. 77 dated February 12, 1960 (entitled "Public Notice Announcing Procedures for Processing Water Right Applications and Certain Other Contracts", the Yuma County Water Users' Association (Licensor) licenses the above named Licensee to construct, install, operate and maintain facilities encroaching upon rights-of-way of the United States forming a part of the Valley Division of the Yuma Project, a reclamation project constructed under the laws of the United States.

2. Description of Encroachment. The encroachment shall be constructed and operated only under the terms and conditions of this license and is specifically described as follows:

a. WIDENING, RECONSTRUCTION, OPERATION AND MAINTENANCE OF U.S. HIGHWAY 95 FROM GADSDEN TO SAN LUIS, ARIZONA.

3. Nature of Right Conferred: Rights of Licensor.

a. The encroachment and consent to construct contained in this license relate only to the rights of the Licensor by virtue of its contractual relationship with the United States Department of Interior, Bureau of Reclamation (USBR) for the maintenance and operation of Federal facilities constituting the Valley Division of the Yuma Project. The lands to which this license pertains are not owned by the Licensor. Nothing in this license constitutes a representation by the Licensor of any authority to grant a right-of-way across any property owned or controlled by any person other than the Licensor.

b. Any right granted to the Licensee hereunder shall be inferior to the right of the Licensor to operate and maintain project irrigation facilities and to reconstruct, repair or improve any works within said rights-of-way without the consent of the Licensee and without liability for damages caused by any non-negligent act of the Licensor to any facilities or property owned or controlled by the Licensee.

c. Except in the case of emergencies, and when deemed appropriate by the Licensor, the Licensor will provide the Licensee with notice of its intent to construct, repair or improve any works within the portion of the right-of-way wherein the Licensee is encroaching. Notwithstanding the foregoing sentence, the Licensor shall give the Licensee prior notice of its intention to perform any work which will require the closing of a public thoroughfare under the Licensee's jurisdiction, or the interruption of utility services operated or controlled by the Licensee.

d. Notification may be either written or oral and shall be given by the Licensor as soon as practicable. The failure of the Licensor to give the Licensee notice in any case shall not subject the Licensor to any liability whatsoever.

4. Administrative Fee. Upon submission of this license to the Licensor, the Licensee agrees to pay the Licensor an administrative fee in the amount of $250.00. Of this amount, $200.00 is non-refundable and shall be retained by the Licensor as compensation for costs incurred in processing and administering this license. The remaining $50.00 shall be paid to the USBR as compensation for their costs incurred pursuant to paragraph 9. In the event this license is not forwarded to the USBR for approval, the $50.00 shall be refunded to the Licensee.

5. Assignments and Sublicenses.

a. The Licensee may not, without the prior written consent of the Licensor and the USBR, assign or otherwise transfer any right created by this license. The Licensee shall not authorize or permit others to utilize any facilities or structures or right-of-way area which are the subject matter of this license in any way not expressly authorized by this license or by the Licensor and the USBR in writing.

b. Any violation of this paragraph shall, at the option of the Licensor and the USBR, constitute grounds for immediate termination of the license without further notice. Upon an election to terminate, any facilities constructed by the Licensee shall be removed in the manner provided in paragraph 11 of this license.

c. Nothing in this paragraph prohibits the Licensee from utilizing the services of a person or entity not a party to this License for the purpose of constructing the encroachment herein contemplated.

6. Licensee's Liability. The Licensee shall be liable for all damages to the property of the United States, the Licensor, or any third party or parties caused by reason of the exercise of the Licensee of any right conferred by this license.

7. Hold Harmless Agreement. To the maximum extent permitted by law, the Licensee agrees to hold forever harmless, indemnify and defend the Licensor and the United States Government, together with all of their respective officers, employees, successors and assigns from any and all claims related to or any way connected with the construction, operation or maintenance of the facilities described in this license. The Licensee's obligation hereunder includes, but is not limited to, the obligation to pay the Licensor attorney fees and costs incurred in connection with any claim without regard to whether such claim results in litigation.

8. Duration of License. This license shall continue in effect so long as the Licensor and the USBR determine, in their sole discretion, that the same is expedient and is not detrimental or incompatible with the proper care, operation and maintenance of the Valley Division and its works.

9. Additional Approval.

a. This license and consent to encroachment are subject to the approval of:

Area Manager, Yuma Area Office
United States Bureau of Reclamation
P.O. Box D
Yuma, AZ 85366

and the Licensee shall take no action nor commence any activities hereunder until such consent is approved as provided in this paragraph.

b. A copy of this license with all attachments shall be mailed by the Licensor to the Area Manager at the above address on the next working day after the date it is fully executed by the Licensee and the Licensor. The license shall be deemed approved by the Area Manager unless the same is disapproved in writing (with a copy to the Licensor) within twenty (20) working days after the date it is fully executed.

10. Notification of Commencement of Work. The Licensee agrees to provide the Licensor with two (2) working days notification prior to the actual encroachment and commencement of work. Failure to provide said notification can be sufficient cause to terminate this license and require the removal of facilities in the manner provided in paragraph 11 of this license.

11. Termination.

a. This license and consent to encroach are subject to termination by the Licensor or the United States on thirty (30) days notice all as provided in Public Notice No. 77. The Licensor agrees, however, that, except in the case of emergencies or in cases where the Licensor is requested or directed by the United States to exercise the aforesaid termination provision, this license shall not be terminated on less than six (6) months prior written notice to the Licensee.

b. In the event this license is terminated, the Licensee agrees to remove all encroachments constructed hereunder within one hundred eighty (180) days after the date of the notice of termination and agrees to return the rights-of-way affected by this license to their original condition (or in a condition acceptable to the Licensor and the USBR) at its sole expense and at no expense to the Licensor or the United States.

c. If the Licensee fails to remove its encroaching facilities as provided above, the Licensor may, without liability for damages to the Licensee, remove such facilities without further notice. The Licensee agrees to pay the Licensor the reasonable cost of the removal of its facilities and the cost of restoring the rights-of-way to their original condition. Payment shall be made by the Licensee to the Licensor within thirty (30) days after the receipt of a statement of costs from the Licensor.

12. Consent to Encroachment: Extent of Consent.

a. The Licensor, for itself and on behalf of the United States, consents to the Licensee's encroachment upon Federal rights-of-way as described in this license and its attachments.

b. Nothing in this license constitutes a grant or other disposition of any land or interest in land which is owned or otherwise occupied by the United States. The Licensee shall not authorize or permit encroachment of any kind by persons not partied to this license or permit the planting of trees upon the encroachment area or otherwise utilize the encroachment area in any manner which may, in the opinion of the Licensor or the USBR, endanger or interfere with the

proper use and operation of any works or property of the United States or the Licensor.

c. Any violation of this paragraph shall constitute grounds for immediate termination of this license without further notice. Upon such termination, all encroaching facilities constructed hereunder shall be removed in the manner provided in paragraph 11 of this license.

13. Plans and Specifications: Construction. All structures constructed under this license shall be erected in accordance with plans and specifications approved in advance by the Licensor and the USBR as herein provided and shall be erected in such a manner as not to obstruct in any manner the flow of water in the canals, laterals or drain ditches of the United States or the Licensor or to interfere in any manner whatsoever with the construction, operation and maintenance of any part of the project by the Licensor or the United States.

14. Specifications and Conditions.

a. The encroachment and the erection of structures of facilities under the terms of this license shall be in accordance with the plans, specifications and conditions described below:

(1) ATTACHED PLANS PREPARED BY THE ARIZONA DEPARTMENT OF TRANSPORTATION ENTITLED "STATE HIGHWAY SAN LUIS TO COUNTY 19TH STREET (GADSDEN) PROJECT NO. STP-063-1(12), 095 YU 000 H4416 01C".

(2) THIS LICENSE WILL BE AMENDED TO INCLUDE FUTURE PLAN SHEETS RELATED TO THIS PROJECT THAT PERTAIN TO THE LOCATIONS LISTED ON PAGE 1 AND IN PARTICULAR TO THOSE RELATING TO THE MAIN DRAIN RIGHTS-OF-WAY (NEW BRIDGE AND STORM WATER DISCHARGE) WHEN THEY BECOME AVAILABLE AND ARE APPROVED BY THE LICENSOR.

(3) ALL PARTIES HEREBY ARE PUT ON NOTICE THAT THIS AGREEMENT IS SUBJECT TO CANCELLATION BY THE GOVERNOR PURSUANT TO A.R.S. SUBJECT 38-511, THE PROVISIONS OF WHICH ARE INCORPORATED HEREIN BY REFERENCE ONLY.

(4) CONSTRUCTION OF THE ENCROACHMENT DESCRIBED IN THIS AGREEMENT IS SUBJECT TO THE BUDGETARY LIMITATIONS SET FORTH IN ARIZONA REVISED STATUTES 28-1823 THROUGH 28-1826, INCLUSIVE, AND IS FURTHER SUBJECT TO THE PROVISIONS OF CHAPTER 1 OF TITLE 35, ARIZONA REVISED STATUTES.

(5) THE PROVISIONS OF PARAGRAPHS 14.a.(3) AND 14.a.(4) ABOVE SHALL NOT CONSTITUTE A DEFENSE TO A TERMINATION OF THE LICENSEE'S RIGHTS UNDER THE LICENSE BY THE UNITED

STATES UNDER ARTICLE 11 OF THIS LICENSE WHERE THE LICENSEE DOES NOT PAY ANY SUMS, PERFORM ANY ACTIONS, FORBEAR FROM TAKING ANY ACTIONS, OR DO ANYTHING ELSE, REQUIRED OF IT BY THIS AGREEMENT AS A RESULT OF THESE PARAGRAPHS; AND PROVIDED FURTHER, THAT THE PROVISIONS OF THESE PARAGRAPHS SHALL NOT RELIEVE THE LICENSEE FROM ANY DAMAGES OR OTHER RELIEF THE UNITED STATES WOULD OTHERWISE BE ENTITLED TO UNDER THIS LICENSE BUT FOR THESE PARAGRAPHS.

(6) THIS ENCROACHMENT IS ALSO CONTINGENT UPON ACQUIRING A NEW 20 FOOT CLEAR EASEMENT IN THE NAME OF THE UNITED STATES, WITH THE ASSISTANCE OF ADOT, FOR THE PIPELINING OF THE INGRAHAM LATERAL IN THE W1/2 SW1/4 OF SECTION 24, T.10S., R.25W. AND THE PARVIN LATERAL IN THE W1/2 NW1/4 OF SECTION 25, T.10S., R.25W.

(7) THIS ENCROACHMENT PERMIT IS IN CONJUNCTION WITH THE UTILITY AGREEMENT NO. 1899-98-YCWUA BETWEEN THE STATE OF ARIZONA AND THE YUMA COUNTY WATER USERS' ASSOCIATION DATED 4/23/98.

(8) OPERATION AND MAINTENANCE TO MAINTAIN IRRIGATION FLOWS WILL BE PERFORMED BY THE LICENSOR. THE LICENSEE WILL BE RESPONSIBLE FOR ANY FUTURE REPAIRS OR RECONSTRUCTION OF THE LICENSOR'S FACILITIES WITHIN THE LICENSEE'S RIGHTS-OF-WAY.

All of the foregoing plans, specifications and conditions are made a part of this license and are subject to the prior approval of the Licensor.

b. Any proposed variation in construction or operation of encroaching facilities from approved plans and specifications must be approved in writing by the Licensor and the USBR before construction or operation.

15. Increased Operation and Maintenance Expense.

a. If the construction and placement of facilities by the Licensee under the terms of this license increases the costs to the Licensor, or its successors, of operation and maintenance functions on the right-of-way herein described, it is agreed that the amount of any such increase shall be paid by the Licensee.

b. Payments under the terms of this paragraph shall be made monthly, or at such other time or times as the Licensor may elect, and shall be made on the basis of statements furnished by the Licensor to the Licensee describing with reasonable particularity the nature and extent of all charges claimed.

c. The amount of any increased operation and maintenance charges payable by the Licensee under this paragraph shall be determined by the Licensor. Any dispute between the Licensor and the Licensee as to the appropriateness or amount of any increased operations and maintenance charge claimed by the Licensor shall be resolved by the Area Manager, Yuma Area Office, USBR. The determination of the Area Manager shall be conclusive upon both parties, unless either party determines to bring a cause of action to resolve the dispute.

16. Attorney Fees. If either party commences a legal action to enforce any term or condition of this license, it is understood and agreed that the prevailing party in any such litigation shall be entitled to recover a reasonable sum as and for attorney fees, said sum to be fixed by the Court. The provisions of this paragraph are supplemental to the provisions of paragraph 7.

17. Covenant Against Contingent Fees.

a. The Licensee warrants that no person or agency has been employed or retained to solicit or secure this license upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial agencies maintained by the Licensee for the purpose of securing business.

b. Any breach of the provisions of this paragraph shall, at the option of the Licensor or the USBR, constitute grounds to terminate this license without further notice and without liability for damages of any type.

c. In the event of a termination under the provisions of this paragraph, the Licensee agrees to remove all encroaching facilities in the manner provided in paragraph 11 of this license.

Dated: 8/24/98

Licensee:
By William J. Higgins
Its ACTING DEPUTY STATE ENGINEER
Representing:
ARIZONA DEPT. OF TRANSPORTATION
206 S. 17TH AVE
PHX, AZ 85007 MD ROW 102A
(Address)
(Licensee sign 3 copies)

Approved:

Dated: 8/31/98

By
Manager, YUMA COUNTY WATER USERS' ASSOCIATION

Copy to: Area Manager
Yuma Area Office
United States Bureau of Reclamation
P.O. Box D
Yuma, AZ 85366

PLACED ON MAPS 9/10/03 RCH

LICENSE NO. **017-03-002**

YUMA COUNTY WATER USERS' ASSOCIATION
P.O. BOX 5775
YUMA, AZ 85366-5775

LICENSE FOR ENCROACHMENTS AND CONSTRUCTION, INSTALLATION, OPERATION AND MAINTENANCE OF FACILITIES

LICENSEE: **CITY OF SAN LUIS**

SERIAL NO(S): **1947, 1114, 1114-1** DIVISION: **N/A**

LOCATION: **THE NOE LATERAL RIGHT-OF-WAY IN THE NW1/4, NE1/4 SECTION 6, T.11S., R.24W, G&SRB&M, ADJACENT TO THE EAST MAIN CANAL RIGHT-OF-WAY, THE MAIN DRAIN RIGHT-OF-WAY IN THE SW1/4, SECTION 31, T.10S., R.24W., G&SRB&M, THE HENRY LATERAL RIGHT-OF-WAY IN THE SW1/4, SW1/4, SW1/4, SECTION 31, T10S., R. 24W., G&SRB&M.**

1. Authority. Pursuant to the provisions of United States Department of the Interior, Bureau of Reclamation, Public Notice No. 77 dated February 12, 1960, entitled "Public Notice Announcing Procedures for Processing Water Right Applications and Certain Other Contracts," and more specifically its Paragraph 4. Utilization of Project Rights of Way and Lands of the United States, the Yuma County Water Users' Association (Licensor) licenses the above named Licensee to construct, install, operate and maintain facilities encroaching upon rights-of-way of the United States forming a part of the Valley Division of the Yuma Project, a reclamation project constructed under the laws of the United States.

2. Description of Encroachment. The encroachment shall be constructed and operated only under the terms and conditions of this license and is specifically described as follows:

   a. **ENCROACHMENT FOR ROADWAY PURPOSES TO PROVIDE A SECONDARY ACCESS ROAD TO SAN LUIS HIGH SCHOOL.**

3. Nature of Right Conferred: Rights of Licensor.
   a. The encroachment and consent to construct contained in this license relate only to

the rights of the Licensor by virtue of its contractual relationship with the United States Department of Interior, Bureau of Reclamation (USBR) for the maintenance and operation of Federal facilities constituting the Valley Division of the Yuma Project. The lands to which this license pertains are not owned by the Licensor. Nothing in this license constitutes a representation by the Licensor of any authority to grant a right-of-way across any property owned or controlled by any person other than the Licensor.

b. Any right granted to the Licensee hereunder shall be inferior to the right of the Licensor to operate and maintain project irrigation facilities and to reconstruct, repair or improve any works within said rights-of-way without the consent of the Licensee and without liability for damages caused by any non-negligent act of the Licensor to any facilities or property owned or controlled by the Licensee.

c. Except in the case of emergencies, and when deemed appropriate by the Licensor, the Licensor will provide the Licensee with notice of its intent to construct, repair or improve any works within the portion of the right-of-way wherein the Licensee is encroaching. Notwithstanding the foregoing sentence, the Licensor shall give the Licensee prior notice of its intention to perform any work which will require the closing of a public thoroughfare under the Licensee's jurisdiction, or the interruption of utility services operated or controlled by the Licensee.

d. Notification may be either written or oral and shall be given by the Licensor as soon as practicable. The failure of the Licensor to give the Licensee notice in any case shall not subject the Licensor to any liability whatsoever.

4. Administrative Fee. Upon submission of this license to the Licensor, the Licensee agrees to pay the Licensor an administrative fee in the amount of $250.00. The entire administrative fee is non-refundable and shall be retained by the Licensor as compensation for costs incurred in processing and administering this license. If this license is approved by the Licensor, $50.00 of the fee shall be paid to the USBR as compensation for their costs incurred pursuant to paragraph 9.

5. Assignments and Sublicenses.

a. The Licensee may not, without the prior written consent of the Licensor and the USBR, assign or otherwise transfer any right created by this license. The Licensee shall not authorize or permit others to utilize any facilities or structures or right-of-way area which are the subject matter of this license in any way not expressly authorized by this license or by the Licensor and the USBR in writing.

b. Any violation of this paragraph shall, at the option of the Licensor and the USBR, constitute grounds for immediate termination of the license without further notice. Upon an

election to terminate, any facilities constructed by the Licensee shall be removed in the manner provided in paragraph 11 of this license.

c. Nothing in this paragraph prohibits the Licensee from utilizing the services of a person or entity not a party to this License for the purpose of constructing the encroachment herein contemplated.

6. Licensee's Liability. The Licensee shall be liable for all damages to the property of the United States, the Licensor, or any third party or parties caused by reason of the exercise of the Licensee of any right conferred by this license.

7. Hold Harmless Agreement. To the maximum extent permitted by law, the Licensee agrees to hold forever harmless, indemnify and defend the Licensor and the United States Government, together with all of their respective officers, employees, successors and assigns from any and all claims related to or any way connected with the construction, operation or maintenance of the facilities described in this license. The Licensee's obligation hereunder includes, but is not limited to, the obligation to pay the Licensor attorney fees and costs incurred in connection with any claim without regard to whether such claim results in litigation.

8. Duration of License. This license shall continue in effect so long as the Licensor and the USBR determine, in their sole discretion, that the same is expedient and is not detrimental or incompatible with the proper care, operation and maintenance of the Valley Division and its works.

9. Additional Notification.

a. This license and consent to encroachment, in accordance with the requirements stated in the paragraph 1 authority, shall be furnished by the Licensor for record keeping purposes to the:

Area Manager, Yuma Area Office
United States Bureau of Reclamation
7301 Calle Aqua Salada
Yuma, AZ 85366

b. A copy of this license with all attachments shall be mailed by the Licensor to the Area Manager at the above address on the next working day after the date it is fully executed by the Licensee and the Licensor.

c. This license and consent to encroachment are made with the understanding that such issuance does not involve a substantial adverse change in any of the works transferred to the Licensor under the provisions of the Contract for the Care, Operation and Maintenance of Works of the Valley Division, Yuma Project, No. 176r-671, dated June 15, 1951, between the United States of America and the Licensor. Should the Licensor determine that this license and consent

to encroachment could potentially involve a substantial adverse change in the works transferred, a statement to that effect shall be made in Paragraph 14. Specifications and Conditions. Subparagraph a. requiring that the license not be considered issued without receiving the advance additional written approval of the Area Manager, with such approval deemed approved by the Area Manager unless the same is disapproved in writing to the Licensor (with a copy to the Licensee) within 45 calendar days after the date it is fully executed by the Licensor. This required Area Managers' approval will also be noted in the forwarding letter to the USBR.

d. In the event of an inadvertent discovery of archaeological or historical cultural resources, the Licensee shall cease all activity in the area of the discovery with respect to Federal lands and Federal facilities, provide immediate telephone notifications of such discovery both to the Licensor by directly contacting the Yuma County Water Users' Association Manager at 520-627-8824 and to the United States Bureau of Reclamation Archeologist at 520-343-8567, and also make all reasonable efforts to protect the cultural resources discovered. The activity may resume only after the USBR has authorized a continuance.

10. Notification of Commencement of Work. The Licensee agrees to provide the Licensor with two (2) working days' notification prior to the actual encroachment and commencement of work. Failure to provide said notification can be sufficient cause to terminate this license and require the removal of facilities in the manner provided in paragraph 11 of this license.

11. Termination.

a. This license and consent to encroach is subject to termination by the Licensor or the United States on thirty (30) days notice all as provided in Public Notice No. 77. The Licensor agrees, however, that, except in the case of emergencies or in cases where the Licensor is requested or directed by the United States to exercise the aforesaid termination provision, this license shall not be terminated on less than six (6) months' prior written notice to the Licensee.

b. In the event this license is terminated, the Licensee agrees to remove all encroachments constructed hereunder within one hundred eighty (180) days after the date of the notice of termination and agrees to return the rights-of-way affected by this license to their original condition (or in a condition acceptable to the Licensor and the USBR) at its sole expense and at no expense to the Licensor or the United States.

c. If the Licensee fails to remove its encroaching facilities as provided above, the Licensor may, without liability for damages to the Licensee, remove such facilities without further notice. The Licensee agrees to pay the Licensor the reasonable cost of the removal of its facilities and the cost of restoring the rights-of-way to their original condition. Payment shall be made by the Licensee to the Licensor within thirty (30) days after the receipt of a statement of costs from the Licensor.

12. Consent to Encroachment: Extent of Consent.

a. The Licensor, for itself and on behalf of the United States, consents to the Licensee's encroachment upon Federal rights-of-way as described in this license and its attachments.

b. Nothing in this license constitutes a grant or other disposition of any land or interest in land which is owned or otherwise occupied by the United States. The Licensee shall not authorize or permit encroachment of any kind by persons not partied to this license or permit the planting of trees upon the encroachment area or otherwise utilize the encroachment area in any manner which may, in the opinion of the Licensor or the USBR, endanger or interfere with the proper use and operation of any works or property of the United States or the Licensor.

c. Any violation of this paragraph shall constitute grounds for immediate termination of this license without further notice. Upon such termination, all encroaching facilities constructed hereunder shall be removed in the manner provided in paragraph 11 of this license.

13. Plans and Specifications: Construction. All structures constructed under this license shall be erected in accordance with plans and specifications approved in advance by the Licensor as herein provided and shall be erected in such a manner as not to obstruct in any manner the flow of water in the canals, laterals or drain ditches of the United States or the Licensor or to interfere in any manner whatsoever with the construction, operation and maintenance of any part of the project by the Licensor or the United States.

14. Specifications and Conditions.

a. The encroachment and the erection of structures of facilities under the terms of this license shall be in accordance with the plans, specifications and conditions described below:

1) **SHEETS 1 THRU 6 OF PLANS PREPARED BY NICKLAUS ENGINEERING, INC., DATED MAY 2003, ENTITLED "SAN LUIS HIGH SCHOOL SECONDARY ACCESS ROAD".**

2) **HENRY LATERAL CROSSING TO BE SHOWN ON PLANS FOR NEXT PHASE OF ROADWAY WITH SAME ALIGNMENT.**

All of the foregoing plans, specifications and conditions are made a part of this license and are subject to the prior approval of the Licensor.

b. Any proposed variation in construction or operation of encroaching facilities from approved plans and specifications must be approved in writing by the Licensor before

construction or operation. If any proposed variation is, in the opinion of the Licensor substantial in nature, notification of such approval and any appropriate revised plans will be provided to the USBR.

c. The Licensee shall, within 15 calendar days of completion of the encroachment(s), submit two (2) copies of as-built drawings to the Licensor. The Licensor shall provide one (1) copy of these submitted as-built drawings to the USBR. The Licensee shall also provide one (1) additional copy of the as-built drawings to any other party or entity associated with this encroachment or as requested by the Licensor. Should there be no changes in the actual work from the planned work and encroachment, these as-built drawings will still be required. In this case the original drawings may be submitted with the notation that the encroachment was accomplished exactly as originally submitted.

15. Increased Operation and Maintenance Expense.

a. If the construction and placement of facilities by the Licensee under the terms of this license increase the costs to the Licensor, or its successors, of operation and maintenance functions on the right-of-way herein described, it is agreed that the amount of any such increase shall be paid by the Licensee.

b. Payments under the terms of this paragraph shall be made monthly, or at such other time or times as the Licensor may elect, and shall be made on the basis of statements furnished by the Licensor to the Licensee describing with reasonable particularity the nature and extent of all charges claimed.

c. The amount of any increased operation and maintenance charges payable by the Licensee under this paragraph shall be determined by the Licensor. Any dispute between the Licensor and the Licensee as to the appropriateness or amount of any increased operations and maintenance charge claimed by the Licensor shall be resolved by the Area Manager, Yuma Area Office, USBR. The determination of the Area Manager shall be conclusive upon both parties, unless either party determines to bring a cause of action to resolve the dispute.

16. Attorney Fees. If either party commences a legal action to enforce any term or condition of this license, it is understood and agreed that the prevailing party in any such litigation shall be entitled to recover a reasonable sum as and for attorney fees, said sum to be fixed by the Court. The provisions of this paragraph are supplemental to the provisions of paragraph 7.

17. Covenant Against Contingent Fees.

a. The Licensee warrants that no person or agency has been employed or retained to solicit or secure this license upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial agencies maintained by the Licensee for the purpose of securing business.

b. Any breach of the provisions of this paragraph shall, at the option of the Licensor, constitute grounds to terminate this license without further notice and without liability for damages of any type.

c. In the event of a termination under the provisions of this paragraph, the Licensee agrees to remove all encroaching facilities in the manner provided in paragraph 11 of this license.

Licensee:

By Alex U. Ruiz
Its City Administrator/Clerk
Representing:
The City of San Luis, Arizona
P.O. Box 1170
767 N. First Avenue, San Luis, AZ 85349
(Address)
(928) 627-2027
(Phone Number)
(Licensee sign 3 copies and return to Licensor)

Approved:

By _____
Manager, YUMA COUNTY WATER USERS' ASSOCIATION

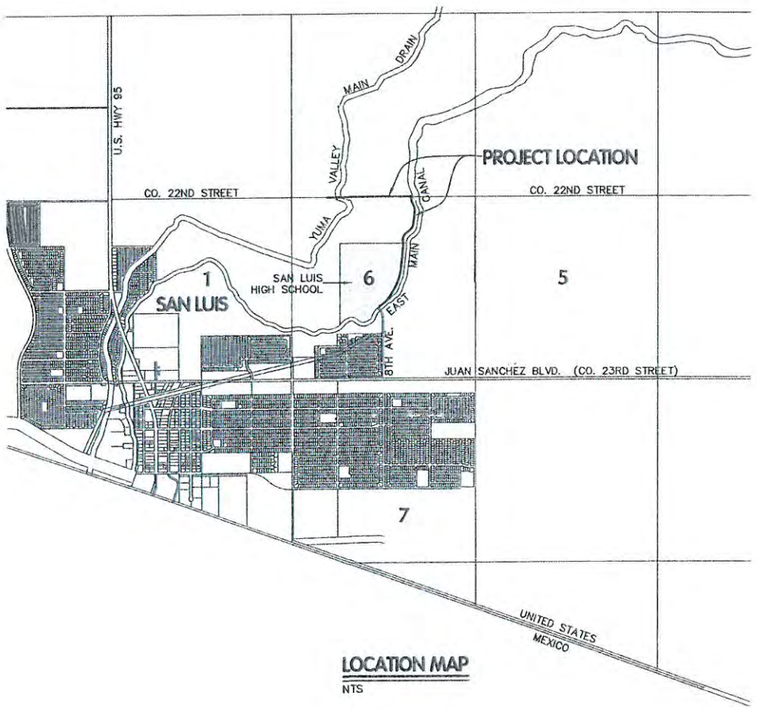
Approval Date 8/11/03

Copy to: Area Manager, Yuma Area Office
United States Bureau of Reclamation
7301 Calle Aqua Salada
Yuma, AZ 85364

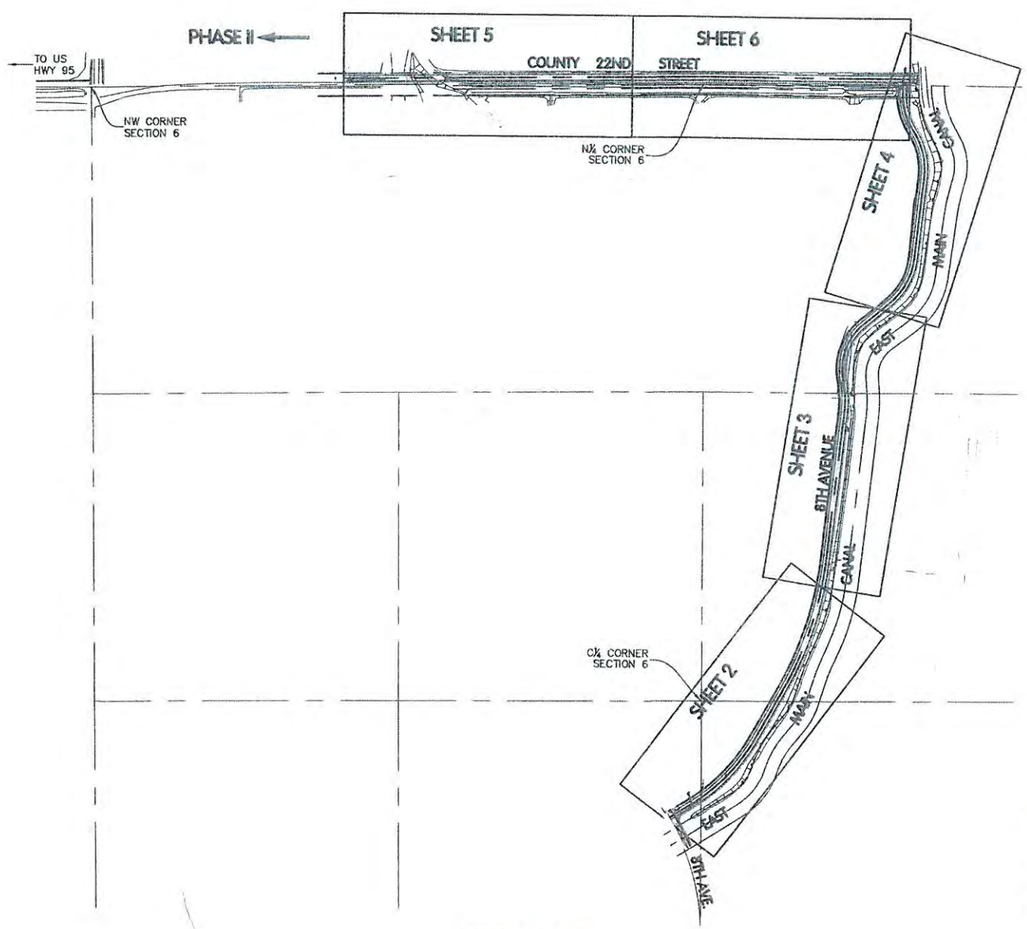
APPROVED AS TO FORM:

Gerald W. Hunt
City Attorney

SAN LUIS HIGH SCHOOL
SECONDARY ACCESS ROAD



LOCATION MAP
NTS



SHEET INDEX MAP
SCALE: 1"=300'

LEGEND (ALL SHEETS)

	NEW CENTER LINE
	NEW RIGHT OF WAY LINE
	EXISTING CANAL RIGHT OF WAY LINE
	EXISTING EDGE OF ROAD
	EXISTING CHAINLINK FENCE
	EXISTING STRIPING
	EXISTING ASPHALT PAVEMENT
	NEW ASPHALT PAVING
	EXISTING CONCRETE
	EXISTING DIRT
	EXISTING SLOPE
D	EXISTING SIGN
WV	EXISTING WATER VALVE
	EXISTING TEST WELL
92.89 C	EXISTING CURB ELEVATION
92.89 G	EXISTING GUTTER ELEVATION
92.89 A	EXISTING ASPHALT ELEVATION
92.89 GRND	EXISTING GROUND ELEVATION
92.89 EP	EXISTING EDGE OF PAVEMENT ELEVATION
92.89 EABC	EXISTING EDGE OF ABC ELEVATION
92.89 EOD	EXISTING EDGE OF DITCH ELEVATION
92.89 ED	EXISTING EDGE OF DRAIN ELEVATION
92.89 EC	EXISTING EDGE OF CANAL ELEVATION
92.89 RE	EXISTING ROAD EDGE ELEVATION
92.89 FE	EXISTING FIELD EDGE ELEVATION
92.89 HW	EXISTING HEADWALL ELEVATION
92.89 FL	EXISTING FLOWLINE ELEVATION
92.89 TOP	EXISTING TOP OF SLOPE ELEVATION
92.89 TOE	EXISTING BOTTOM OF SLOPE ELEVATION
92.89 A	NEW ASPHALT ELEVATION

SHEET INDEX

SHEET 1	COVER SHEET
SHEET 2	8TH AVENUE ALIGNMENT STA. 10+00 TO 22+40
SHEET 3	8TH AVENUE ALIGNMENT STA. 22+40 TO 35+00
SHEET 4	8TH AVENUE ALIGNMENT STA. 35+00 TO 45+77.60
SHEET 5	22ND STREET ALIGNMENT STA. 76+00 TO 88+00
SHEET 6	22ND STREET ALIGNMENT STA. 88+00 TO 99+75
SHEET 7	DETAIL SHEET

APPROVALS:

APPROVED BY:

Mayor _____ Date _____

ATTEST:

CITY Manager _____ Date _____

Y.U.H.S.D. _____ Date _____

License #017-03-002
City of San Luis

PREPARED BY:

Nicklaus Engineering Inc.
1851 West 24th Street P.O. Box 6079
YUMA, ARIZONA 85364 (928)344-8374
Email: nei@neiaw.com

SCHEDULE OF WORK

1. 2½" AC PAVEMENT COMPACTED TO MINIMUM 95% (ASTM D1559) OVER 6" EXISTING ABC –SEE DETAIL A/7
2. NEW 8'X6" ABC SHOULDER COMPACTED TO MINIMUM 95% (ASTM D698) –SEE DETAIL A/7
3. ADJUST WATER VALVE TO FINISHED ASPHALT ELEVATION
4. MATCH EXISTING CURB AND GUTTER AND ASPALT ELEVATION
5. SAW-CUT EXISTING PAVEMENT –SEE DETAIL E/7
6. NEW STOP SIGN –SEE DETAIL D/7
7. NEW YUMA COUNTY STREET MONUMENT –SEE DETAIL F/7

CURVE TABLE				
CURVE	LENGTH	RADIUS	DELTA	TANGENT
C1	396.60	812.00	27°59'04"	202.34
C2	616.16	1512.00	23°20'56"	312.42
C3	147.77	481.19	17°35'45"	74.47
C4	271.39	250.00	62°11'55"	150.81
C5	233.07	300.00	44°30'48"	122.77
C6	207.91	300.00	39°42'26"	108.32
C7	174.80	300.00	33°23'05"	89.96
C8	159.88	232.90	39°20'00"	83.24
C9	178.65	465.30	22°00'00"	90.45
C10	89.43	232.90	22°00'00"	45.27
C11	62.18	628.70	5°40'00"	31.12
C12	277.63	900.40	17°40'00"	139.93
C13	102.60	518.70	11°20'00"	51.47
C14	249.08	248.20	57°30'00"	136.17
C15	182.24	232.90	44°50'00"	96.07
C16	98.78	771.80	7°20'00"	49.46
C17	106.13	138.20	44°00'00"	55.84
C18	211.15	465.30	26°00'00"	107.42

LINE TABLE		
LINE	LENGTH	BEARING
L1	334.90	N57°31'29"E
L2	14.00	N18°11'29"E
L3	69.10	N40°11'29"E
L4	112.20	N18°11'29"E
L5	90.40	N23°51'29"E
L6	713.00	N06°11'29"E
L7	48.80	N05°08'31"W
L8	139.40	N52°21'29"E
L9	279.80	N07°31'29"E
L10	62.70	N14°51'29"E
L11	55.90	N29°08'31"W
L12	32.56	N24°46'17"W

SAN LUIS H.S. SECONDARY ACCESS ROAD

8TH AVENUE PLAN AND PROFILE STA-10+00 TO 22+40

Nicklaus Engineering Inc.
1851 West 24th Street P.O. Box 6029
YUMA, ARIZONA, 85364 (928)344-8374
Email: nel@nelaw.com

SCALE:	AS SHOWN
DATE:	MAY, 2003
DES. BY:	M.A.C.
DRAWN BY:	J.F.T.
SURVEYED BY:	M.A.C.
JOB. No.	03-036
FILE No.	I-8-25

SHEET 2 OF 7

N¼ CORNER SECTION 6 T.11S, R.24W, G.&S.R.M. FOUND USDOI BRASS CAP N=10036.97 E=12647.35

C¼ CORNER SECTION 6 T.11S, R24W G.&S.R.B.M. N=7366.48 E=12667.03

S00°25'19"E 476.70'

N89°27'27"E 393.82'

SCALE HORIZ: 1"=40' VERT: 1"=2'

BEGIN PROJECT STA.-10+00 EAST MAIN CANAL ALIGNMENT N=6857.45 E=12529.14

SAN LUIS HIGH SCHOOL

EXISTING CONCRETE VALLEY GUTTER

N57°33'12"E 118.94'

CONSTRUCTION CENTERLINE

PT = 15+15.54

PC = 17+48.38

FUTURE 25' ROAD R/W

8TH AVENUE 16+00 N29°34'08"E 232.84'

MATCH LINE STA 22+40 SEE SHEET 3

CANAL

EAST MAIN

FOUND 2" IP IN HH S¼ COR. SECTION 6 N=4728.978 E=12686.443

W¼ CORNER SECTION 6 T.11S, R.24W, G.&S.R.B.M.

10+00 11+00 12+00 13+00 14+00 15+00 16+00 17+00 18+00 19+00 20+00 21+00 22+00 22+40

98.0 96.0 94.0 92.0 90.0 88.0 86.0 84.0 82.0

EXISTING PAVEMENT

STA 10+60± MATCH EX. AC ELEV. 94.0±

STA = 11+18.94 ELEV = 92.90

BVC 11+58 ELEV.= 91.68

PIVC STA = 12+18
PIVC ELEV = 89.60
E=0.47'
120.00' VC

PI STA 12+18 A=90.27

EVC 12+78 ELEV.= 89.80

-1.67%

-3.13%

NEW AC PAVEMENT ℄ ELEVATION=89.80

0.00%

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SAN LUIS H.S. SECONDARY ACCESS ROAD

8TH AVENUE PLAN AND PROFILE STA-22+40 TO 35+00

Nicklaus Engineering Inc.
1851 West 24th Street P.O. Box 6029
YUMA, ARIZONA 85364 (928)344-8374
Email: nei@neiaw.com

SCALE:	AS SHOWN
DATE:	MAY, 2003
DES. BY:	M.A.C.
DRAWN BY:	I.F.T.
SURVEYED BY:	M.A.C.
JOB. No.:	03-059
FILE No.:	I-B-25
SHEET	3
OF	7

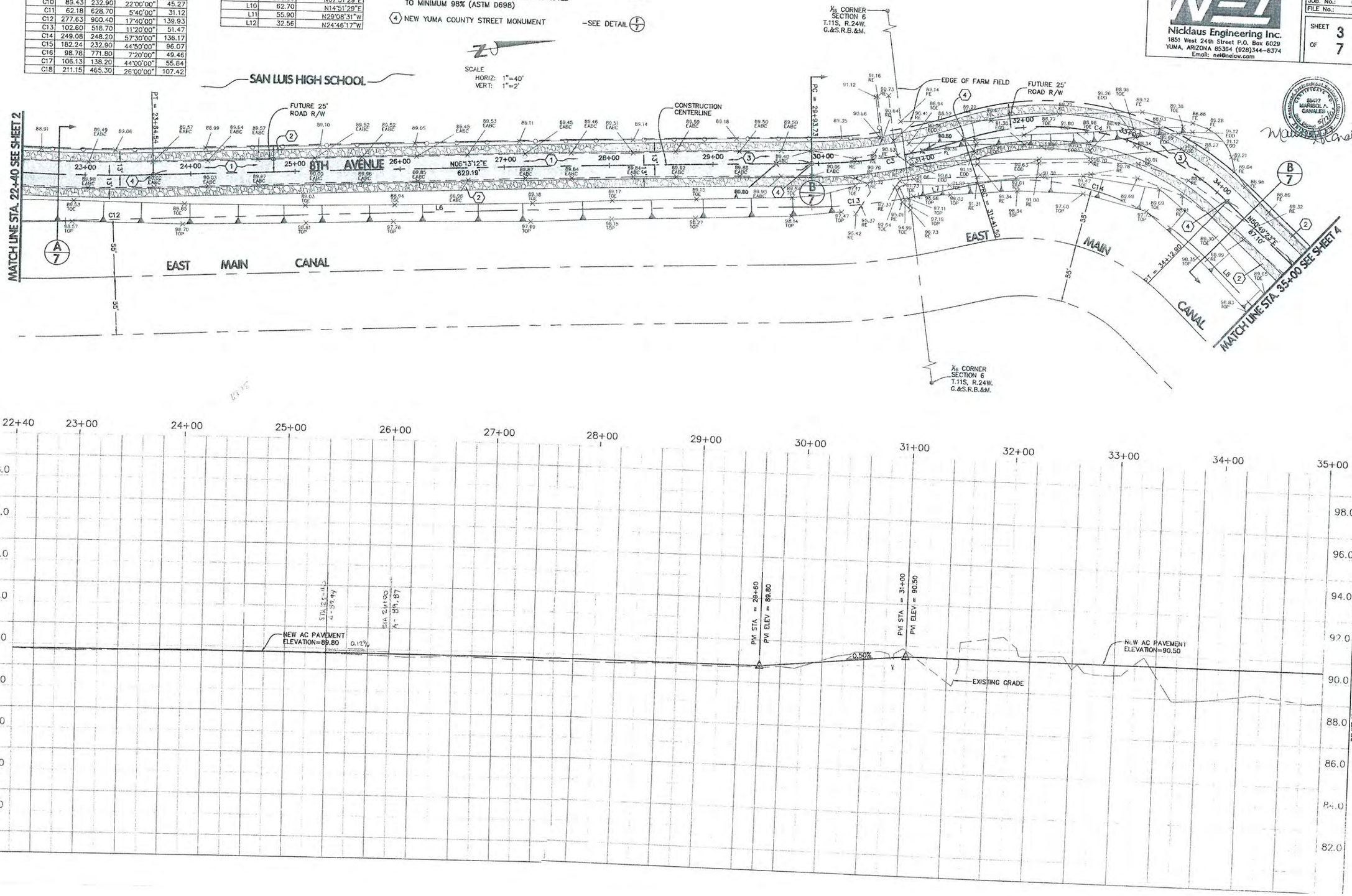
CURVE TABLE				
CURVE	LENGTH	RADIUS	DELTA	TANGENT
C1	396.60	812.00	27°59'04"	202.34
C2	616.16	1512.00	23°20'56"	312.42
C3	147.77	481.19	17°35'45"	74.47
C4	271.39	250.00	62°11'55"	150.81
C5	233.07	300.00	44°30'48"	122.77
C6	207.91	300.00	39°42'26"	108.32
C7	174.80	300.00	33°23'05"	89.96
C8	159.88	232.90	39°20'00"	83.24
C9	178.66	465.30	22°00'00"	90.45
C10	89.43	232.90	22°00'00"	45.27
C11	62.18	628.70	5°40'00"	31.12
C12	277.63	900.40	17°40'00"	139.93
C13	102.60	518.70	11°20'00"	51.47
C14	249.08	248.20	57°30'00"	136.17
C15	182.24	232.90	44°50'00"	96.07
C16	98.76	771.80	7°20'00"	49.46
C17	106.13	138.20	44°00'00"	55.84
C18	211.15	465.30	26°00'00"	107.42

LINE TABLE		
LINE	LENGTH	BEARING
L1	334.90	N57°31'29"E
L2	14.00	N18°11'29"E
L3	69.10	N40°11'29"E
L4	112.20	N18°11'29"E
L5	90.40	N23°51'29"E
L6	713.00	N06°11'29"E
L7	48.80	N05°08'31"W
L8	139.40	N52°21'29"E
L9	279.80	N07°31'29"E
L10	62.70	N14°51'29"E
L11	55.90	N29°08'31"W
L12	32.56	N24°46'17"W

SCHEDULE OF WORK

1. 2½" AC PAVEMENT COMPACTED TO MINIMUM 95% (ASTM D1559) OVER 6" EXISTING ABC —SEE DETAIL A/7
2. NEW 8"X6" ABC SHOULDER COMPACTED TO 95% (ASTM D698) —SEE DETAIL B/7
3. 2½" AC PAVEMENT COMPACTED TO MINIMUM 95% (ASTM D1559) OVER 8" ABC COMPACTED TO MINIMUM 98% (ASTM D698) —SEE DETAIL B/7
4. NEW YUMA COUNTY STREET MONUMENT —SEE DETAIL F/7

SCALE
HORIZ: 1"=40'
VERT: 1"=2'



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SCHEDULE OF WORK

1. 2½" AC PAVEMENT COMPACTED TO MINIMUM 95% (ASTM D1559) OVER 8" EXISTING ABC COMPACTED TO MINIMUM 95% (ASTM D698) -SEE DETAIL B/7
2. NEW 8'X6" ABC SHOULDER COMPACTED TO 95% (ASTM D698) -SEE DETAIL B/7
3. INSTALL NEW VERTICAL REFLECTIVE MARKERS @ 20' O.C. (15 TOTAL)
4. 6" ABC TRANSITION TO EXISTING ROAD GRADE.

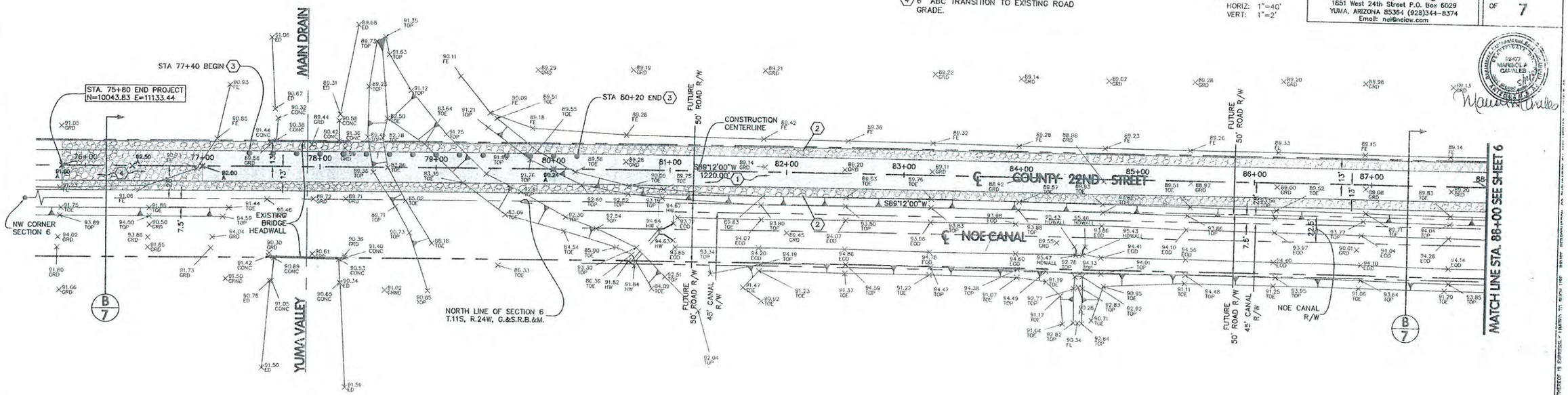
SCALE
HORIZ: 1"=40'
VERT: 1"=2'

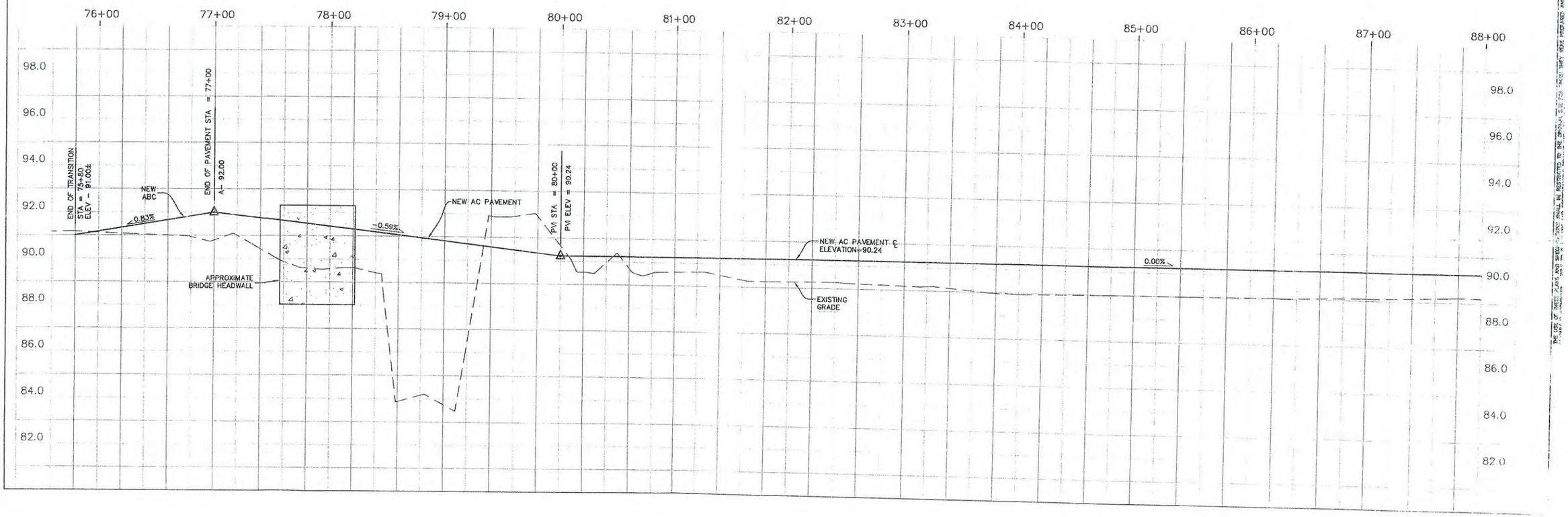
SAN LUIS H.S. SECONDARY ACCESS ROAD

COUNTY 22ND ST. PLAN AND PROFILE
STA- 76+00 TO 88+00

SCALE:	AS SHOWN
DATE:	MAY, 2003
DES. BY:	M.A.C.
DRAWN BY:	T.F.T.
SURVEYED BY:	M.A.C.
JOB. No.:	03-07
FILE No.:	I-B-23
SHEET	5
OF	7

Nicklaus Engineering Inc.
1651 West 24th Street P.O. Box 6029
YUMA, ARIZONA 85364 (928)344-8374
Email: nei@neiaz.com





CURVE TABLE				
CURVE	LENGTH	RADIUS	DELTA	TANGENT
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C9	178.66	465.30	22°00'00"	90.45
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C15	182.24	232.90	44°50'00"	96.07
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C17	106.13	138.20	44°00'00"	55.84
C18	211.15	465.30	26°00'00"	107.42

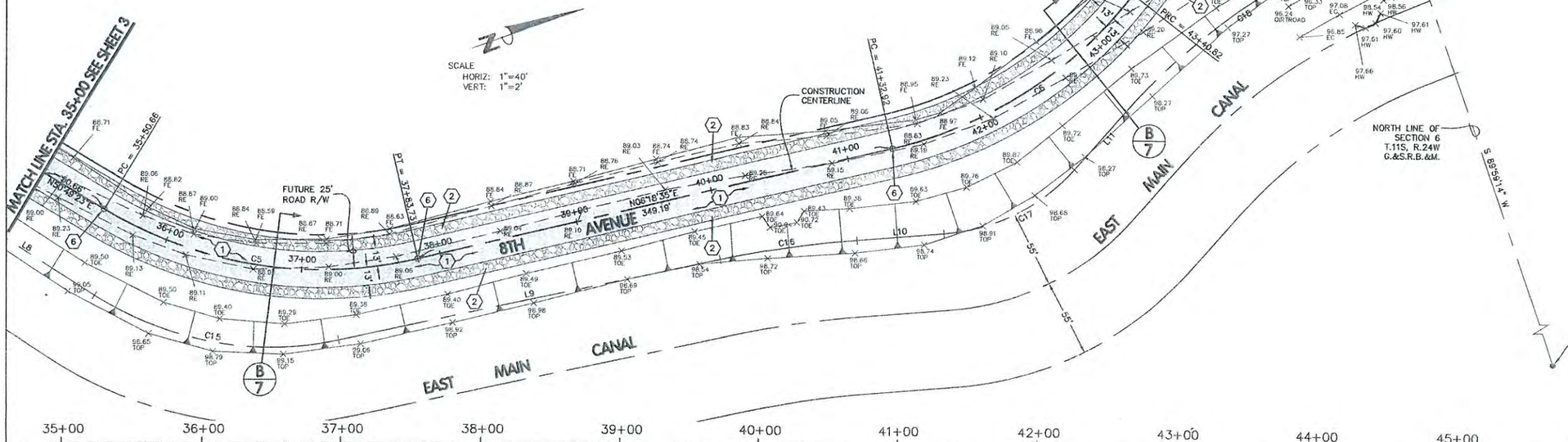
LINE TABLE		
LINE	LENGTH	BEARING
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L2	14.00	N18°11'29"E
L3	69.10	N40°11'29"E
L4	112.20	N18°11'29"E
L5	90.40	N23°51'29"E
L6	713.00	N06°11'29"E
L7	48.80	N05°08'31"W
L8	139.40	N52°21'29"E
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L10	62.70	N14°51'29"E
L11	55.90	N29°08'31"W
L12	32.56	N24°46'17"W

SCHEDULE OF WORK

1. 2½" AC PAVEMENT COMPACTED TO MINIMUM 95% (ASTM D1559) OVER 8" EXISTING ABC COMPACTED TO MINIMUM 95% (ASTM D698) –SEE DETAIL B/7
2. NEW 8'X6" ABC SHOULDER COMPACTED TO 95% (ASTM D698) –SEE DETAIL B/7
3. NEW DOUBLE FACED STREET/STOP SIGN –SEE DETAIL D/7
4. NEW BARRICADE –SEE DETAIL C/7
5. PROTECT EXISTING TEST WELLS
6. NEW YUMA COUNTY STREET MONUMENT –SEE DETAIL F/7

SEE SHEET 6 FOR CONTINUATION

EQUATION:
STA. 99+75 COUNTY 22ND STREET ALIGNMENT
=STA. 45+77.66 8TH AVENUE ALIGNMENT
N=10065.16 E=13508.29



SAN LUIS H.S. SECONDARY ACCESS ROAD

8TH AVENUE PLAN AND PROFILE STA-35+00 TO 45+77.66

Nicklaus Engineering Inc.
1851 West 24th Street P.O. Box 6029
YUMA, ARIZONA 85364 (928)344- 8374
Email: nei@neiaw.com

SCALE:	AS SHOWN
DATE:	MAY, 2005
DES. BY:	M.A.C.
DRAWN BY:	T.F.T.
SURVEYED BY:	M. V.F.
JOB. No.:	05-039
FILE:	I-E-25

SHEET 4 OF 7

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SCHEDULE OF WORK

1. 2½" AC PAVEMENT COMPACTED TO MINIMUM 95% (ASTM D1559) OVER 8" EXISTING ABC COMPACTED TO MINIMUM 95% (ASTM D698) – SEE DETAIL B/7
2. NEW 8'X6" ABC SHOULDER COMPACTED TO 95% (ASTM D698) – SEE DETAIL B/7
3. NEW DOUBLE FACED STREET/STOP SIGN – SEE DETAIL B/7
4. NEW BARRICADE – SEE DETAIL C/7
5. NEW YUMA COUNTY STREET MONUMENT – SEE DETAIL F/7
6. PROTECT EXISTING MONUMENT (REPLACE IF DESTROYED AT CONTRACTOR'S EXPENSE)

SCALE
HORIZ: 1"=40'
VERT: 1"=2'

SAN LUIS H.S. SECONDARY ACCESS ROAD

COUNTY 22ND ST. PLAN AND PROFILE
STA- 88+00 TO 100+60

Nicklaus Engineering Inc.
1851 West 24th Street P.O. Box 6029
YUMA, ARIZONA 85364 (928) 344-8374
Email: nei@neiyuma.com

SCALE AS SHOWN
DATE 2023
DR. M.A.C.
DES. D.N.
CHK. M.A.C.
SURV. D.N.
JOB. NO.
FILE

SHEET 3 OF 7

EQUATION:
STA. 99+75 COUNTY 22ND STREET ALIGNMENT
=STA. 45+77.66 8TH AVENUE ALIGNMENT
N=10065.16 E=13508.29

MATCH LINE STA. 88+00 SEE SHEET 5

ANGLE POINT
STA.=91+13.85
N=10064.97
E=12647.15

313.85'

S89°12'00"W

S89°59'14"W
861.15

COUNTY 22ND STREET

℄ NOE CANAL

CONSTRUCTION CENTERLINE

NOE CANAL R/W ℄

FUTURE 50' R/W

FUTURE 50' ROAD R/W

22.5' NOE CANAL R/W

45' CANAL R/W

FOUND USDOI BRASS CAP
N¼ CORNER SECTION 6
T.11S, R.24W, G.&S.R.B.M.
N=10036.97 E=12647.35
ELEV.=89.87

N00°25'20"W

C¼ CORNER
SECTION 6

NORTH LINE OF SECTION 6
T.11S, R.24W, G.&S.R.B.&M.

N00°00'46"W
S.C.05'

STA 100+18
A=90.50

R=30'

SEE SHEET 4 FOR CONTINUATION

88+00 89+00 90+00 91+00 92+00 93+00 94+00 95+00 96+00 97+00 98+00 99+00 100+00 100+60

98.0
96.0
94.0
92.0
90.0
88.0
86.0
84.0
82.0

0.00%

NEW AC PAVEMENT ℄
ELEVATION=90.24

EXISTING GRADE

℄ 8TH AVE.
STA. 99+75

STA 100+18
END OF PAVEMENT
A=90.24

LICENSE NO. **017-20-001**

YUMA COUNTY WATER USERS' ASSOCIATION
P. O. BOX 5775
YUMA, AZ 85366-5775

LICENSE FOR ENCROACHMENT AND CONSTRUCTION, INSTALLATION, OPERATION AND MAINTENANCE OF FACILITIES

LICENSEE: **CITY OF SAN LUIS**

LOCATION(S): **USBR EAST MAIN CANAL RIGHTS-OF-WAY LOCATED IN SECTIONS 1 & 12, TOWNSHIP 11 SOUTH, RANGE 25 WEST, GILA & SALT RIVER BASE & MERIDIAN, YUMA COUNTY, ARIZONA.**

USBR MAIN DRAIN RIGHTS-OF-WAY LOCATED IN SECTIONS 1, 2, 11 & 12, TOWNSHIP 11 SOUTH, RANGE 25 WEST, GILA & SALT RIVER BASE & MERIDIAN, YUMA COUNTY, ARIZONA.

1. Authority.

(a) Pursuant to the provisions of United States Department of the Interior, Bureau of Reclamation (the Bureau), Public Notice No. 77 dated February 12, 1960 (the Public Notice), the Yuma County Water Users' Association (Licensor) licenses the above named Licensee to construct, install, operate and maintain facilities encroaching upon rights-of-way of the United States forming part of the Valley Division of the Yuma Project, a reclamation project constructed under the laws of the United States (the Project), but only in strict compliance with the terms of this license.

(b) The Licensor is not authorized to grant or otherwise dispose of any right, title or interest in any land or interest in land owned by the United States, and this license does not constitute a grant or other disposition of any land or interest in land owned by the United States. Requests involving the granting or other disposition of any right, title or interest in any land or interest in land owned by the United States must be submitted to the Bureau as provided in the Public Notice.

(c) The Encroachment authorized by this license is subject to termination as provided in the Public Notice and in this license.

(d) This license is issued with the understanding that the issuance does not involve a substantial adverse change in any of the Project works transferred to

the Licensor under the provisions of the Contract for the Care, Operation and Maintenance of Works of the Valley Division, Yuma Project, No. 176r-671, dated June 15, 1951, between the United States of America and the Licensor.

(e) Upon discovery of archaeological or historical cultural resources in the course of constructing the Encroachment, the Licensee shall cease all activity in the area of the discovery and provide immediate telephone notifications of the discovery to the Licensor by directly contacting the Licensor's Manager at 928-627-8824 and the Bureau Archeologist at 928-343-8567, and also make all reasonable efforts to protect the cultural resources discovered. Activity under the license may resume only after the Bureau has authorized it to continue.

2. Description of Encroachment and Applicable Conditions The encroachment proposed by Licensee (the Encroachment) is described as follows:

(i) CONSTRUCTION, OPERATION AND MAINTENANCE OF THE EXISTING JUAN SANCHEZ BOULEVARD (COUNTY 23RD STREET OR G STREET) ROADWAY AND APPURTENANCES ACROSS THE EAST MAIN CANAL BETWEEN MESA STREET AND SAN LUIS PLAZA DRIVE.

(ii) INSTALLATION, OPERATION AND MAINTENANCE OF AN EXISTING GRAVITY FLOW SANITARY SEWER MAIN LINE AND APPURTENANCES ALONG JUAN SANCHEZ BOULEVARD (COUNTY 23RD STREET OR G STREET) AND ACROSS THE EAST MAIN CANAL BETWEEN MESA STREET AND SAN LUIS PLAZA DRIVE.

(iii) INSTALLATION, OPERATION AND MAINTENANCE OF AN EXISTING WATER LINE AND APPURTENANCES ALONG JUAN SANCHEZ BOULEVARD (COUNTY 23RD STREET OR G STREET) AND ACROSS THE EAST MAIN CANAL BETWEEN MESA STREET AND SAN LUIS PLAZA DRIVE.

(iv) CONSTRUCTION, OPERATION AND MAINTENANCE OF THE EXISTING JUAN SANCHEZ BOULEVARD (COUNTY 23RD STREET OR G STREET) BRIDGE, ROADWAY AND APPURTENANCES ACROSS THE MAIN DRAIN BETWEEN ESCONDIDO STREET AND HIDALGO AVENUE.

(v) INSTALLATION, OPERATION AND MAINTENANCE OF AN EXISTING 15" PVC SANITARY SEWER MAIN LINE IN 20" STEEL CASING AND APPURTENANCES ALONG JUAN SANCHEZ BOULEVARD (COUNTY 23RD STREET OR G STREET) AND ACROSS THE MAIN DRAIN BETWEEN ESCONDIDO STREET AND HIDALGO AVENUE.

(vi) INSTALLATION, OPERATION AND MAINTENANCE OF AN EXISTING 10" DIP WATER MAIN LINE AND APPURTENANCES ALONG JUAN SANCHEZ BOULEVARD (COUNTY 23RD STREET OR G STREET) AND ACROSS THE MAIN DRAIN BETWEEN ESCONDIDO STREET AND HIDALGO AVENUE.

(vii) INSTALLATION, OPERATION AND MAINTENANCE OF AN EXISTING SECONDARY VOLTAGE CONDUIT LINE MOUNTED OFF OF BRIDGE ALONG THE SOUTH SIDE OF JUAN SANCHEZ BOULEVARD (COUNTY 23RD STREET OR G STREET) AND ACROSS THE MAIN DRAIN BETWEEN ESCONDIDO STREET AND HIDALGO AVENUE.

(viii) SECTION 3. (a) EXHIBIT "A" IS DEFINED AS FOLLOWS:

PLANS PREPARED FOR THE CITY OF SAN LUIS, TITLED "JUAN SANCHEZ BOULEVARD, MERRILL AVENUE TO MAIN STREET PAVING PROJECT", PREPARED BY JAMES DAVEY AND ASSOCIATES, STAMPED AND SIGNED BY JAMES V. DAVEY ON 05/04/2017, AS-BUILT SIGNED AND DATED ON 01/29/2018.

3. Plans, Specifications; Construction and Inspection.

(a) All structures constructed under this license shall be erected in accordance with plans and specifications approved in writing in advance by Licensor. The approved plans and specifications for the Encroachment contemplated by this license are attached as Exhibit "A" and are incorporated by reference into the terms of this license (the Approved Plans). Any proposed deviation in construction or operations from the Approved Plans must be approved by Licensor in advance in writing before construction or operation of the Encroachment.

(b) All construction shall be completed in a manner so as not to obstruct in any way the flow of water in any canals, laterals, or drain ditches of the Project, or to interfere in any way with the construction, operation and maintenance of any part of the Project by the Licensor or the Bureau.

(c) Within **N/A** (**N/A**) calendar days after completion of the Encroachment, Licensee shall submit two (2) copies of as-built drawings to the Licensor. The Licensor shall provide one (1) copy of the as-built drawings, with a cover letter of transmittal, to the Bureau and provide a copy to any other party or entity associated with the Encroachment as determined by the Licensor. As-built drawings are required even in cases where Licensee claims that there have been no changes from the Approved Plans.

(d) Upon receipt of the as-built drawings, the Licensor shall conduct an inspection of the Encroachment to verify that the Encroachment conforms to the as-built drawings and that the as-built drawings conform to the Approved Plans. If the Licensor determines that the Encroachment, as built, does not comply with the Approved Plans, the Licensee shall, at Licensee's expense, immediately make such changes to the Encroachment as are necessary to make the Encroachment conform to the Approved Plans.

(e) Licensee shall provide Licensor with two (2) working days advance notification before the commencement of construction of Encroachment and any preliminary activity connected with the construction of the Encroachment.

(f) If Licensee does not commence work on the construction of the Encroachment within one (1) year from the date this license is issued, the license shall automatically expire unless extended by the Licensor in writing.

4. Administrative and Inspection Fees.

(a) Licensee shall pay the Licensor, upon submission of its application for the Encroachment, an all inclusive, non-refundable administrative fee of Two Hundred Fifty and No/100 Dollars ($250.00) per encroachment per location.

(b) In addition to the fees required by paragraph 4(a), the Licensee shall reimburse the Licensor all costs incurred by the Licensor in inspecting the Encroachment during and after construction and all costs incurred by the Licensor in causing any changes to the Encroachment necessary to bring the final construction of the Encroachment into accord with the Approved Plans. Licensor's inspection costs will be billed at Licensor's actual costs within forty-five (45) days of completion of the inspection and are due and payable within thirty (30) days after receipt by Licensee of a billing from Licensor.

5. Termination.

(a) As provided in the Public Notice, this license is subject to termination by the Licensor or the Bureau on thirty (30) days notice. Licensor agrees, however, that, except in the case of emergencies, or in cases where Licensor is requested or directed by the Bureau for an earlier termination of the license, or in cases where the Licensee is in default under any term or provision of this license, Licensor will not terminate this license on less than six (6) months prior written notice to the Licensee.

(b) If the Licensee is subject to the provisions of ARS 38-511, the provision of ARS 38-511 shall apply to this license.

(c) On termination of the license, the Licensee shall remove the Encroachment within one hundred eighty (180) days after the date of notice of termination and shall return the rights-of-way affected by this license to their original condition, or a condition acceptable to the Licensor and the Bureau, at Licensee's sole expense and at no expense to the Licensor or the Bureau. If Licensee fails to remove the Encroachment, Licensor may, without liability to Licensee and without further notice to Licensee, remove the Encroachment and charge the Licensee for the cost of removing the Encroachment and restoring the rights-of-way to their original condition. Payment to the Licensor is due within thirty (30) days after receipt of a statement of the costs incurred by Licensor in the removal of the Encroachment and restoration of the rights-of-way.

6. Increased Operation and Maintenance Expenses. If the construction and placement of the Encroachment increases the cost to Licensor, or its successors, of operation and maintenance functions on the rights-of-way that are affected by the Encroachment, the amount of any increase shall be paid by the Licensee. The amount of any increased operation and maintenance expense charged to the Licensee under this paragraph shall be determined by the Licensor in the Licensor's reasonable discretion. Any dispute between Licensor and Licensee as to the appropriateness or amount of any claimed increase in operation and maintenance charges claimed by the Licensor shall be resolved by the Area Manager. The determination of the Area Manager shall be conclusive and binding upon both parties and shall not be subject to review by any other person, entity or court.

7. Maintenance of Encroachment; Repairs to Damage.

(a) Maintenance of the Encroachment is the complete responsibility of the Licensee. If Licensee fails to perform proper maintenance of the Encroachment within fifteen (15) days after receipt of notice from the Licensor, either orally or in writing, of necessary maintenance to the Encroachment, the Licensor may, but is not obligated to, perform the necessary maintenance and bill Licensee for its costs incurred. Payment to the Licensor is due within thirty (30) days after receipt of statement of the costs incurred by Licensor in performing the necessary maintenance.

(b) If the Encroachment is damaged by the Licensor in the course of performing maintenance and operations on any right-of-way in the Project, the cost of repairing the Encroachment shall be paid by the Licensee unless, and only unless, the damage was caused by the gross (not ordinary) negligence of the Licensor or as a consequence of the Licensor's intentional wrongdoing.

8. Hold Harmless and Indemnification.

(a) To the maximum extent permitted by law, the Licensee agrees to hold forever harmless, indemnify and defend the Licensor and the Bureau, together with all of their respective officers, employees, successors and assigns from and against any and all claims related to or in any way connected with the construction, operation or maintenance of the Encroachment. The Licensee's obligation includes,

but is not limited to, the obligation to pay Licensor and the Bureau's attorney fees and costs incurred in connection with any claim whether or not litigation is commenced.

(b) If the Licensee contracts with or employs independent contractors to perform any of the construction of the Encroachment or otherwise provide services to the Licensee in connection with this license, the Licensee agrees to indemnify, defend and hold the Licensor and the Bureau forever harmless against any and all claims or demands of any nature whatsoever arising out of or in any way connected with the independent contractors retained by Licensee.

9. Covenant Against Contingent Fees. The Licensee warrants that no person or agency has been employed or retained to solicit or secure this license upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial agencies maintained by the Licensee for the purpose of securing business.

10. Assignment and Sublicenses.

(a) The Licensee may not, without the prior written consent of Licensor and the Bureau, assign, sublease or otherwise transfer any interest under this license to any other person or entity. The Licensee may not authorize or permit others to utilize any facility or structure or rights-of-way area which are the subject matter of this license except as expressly authorized by this license or by the Licensor and the Bureau in writing.

(b) If any assignment or sublicense is approved by the Licensor and the Bureau, all of the terms and conditions of this license shall be binding upon the successors and assigns of the Licensee to the full extent those terms and conditions were binding on the Licensee prior to the assignment or sublicense.

(c) For purposes of this license, an annexation of the Encroachment area by any governmental entity from another governmental entity shall constitute an assignment of this license to the annexing governmental entity and the annexing governmental entity shall be bound by all of its terms and conditions to the same extent as the Licensee for so long as the Encroachment remains in place.

11. Disputes, Jurisdiction, Venue and Attorney Fees.

(a) Any action between Licensor and Licensee to interpret or enforce any term of this license shall be commenced and concluded in the Superior Court of the State of Arizona, in Yuma County, Arizona, and not elsewhere. Licensee submits itself to the personal jurisdiction of the Superior Court and waives any objection to venue in Yuma County, Arizona.

(b) In any action to enforce or interpret this license, the prevailing party shall be entitled to recover that party's reasonable attorney fees and costs in an amount fixed by the Court or arbitrator, as the case may be.

IN WITNESS WHEREOF, the parties have signed this License for Encroachment on the dates shown below to be effective as of 2-13-20.

Licensee: **CITY OF SAN LUIS**

s/ Tadeo Azael De La Hoya

By: Tadeo Azael De La Hoya

Title: City Manager

Dated: 2-12-20

PO Box 1170
San Luis, AZ 85349
Address
928-341-8520
Phone

Approved: **YUMA COUNTY WATER USERS' ASSOCIATION**

s/ Tom W. Davis

Name: Tom W. Davis

Title: Manager

Dated: 2-13-20

Encroachment
License #017-20-001

CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

Mayor
GERARDO SANCHEZ

Vice-Mayor
MATIAS ROSALES

City Council
AFRICA LUNA-CARRASCO
GLORIA TORRES
MARIA CECILIA RAMOS
MARIO BUCHANAN JR.
RUBEN WALSHE



City Manager
TADEO A. DE LA HOYA

Director of Public Works
EULOGIO VERA, P.E.

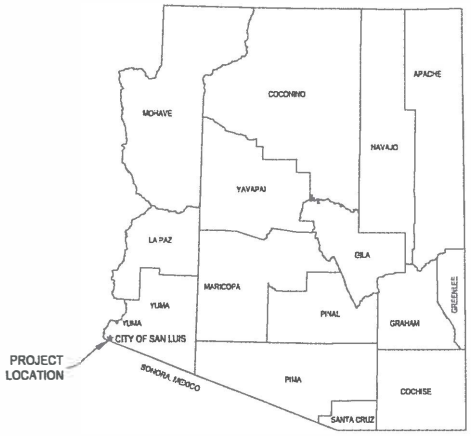
APPROVED: _____ City Manager Date: 04/25/17

APPROVED: _____ Director of Public Works Date: 04/25/17

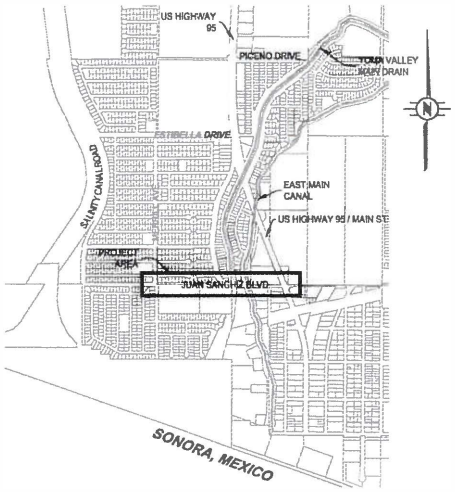
AS-BUILT

PREPARED BY:
JAMES DAVEY AND ASSOCIATES
1025 W. 24th STREET, SUITE 2
YUMA, AZ 85364
(928) 782-7926

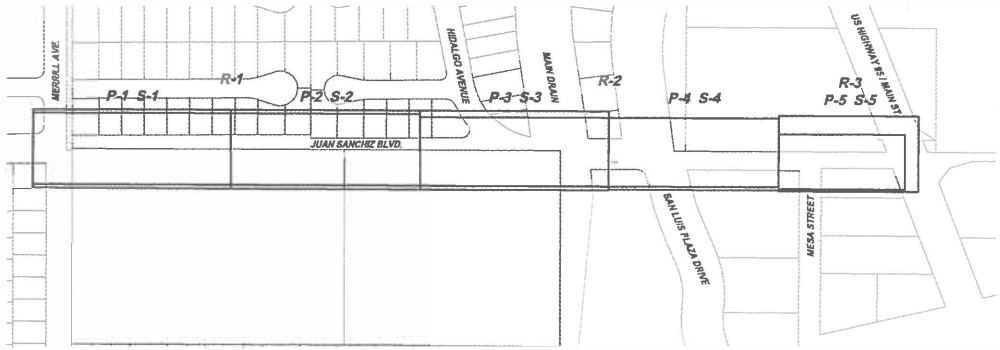
CITY OF SAN LUIS JUAN SANCHEZ BOULEVARD - MERRILL AVENUE TO MAIN STREET PAVING PROJECT



LOCATION MAP
NTS



SAN LUIS VICINITY MAP
NTS



KEY MAP
NTS

SHEET INDEX

SHEET NUMBER:	TITLE:
T-1	COVER SHEET
G-1	GENERAL NOTES, & KEY MAP
G-2	LEGEND & ABBREVIATIONS
G-3	GEOMETRIC CONTROL
R-1	TOPOGRAPHIC SURVEY AND REMOVAL PLAN - BEGIN PROJECT TO STA 19+50
R-2	TOPOGRAPHIC SURVEY AND REMOVAL PLAN - STA 19+50 TO STA 29+00
R-3	TOPOGRAPHIC SURVEY AND REMOVAL PLAN - STA 29+00 TO END PROJECT
P-1	ROADWAY PLAN AND PROFILE - BEGIN PROJECTTO STA 14+50
P-2	ROADWAY PLAN AND PROFILE - STA 14+50 TO STA 19+50
P-3	ROADWAY PLAN AND PROFILE -STA 19+50 TO STA 24+50
P-4	ROADWAY PLAN AND PROFILE - STA 24+50 TO STA 29+00
P-4A	ROADWAY PROFILE- STA 24+50 TO STA 29+00
P-5	ROADWAY PLAN AND PROFILE - STA 29+00 TO END PROJECT
S-1	SEWER PLAN AND PROFILE - BEGIN PROJECT TO STA 14+50
S-2	SEWER PLAN AND PROFILE - STA 14+50 TO STA 19+50
S-3	SEWER PLAN AND PROFILE - STA 19+50 TO STA 24+50
S-4	SEWER PLAN AND PROFILE - STA 24+50 TO STA 29+00
S-5	SEWER PLAN AND PROFILE - STA 29+00 TO END PROJECT
PM-1	PAVEMENT MARKING PLAN - BEGIN PROJECT TO STA 19+50
PM-2	PAVEMENT MARKING PLAN - STA 19+50 TO STA 29+00
PM-3	PAVEMENT MARKING PLAN - STA 29+00 TO END PROJECT
D-1	DETAILS
D-2	DETAILS

BENCHMARKS

STA 10+00, 0.00' Rt
INTERSECTION OF JUAN SANCHEZ BLVD.
AND MERRILL AVE.
FD CITY OF SAN LUIS BRASS CAP LS 6022
NORTHING = 545086.24
EASTING = 379056.64
ELEVATION = 86.51

TEMPORARY BENCHMARKS

TBM #1
VILLA ST. 282' WEST OF HIDALGO AVENUE
FD BRASS CAP RCE 7080
NORTHING = 546275.04
EASTING = 379799.82
ELEVATION = 88.18

NOTE: SEE SHEETS R-1 THRU R-3 FOR ADDITIONAL FOUND SURVEY MONUMENTS.

GENERAL NOTES

1. UTILITY LOCATIONS ARE APPROXIMATE ONLY. CONTRACTOR SHALL VERIFY EXISTENCE, LOCATION AND DEPTH OF ALL UNDERGROUND UTILITIES PRIOR TO TRENCHING. CONTRACTOR SHALL PROTECT ALL UTILITIES IN PLACE UNLESS OTHERWISE SPECIFIED IN THE PLANS. CALL ARIZONA BLUESTAKE-1-800-STAKE-IT AT LEAST 48 HRS PRIOR TO EXCAVATION.
2. NOT ALL STANDARD DRAWINGS ARE INCLUDED HEREIN. STANDARD DRAWINGS LISTED BUT NOT SHOWN ARE INCLUDED BY REFERENCE.

JAMES DAVEY AND ASSOCIATES
CONSULTING CIVIL ENGINEERS
1025 W. 24th Street, Suite 2 - YUMA, AZ 85364 - (928) 782-7826

CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

PROJECT LOCATION, VICINITY MAP
GENERAL NOTES, & KEY MAP

Call all local one call working days before you begin excavation.
ARIZONA811
Dial 8-1-1 or 1-800-STAKE-IT (782-5348)
In Northern Counties (602) 263-1100

CSL-10

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY: T.S.	
DRAWN BY: O.J.Z.	
APPROVED BY: J.V.D.	
SHEET G-1	
APRIL 21, 2017	

ABBREVIATIONS

@	AT
AB	AGGREGATE BASE
ABC	AGGREGATE BASE COURSE
ABDN	ABANDONED
ABUTMT	ABUTMENT
AC	ASPHALTIC CONCRETE, ALUMINUM CAP, ASBESTOS CEMENT
ACI	AMERICAN CONCRETE INSTITUTE
ACP	ASBESTOS CEMENT PIPE
ADDL	ADDITIONAL
ADJ	ADJACENT, ADJUSTABLE
ADOT	ARIZONA DEPARTMENT OF TRANSPORTATION
AFF	AT FINISH FLOOR
AG	AGRICULTURAL
AGGR	AGGREGATE
AISC	AMERICAN INSTITUE OF STEEL CONSTRUCTION
ALUM	ALUMINUM
ANG	ANGLE
APPRX.	APPROXIMATE, APPROXIMATELY
APS	ARIZONA PUBLIC SERVICE
ASTM	AMERICAN SOCIETY OF TESTING MATERIALS
ASSY	ASSEMBLY
AUTO	AUTOMATIC
AUX	AUXILIARY
AVE	AVENUE
AVG	AVERAGE
AWWA	AMERICAN WATER WORKS ASSOCIATION
BC	BRASS CAP/BACK CURB
BEG	BEGIN, BEGINNING
BF	BLIND FLANGE, BOTTOM FACE
BK	BACK
BLDG	BUILDING
BM	BENCH MARK
BOTT	BOTTOM
BRG	BEARING
BTWN	BETWEEN
BV	BALL VALVE, BUTTERFLY VALVE
BVC	BEGINNING OF VERTICAL CURVE
BW	BARBED WIRE
C/L	CHAIN LINK
C, CONC	CONCRETE, CENTER
CAP	CAPACITY
CATV	CABLE TELEVISION
CB	CATCH BASIN
CCP	CONCRETE CYLINDER PIPE
CD	CROSS-DRAINAGE STRUCTURE
CF	CUBIC FEET
CFM	CUBIC FEET PER MINUTE
CFS	CUBIC FEET PER SECOND
CI	CAST IRON
CJ	CONSTRUCTION JOINT
℄	CENTERLINE
CLR	CLEAR, CLEARANCE
CMP	CORRUGATED METAL PIPE
CMU	CONCRETE MASONRY UNITS
C.O.	CLEANOUT
CO.	COUNTY
CONN	CONNECTION, CONNECT
CONST	CONSTRUCTION, CONSTRUCT
CONT	CONTINUOUS
COORD	COORDINATE
COY	CITY OF YUMA
CP	CONTROL POINTS
CPLG	COUPLING
CC,	CENTER TO CENTER
CTR	CENTER
CTRD	CENTERED
CU	CUBIC
CULV	CULVERT
CV	CHECK VALVE
CWS	CALCULATED WATER SURFACE
DW	DRIVEWAY
D	DEPTH
DBL	DOUBLE
DC	DEPRESSED CURB
DEG	DEGREE
DEMO	DEMOLITION
DG	DOWN GUY
DIA	DIAMETER
DIAG	DIAGONAL
DIM	DIMENSION
DIP	DUCTILE IRON PIPE
DISCH	DISCHARGE
DOI	U.S. DEPARTMENT OF THE INTERIOR
DN	DOWN
DR	DRIVE
DW	DRIVEWAY
DWG	DRAWING
DWS	DESIGN WATER SURFACE
E	EAST, ELECTRIC
EA	EACH
EASE	EASEMENT
EB	EASTBOUND
ECC	ECCENTRIC
EF	EACH FACE
EG,EX,GR	EXISTING GRADE
EL. ELEC	ELECTRIC, ELECTRICAL
ELB	ELBOW
ELEV	ELEVATION
ENGR	ENGINEER
EP	EDGE OF PAVEMENT
EQPMT	EQUIPMENT
EVC	END OF VERTICAL CURVE
EW	EACH WAY
EX., EXIST.	EXISTING
EXP	EXPOSED
EXP JT	EXPANSION JOINT
FAB	FABRICATION
FC	FLEXIBLE COUPLING
FCA	FLANGED COUPLING ADAPTER
FD	FOUND
F.D.C.	FIRE DEPARTMENT CONNECTION
FDN	FOUNDATION
F.F.	FINISHED FLOOR ELEVATION
FG	FINISH GRADE
FH	FIRE HYDRANT
FIG.	FIGURE
FL	FLOW LINE
FLEX	FLEXIBLE
FLG	FLANGE
FLR	FLOOR
F.O.	FIBER OPTIC
FOW	FACE OF WALL
FT	FOOT, FEET
FTG	FOOTING, FILLING
FWD	FORWARD
G	GAS
GA	GAUGE
GAL	GALLON
GALV	GALVANIZED
G.I.	GALVANIZED IRON
G.S.	GALVANIZED STEEL
GB	GRADE BREAK
GC	GROOVED COUPLING
GND	GROUND
GPD	GALLONS PER DAY
GPH	GALLONS PER HOUR
GPM	GALLONS PER MINUTE
GRTG	GRATING
GSP	GALVANIZED STEEL PIPE
GSRBM	G.I.A & S.A.L.T. RIVER BASE & MERIDIAN
GT,GTR	GUTTER
GV	GATE VALVE, GAS VALVE
HC	HANDICAPPED
HB	HOSE BIB
HDPE	HIGH DENSITY POLYETHYLENE
HDWR	HARDWARE
HDWL	HEADWALL
HGL	HYDRAULIC GRADE LINE
HGT	HEIGHT
HH	HANDHOLE
HORIZ	HORIZONTAL
HP	HORSEPOWER
HWS	HIGH WATER SURFACE
HWY	HIGHWAY
ID	INSIDE DIAMETER
IE	INVERT ELEVATION
IF	INSIDE FACE
IN.	INCH
INSTM	INSTRUMENTATION
INSUL	INSULATE
INT	INTERIOR
INV	INVERT
IRR	IRRIGATION
JT	JOINT
L	LENGTH
LAT	LATERAL
LB	POUND
LF	LINEAR FEET
LH	LEFT HAND
LN	LANE
LR	LONG RADIUS
LS	LAND SURVEYOR
LT	LIGHT, LEFT
L/G	LIP OF GUTTER
M	MEASURED
MAINT	MAINTENANCE, MAINT.AIN
MATL	MATERIAL
MAX	MAXIMUM
MB	MAIL BOX
MCC	MOTOR CONTROL CENTER
MECH	MECHANICAL
MFR	MANUFACTURER
MH	MANHOLE
MBI	MUNICIPAL AND INDUSTRIAL
MIN	MINIMUM
MISC	MISCELLANEOUS
MJ	MECHANICAL JOINT
MO	MONTH
MON	MONUMENT
MTD	WALL MOUNTED
MTG	MOUNTING
MTL	METAL
MW	MONITORING WELL
MWS	MAXIMUM WATER SURFACE
N/A	NOT APPLICABLE
N	NORTH
NAD	NORTH AMERICAN DATUM
NAVD	NORTH AMERICAN VERTICAL DATUM
NB	NORTHBOUND
NE	NORTHEAST
NIC	NOT IN CONTRACT
NO.	NUMBER
NOM	NOMINAL
NORM	NORMAL
NPT	NATIONAL PIPE THREAD
NTS	NOT TO SCALE
NW	NORTHWEST
NWS	NORMAL WATER SURFACE
O/H	OVERHEAD
O&M	OPERATION & MAINTENANCE
OC	ON CENTER
OD	OUTSIDE DIAMETER
OF	OUTSIDE FACE, OVERFLOW
OPNG	OPENING
OPP	OPPOSITE
O T O O	OUT T O OUT
OVFL	OVERFLOW
P&ID	PROCESS AND INSTRUMENTATION DIAGRAM
PC	POINT OF CURVATURE
PCC	PORTLAND CEMENT CONC, POINT OF COMMAND CURVATURE
PE	POLYETHYLENE
PERM	PERMANENT
PI	POINT OF INTERSECTION
PJF	PREMOLDED JOINT FILLER
PL	PROPERTY LINE
POB	POINT OF BEGINNING
POC	POINT OF CURVATURE
POE	POINT OF ENDING
POT	POINT OF TANGENT
PP	POWER POLE
PRC	POINT OF REVERSE CURVE
PREFAB	PREFABRICATED
PRESS.	PRESSURE
PRI	PRIMARY
PROP	PROPERTY
PS	PUMP STATION, PRESSURE SWITCH
PSF	POUNDS PER SQUARE FOOT
PSI	POUNDS PER SQUARE INCH
PSIG	POUNDS PER SQUARE INCH, GAUGE
PT	POINT, POINT OF TANGENCY
PV	PLUG VALVE, PRESSURE VALVE
PVC	POLYVINYL CHLORIDE
PVMT	PAVEMENT
PVT	POINT OF VERTICAL TANGENCY
Q	FLOW RATE (CFS)
QUAD	QUADRANT
QTY	QUANTITY
ROW	RIGHT OF WAY
R	RECORD, RIGHT, RANGE
RAD	RADIUS
RB	REBAR
RC	REINFORCED CONCRETE
R.C.&G.	ROLL CURB AND GUTTER
RCP	REINFORCED CONCRETE PIPE
RD	ROAD
RED	REDUCER
REF	REFER, REFERENCE
REHAB	REHABILITATED, REHABILITATION
REINF	REINFORCE, REINFORCED, REINFORCING
REQD	REQUIRED
RESIL	RESILIENT
RGRCP	RUBBER GASKET REINFORCED CONCRETE PIPE
RM	ROOM
RR	RAILROAD
RTN	RETURN
S	SEWER, SOUTH
SB	SOIL BORING, SOUTHBOUND
SCHED	SCHEDULE
SD	STORM DRAIN
SE	SOUTHEAST
SEC	SECTION
SF	SQUARE FEET
SH	SHEET
SIM	SIMILAR
SL, ℄	SECTION LINE, SURVEY LINE, STREET LIGHT
SMH	SEWER MANHOLE
SP	SPACE, SPACES
SPEC	SPECIFICATIONS
SPECD	SPECIFIED
SPLY	SUPPLY
SQ	SQUARE
SR	STATE ROUTE
SS	SANITARY SEWER
SST, SS	STAINLESS STEEL
ST	STREET
STA	STATION
STD	STANDARD
STL	STEEL
STRL	STRUCTURAL
STRUCT	STRUCTURE
SUSP	SUSPEND
SW	SOUTHWEST
SYMM	SYMMETRICAL
T	TANGENT, TOWNSHIP, TELEPHONE
TAB	TOP AND BOTTOM
TB	THRUST BLOCK
TBM	TEMPORARY BENCH MARK
TC	TOP OF CONCRETE, TOP OF CURB
TCE	TEMPORARY CONSTRUCTION EASEMENT
TDH	TOTAL DYNAMIC HEAD
TECH	TECHNICAL
TEL	TELEPHONE
TEMP	TEMPORARY
TF	TOP FACE
THD	THREAD
THK	THICK
THRD	THREADED
TMH	TELEPHONE MANHOLE
T.O.	TOP OF TURNOUT
TOB	TOP OF BANK
TOL	TOP OF LINING
TOP	TOP OF PIPE
TORL	TOP OF RAISED LINING
TP	TELEPHONE POLE, TEST PIT, TURNING POINT
TPI	TURNOUT POINT OF INTERSECTION
TRANS	TRANSITION
TRS	TRAFFIC SIGNAL
TS	TRAFFIC SIGN, TOP OF SLOPE
TW	TOP OF WALL
TYP	TYPICAL
U/G	UNDERGROUND
UBC	UNIFORM BUILDING CODE
UNK	UNKNOWN
UNO	UNLESS NOTED OTHERWISE
USBR	UNITED STATES BUREAU OF RECLAMATION
VC	VERTICAL CURVE
V.C.&G.	VERTICAL CURVE AND GUTTER
VG	VALLEY GUTTER
VERT	VERTICAL
VOL	VOLUME
VPI	VERTICAL POINT OF INTERSECTION
VTR	VENT THRU ROOF
W	WITH
W	WATER, WEST
WB	WESTBOUND
WI	WROUGHT IRON
WM	WATER METER
WMCDD	WELLTON MOHAWK IRRIGATION AND DRAINAGE DISTRICT
WS	WATER STOP, WATER SURFACE
WSEL	WATER SURFACE ELEVATION
WSP	WELDED STEEL PIPE
WWF	WELDED WIRE FABRIC
WV	WATER VALVE
XFMR	ELECTRICAL TRANSFORMER
YC	YUMA COUNTY
YCWUA	YUMA COUNTY WATER USERS' ASSOCIATION
YD	YARD
YID	YUMA IRRIGATION DISTRICT
YMC	YUMA MESA CONDUIT
YMIDD	YUMA MESA IRRIGATION AND DRAINAGE DISTRICT
YR	YEAR

NOTES:

1) THIS IS A STANDARD ABBREVIATION AND LEGEND SHEET; THEREFORE, SOME SYMBOLS OR ABBREVIATIONS MAY APPEAR ON THIS SHEET AND NOT ON THE DRAWINGS.

2) CONTACT THE ENGINEER FOR ABBREVIATIONS NOT LISTED OR REFER TO "ABBREVIATIONS FOR USE ON DRAWINGS AND TEXT" PUBLISHED BY THE AMERICAN NATIONAL STANDARDS INSTITUTE (ANSI).

LEGEND

- NEW DRIVEWAY ENTRANCE WITH DEPRESSED CURB (D.C.)
- EXIST. DRIVEWAY ENTRANCE/ HANDICAP RAMP
- EXIST./NEW STRUCTURE
- EXIST. ASPHALT PAVEMENT
- NEW ASPHALT PVMT. AS NOTED
- EXIST. CONST. TO BE REMOVED
- NEW CONCRETE SIDEWALK OR SLAB (HATCH OPTIONAL)
- EXIST. CONCRETE SIDEWALK OR SLAB (HATCH OPTIONAL)
- NEW VERTICAL CURB & GUTTER (VC&G)
- EXIST. VERTICAL CURB & GUTTER (VC&G)
- NEW ROLL CURB & GUTTER (RC&G)
- EXIST. ROLL CURB & GUTTER (RC&G)
- NEW CONCRETE VALLEY GUTTER
- EXIST. CONCRETE VALLEY GUTTER
- GUTTER CATCH BASIN
- FLUSH CATCH BASIN
- EXIST./NEW PROPERTY LINE - PL
- EXIST./NEW CENTER LINE - ℄
- EXIST./NEW RIGHT-OF-WAY LINE - R/W
- EXIST./NEW WOOD FENCE
- EXIST./NEW WIRE FENCE
- EXIST./NEW MASONRY FENCE
- EXIST./NEW CHAIN LINK FENCE
- EXIST./NEW WROUGHT IRON FENCE
- NEW DITCH AS NOTED
- EXIST. DITCH AS NOTED
- NEW IRRIGATION OR STORM DRAIN PIPE
- EXIST. IRRIGATION OR STORM DRAIN PIPE
- EXIST. STAND PIPE
- NEW STAND PIPE
- EXIST. IRRIGATION OR DRAINAGE JUNCTION BOX
- NEW IRRIGATION OR DRAINAGE JUNCTION BOX
- EXIST./NEW IRRIGATION/SPRINKLER VALVE
- EXIST. SANITARY SEWER PIPE
- NEW SANITARY SEWER PIPE
- EXIST. SANITARY CLEAN OUT
- NEW SANITARY CLEANOUT
- EXIST. MANHOLE AS NOTED
- EXIST. MANHOLE TO BE BROUGHT TO GRADE
- NEW MANHOLE
- DRAINAGE DIVIDE
- EXIST. SLOPES
- NEW SLOPES
- EXIST. ELEVATION
- NEW ELEVATION
- EXIST. GAS LINE
- NEW GAS LINE
- EXIST./NEW DOWN GUY

- EXIST. POWER POLE
- NEW POWER POLE
- EXIST. TELEPHONE POLE
- NEW TELEPHONE POLE
- EXIST. TRAFFIC SIGNAL (T.S.)
- NEW TRAFFIC SIGNAL
- EXIST. LIGHT POLE (L.P.)
- NEW LIGHT POLE
- EXIST. WATER LINE
- NEW WATER LINE
- EXIST. END CAP W/ BLOW-OFF
- NEW END CAP W/ BLOW-OFF
- EXIST. FIRE HYDRANT (F.H.)
- NEW FIRE HYDRANT
- EXIST. FIRE DEPARTMENT CONNECTION (F.D.C.)
- NEW FIRE DEPARTMENT CONNECTION
- EXIST. VALVE
- EXIST. VALVE TO BE BROUGHT TO GRADE
- NEW VALVE & VALVE BOX
- EXIST. THRUST BLOCK
- NEW THRUST BLOCK
- NEW WATER METER BOX
- EXIST. WATER METER BOX (WM.)
- EXIST. W.M. BOX TO BE RELOCATED
- EXIST. TRAFFIC SIGN
- NEW TRAFFIC SIGN
- EXIST. STREET SIGN
- NEW STREET SIGN
- EXIST. STREET LIGHT
- NEW STREET LIGHT
- ROCK RIPRAP (AS NOTED)
- EXIST. TREE, PALM OR SHRUB
- EXIST. TREE, PALM OR SHRUB TO BE REMOVED
- EXIST. HEDGE (AS NOTED)
- EXIST. STORM DRAIN PIPE
- NEW STORM DRAIN PIPE
- EXIST. MAIL BOX
- EXIST. MAIL BOX TO BE RE-SET
- EXIST. SURVEY MONUMENT & COVER
- NEW SURVEY MONUMENT & COVER NO. 4-040 OR 4-050
- EXIST. SURVEY MONUMENT COVER TO BE BROUGHT TO GRADE
- NEW SURVEY MONUMENT, AS NOTED
- NEW SURVEY MONUMENT No. 4-080
- FOUND SURVEY MONUMENT
- SURVEY CONTROL POINT
- PROJECT BENCH MARK/TEMPORARY BENCHMARK
- NEW CONSTRUCTION NOTE
- REMOVAL NOTE

SECTION AND DETAIL STANDARDS:

DETAIL (NUMERAL) DESIGNATION ON DRAWING WHERE DETAIL IS TAKEN

SECTION (LETTER) DESIGNATION ON DRAWING WHERE SECTION IS TAKEN. ARROW INDICATES DIRECTION OF SECTION

DRAWING NUMBER (OR LINE IF TAKEN AND SHOWN ON SAME DRAWING) ON DRAWING WHERE SECTION OR DETAIL IS SHOWN

SCREENING:

SCREENED ELEMENTS ON AREA MAPPING REPRESENT EXISTING FACILITIES OR ELEVATIONS.

SCREENED BACKGROUNDS ON OTHER DRAWINGS CAN REPRESENT EXISTING FACILITIES OR FACILITIES TO BE CONSTRUCTED UNDER THIS CONTRACT, WHICH, IF DRAWN IN SOLID LINES, WOULD OBSCURE THE PARTICULAR DETAILS BEING SHOWN. CONSULT THE ENGINEER IF SCREENING OF ANY ELEMENTS IS NOT SELF-EXPLANATORY

STANDARD DETAILS:

STANDARD DETAIL CALLOUTS ARE SHOWN TO INDICATE DETAIL REQUIRED AT SPECIFIC LOCATIONS. AT ALL LOCATIONS WHERE A STANDARD DETAIL CALLOUT IS NOT SHOWN, THE CONTRACTOR SHALL USE THE STANDARD DETAIL MOST APPLICABLE AND CONSISTENT WITH OTHER WORK UNDER THIS CONTRACT.

Dial 811 at least two full working days before your begin excavation
ARIZONA 811
Arizona Blue Stake, Inc.

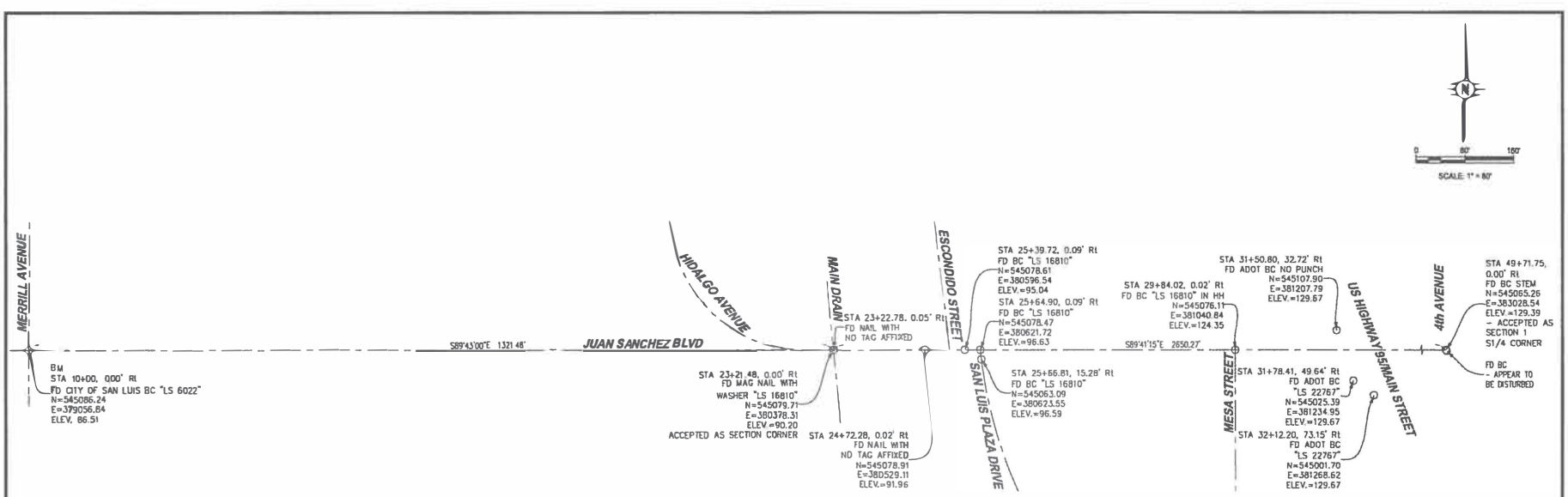
JAMES DAVEY AND ASSOCIATES
CONSULTING CIVIL ENGINEERS
1025 W. 24th Street, Suite 2 - YUMA, AZ 85364 - (928) 782-7926

CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

LEGEND & ABBREVIATIONS

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY:	T.S.
DRAWN BY:	O.J.Z.
APPROVED BY:	J.V.O.
SHEET	G-2
	APRIL 21, 2017



Call all local (non-toll) working days before you begin excavation.
ARIZONA 811
Dial 8-1-1 or 1-800-STAKE-IT (782-5348)
In Maricopa County (602) 263-1100

CSL-19

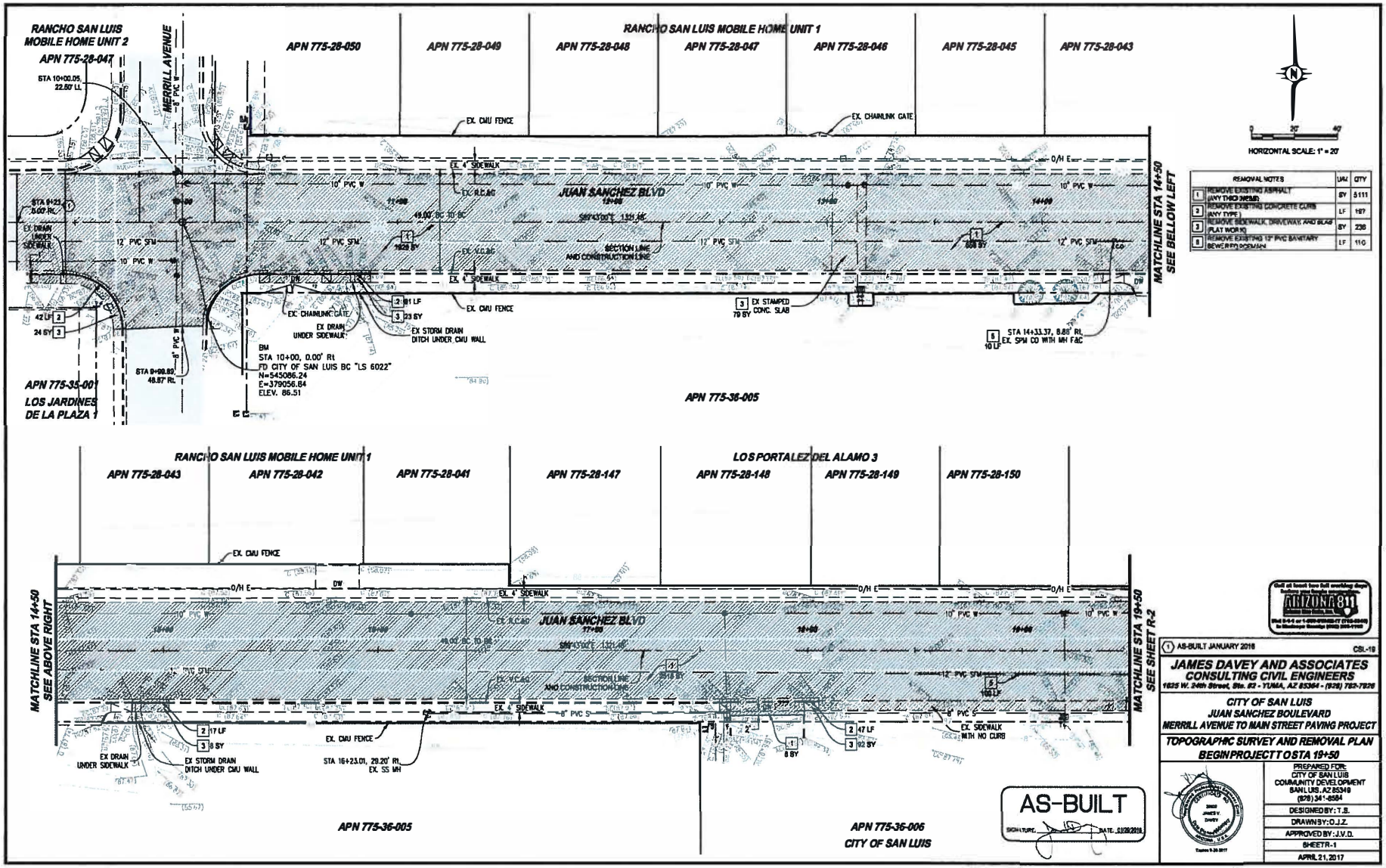
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CONSULTING CIVIL ENGINEERS
1025 W. 24th Street, Ste. #2 - YUMA, AZ 85364 - (928) 782-7826

CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

GEOMETRIC CONTROL

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY: T.S.
DRAWN BY: O.J.Z.
APPROVED BY: J.V.D.
SHEET G-3
APRIL 21, 2017



REMOVAL NOTES		UNI	QTY
1	REMOVE EXISTING ASPHALT (ANY THICKNESS)	SY	5111
2	REMOVE EXISTING CONCRETE CURB (ANY TYPE)	LF	197
3	REMOVE SIDEWALK, DRIVEWAY AND SLAB (ALL WORK)	SY	236
5	REMOVE EXISTING 12" PVC SANITARY SEWER PIPE/MAN	LF	110

AS-BUILT JANUARY 2018 CSL-19

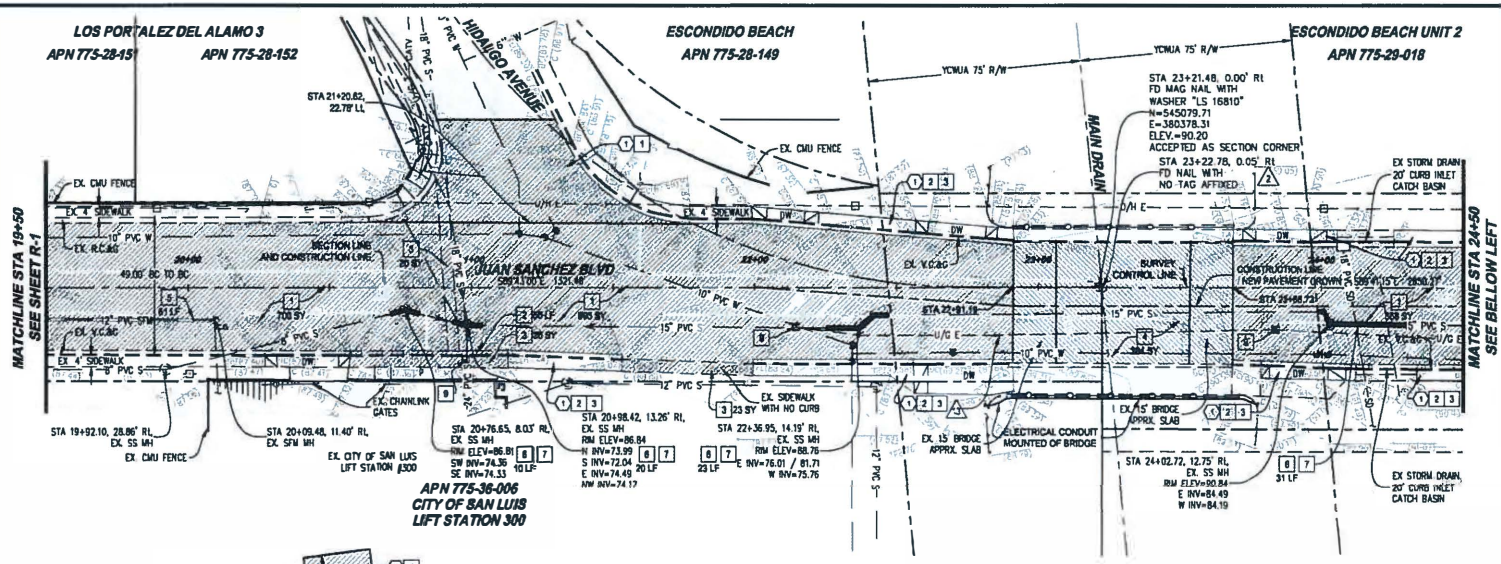
JAMES DAVEY AND ASSOCIATES
CONSULTING CIVIL ENGINEERS
1629 W. 24th Street, Ste. #2 - YUMA, AZ 85364 - (928) 782-7826

CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

TOPOGRAPHIC SURVEY AND REMOVAL PLAN
BEGIN PROJECT TO STA 19+50

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY: T.S.
DRAWN BY: O.J.Z.
APPROVED BY: J.V.D.
SHEET R-1
APRIL 21, 2017





REMOVAL NOTES		U/M	QTY
1	REMOVE EXISTING ASPHALT (ANY THICKNESS)	SY	4335
2	REMOVE EXISTING CONCRETE CURB (ANY TYPE)	LF	243
3	REMOVE SIDEWALK, DRIVEWAY, AND SLAB (FLAT WORK)	SY	523
4	REMOVE EXISTING ASPHALT ON BRIDGE DECK	SY	364
5	REMOVE EXISTING 12" PVC SANITARY SEWER FORCEMAIN	LF	61
6	REMOVE EXISTING GRAVITY SEWERMAIN (ANY SIZE)	LF	104
7	REMOVE EXISTING SEWER MANHOLE (ANY SIZE)	EA	6
8	REMOVE EXISTING ELECTRICAL PULL JUNCTION BOX	EA	4

GENERAL NOTES
1 FOUND NAIL WITH NO SURVEY TAG AFFIXED ON EXISTING PAVEMENT SURFACE. CONTRACTOR TO SURVEY THE EXISTING WITNESS CORNER USBR RB RASS CAP UNDER PAVEMENT.
2 EXISTING UNDER GROUND ELECTRICAL CONDUIT AND CONDUCTORS BETWEEN LIFT STATION #200 AND #300 TO BE RELOCATED BY THE CITY OF SAN LUIS PRIOR TO CONSTRUCTION.



1 AS-BUILT JANUARY 2018 CS.-19

REV. 1 - MAY 4, 2017

JAMES DAVEY AND ASSOCIATES
CONSULTING CIVIL ENGINEERS
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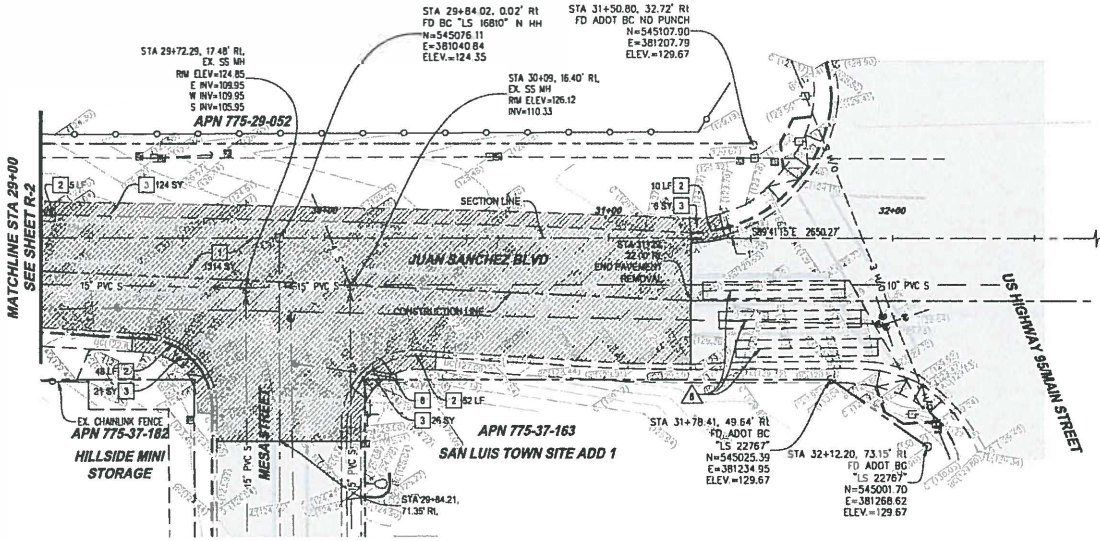
CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

TOPOGRAPHIC SURVEY AND REMOVAL PLAN
STA 19+50 TO STA 29+00



PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY: T.B.
DRAWN BY: O.J.Z.
APPROVED BY: J.V.D.
SHEET R-2
APRIL 21, 2017



HORIZONTAL SCALE: 1" = 20'

REMOVAL NOTES		U/M	QTY
1	REMOVE EXISTING ASPHALT (ANY THICKNESS)	SY	1313
2	REMOVE EXISTING CONCRETE CURB (ANY TYPE)	LF	115
3	REMOVE SIDEWALK, DRIVEWAY, AND SLAB (FLAT WORK)	SY	177
8	REMOVE AND SALVAGE EXISTING FIRE HYDRANT	EA	1

GENERAL NOTES
⚠ PROTECT EXISTING LOOP DETECTORS.

ARIZONA 811

CSL-19

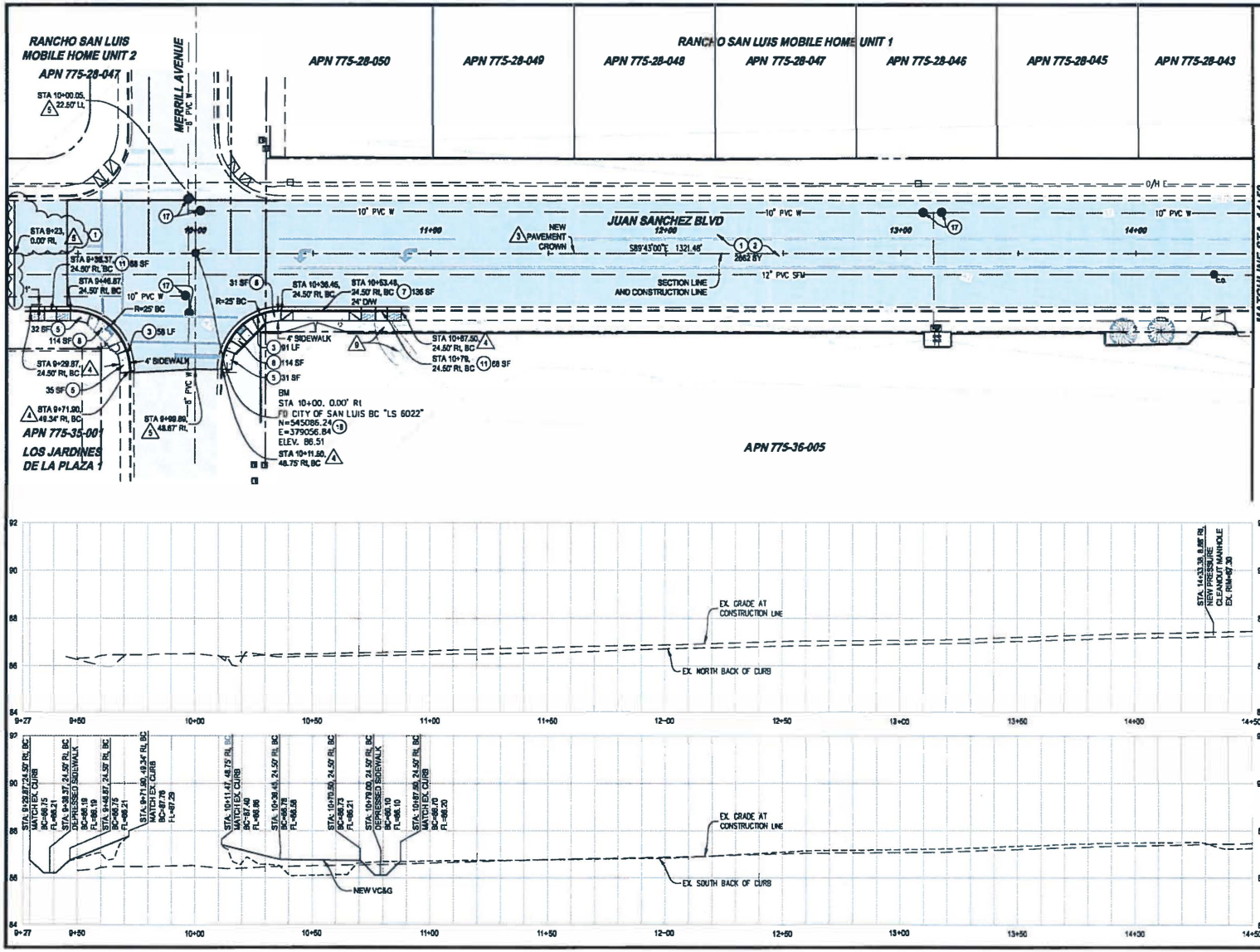
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CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

TOPOGRAPHIC SURVEY AND REMOVAL PLAN
STA 29+00 TO END PROJECT

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY: T.S.
DRAWN BY: O.J.Z.
APPROVED BY: J.V.D.
SHEET R-3
APRIL 21, 2017



HORIZONTAL SCALE 1" = 20'
VERTICAL SCALE 1" = 2'

	CONSTRUCTION NOTES	U/M	QTY
1	ASPHALT PAVEMENT SECTION No. 1 (4" AC / 12" ABC)	SY	2662
2	GRADING FOR PAVEMENT	SY	2662
3	VERTICAL CURB AND GUTTER / 4" ASC (CITY OF YUMA STD. 3-120)	LF	149
5	CONCRETE SIDEWALK / 4" ABC (CITY OF YUMA STD 3-270)	SF	129
7	DRIVEWAY AND PARKWAY (T=6")	SF	136
8	SIDEWALK RAMP (CITY OF YUMA STD. 3-280)	SF	228
11	STORM DRAIN SPILLWAY DEPRESSED SIDEWALK (1 / D-1)	SF	136
17	ADJUST EXISTING WATER VALVE WITH NEW FRAME AND COVER (CITY OF YUMA STD. 6-212)	EA	6
18	SURVEY MONUMENT (CITY OF YUMA STD. 4-080)	EA	1

	GENERAL NOTES
1	PAVEMENT REPLACEMENT SHALL HAVE A 2% MINIMUM CROSS SLOPE WITH A TYPICAL CENTER CROWN.
2	MATCH EXISTING CURB AND SIDEWALK.
3	MATCH EXISTING PAVEMENT.
4	EXISTING DRAINAGE CHANNEL UNDER CMU WALL TO BE REGRADED BY OTHERS AFTER CONSTRUCTION.

AS-BUILT
SIGNATURE DATE: 01/26/2018

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

1 AS-BUILT JANUARY 2018 CSL-18

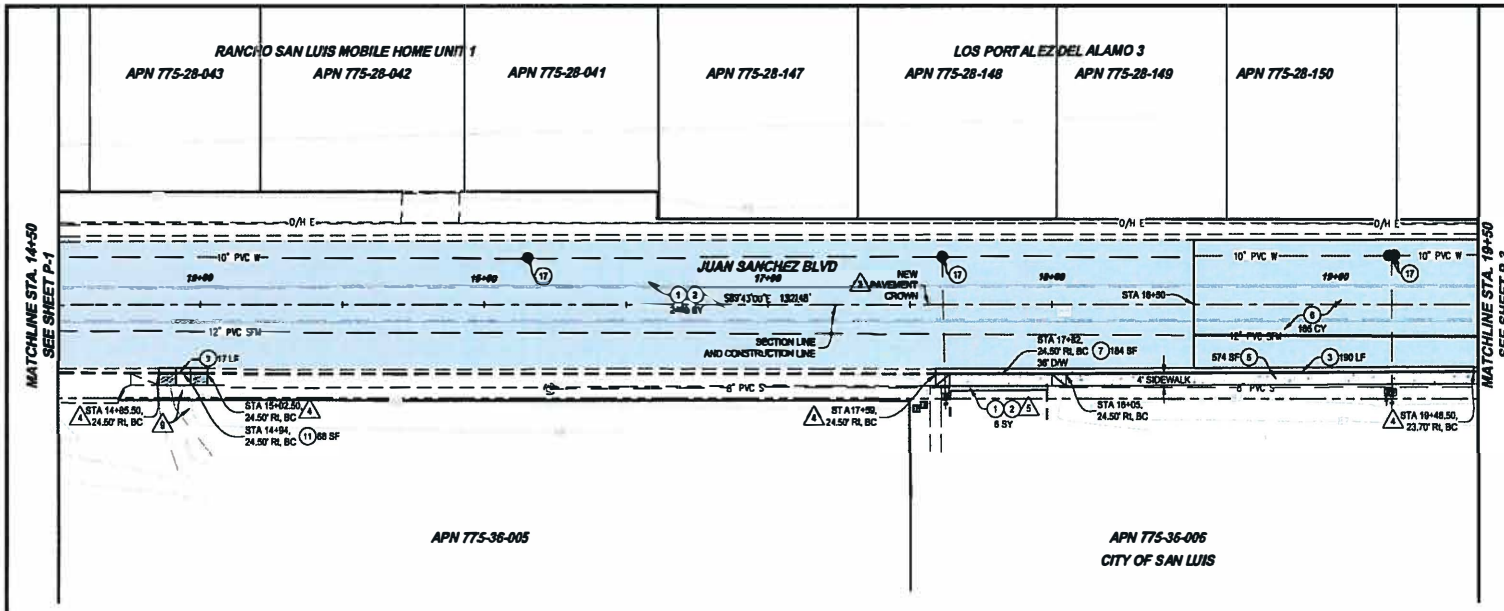
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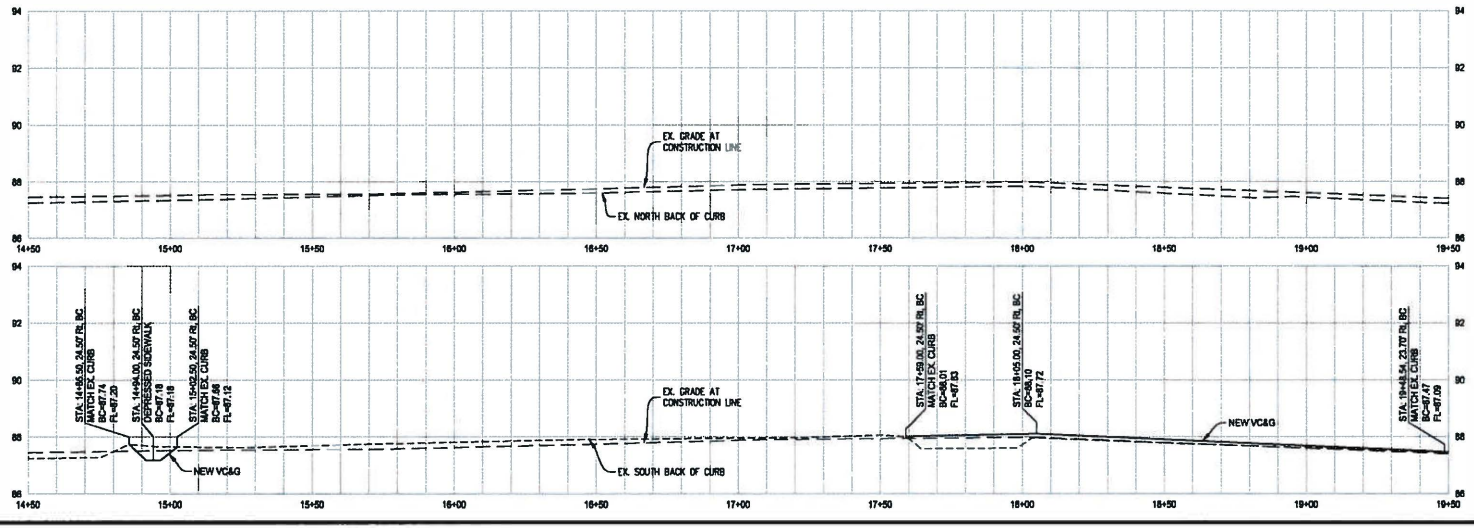
CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

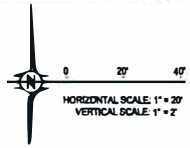
ROADWAY PLAN AND PROFILE
BEGIN PROJECT TO STA 14+50

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY: T.S.
DRAWN BY: O.J.Z.
APPROVED BY: J.V.D.
SHEET P-1
APRIL 21, 2017







CONSTRUCTION NOTES		U/M	QTY
1	ASPHALT PAVEMENT SECTION No. 1 (4" AC / 12" ABC)	SY	2505
2	GRADING FOR PAVEMENT	SY	2505
3	VERTICAL CURB AND GUTTER / 4" ABC (CITY OF YUMA STD. 3-120)	LF	207
5	CONCRETE SIDEWALK / 4" ABC (CITY OF YUMA STD 3-210)	SF	574
6	ROADWAY OVER EXCAVATION (TOP 12" OF SUBGRADE)	CY	165
7	DRIVEWAY AND PARKWAY (T=6")	SF	184
11	STORM DRAIN SPILLWAY DEPRESSED SIDEWALK (1) D-7	SF	68
17	ADJUST EXISTING WATER VALVE WITH NEW FRAME AND COVER (CITY OF YUMA STD. 5-210)	EA	4

GENERAL NOTES
3 PAVEMENT REPLACEMENT SHALL HAVE A 2% MINIMUM CROSS SLOPE WITH A TYPICAL CENTER CROWN.
4 MATCH EXISTING CURB AND SIDEWALK.
5 MATCH EXISTING PAVEMENT.
8 EXISTING DRAINAGE CHANNEL UNDER CMU WALL TO BE REGRADED BY OTHERS AFTER CONSTRUCTION.

CALL at least two full working days before you begin excavation
ARIZONA 811
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for Maricopa County (602) 263-1100

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JAMES DAVEY AND ASSOCIATES
CONSULTING CIVIL ENGINEERS
1025 W. 24th Street, Ste. B2 - YUMA, AZ 85364 - (928) 782-7926

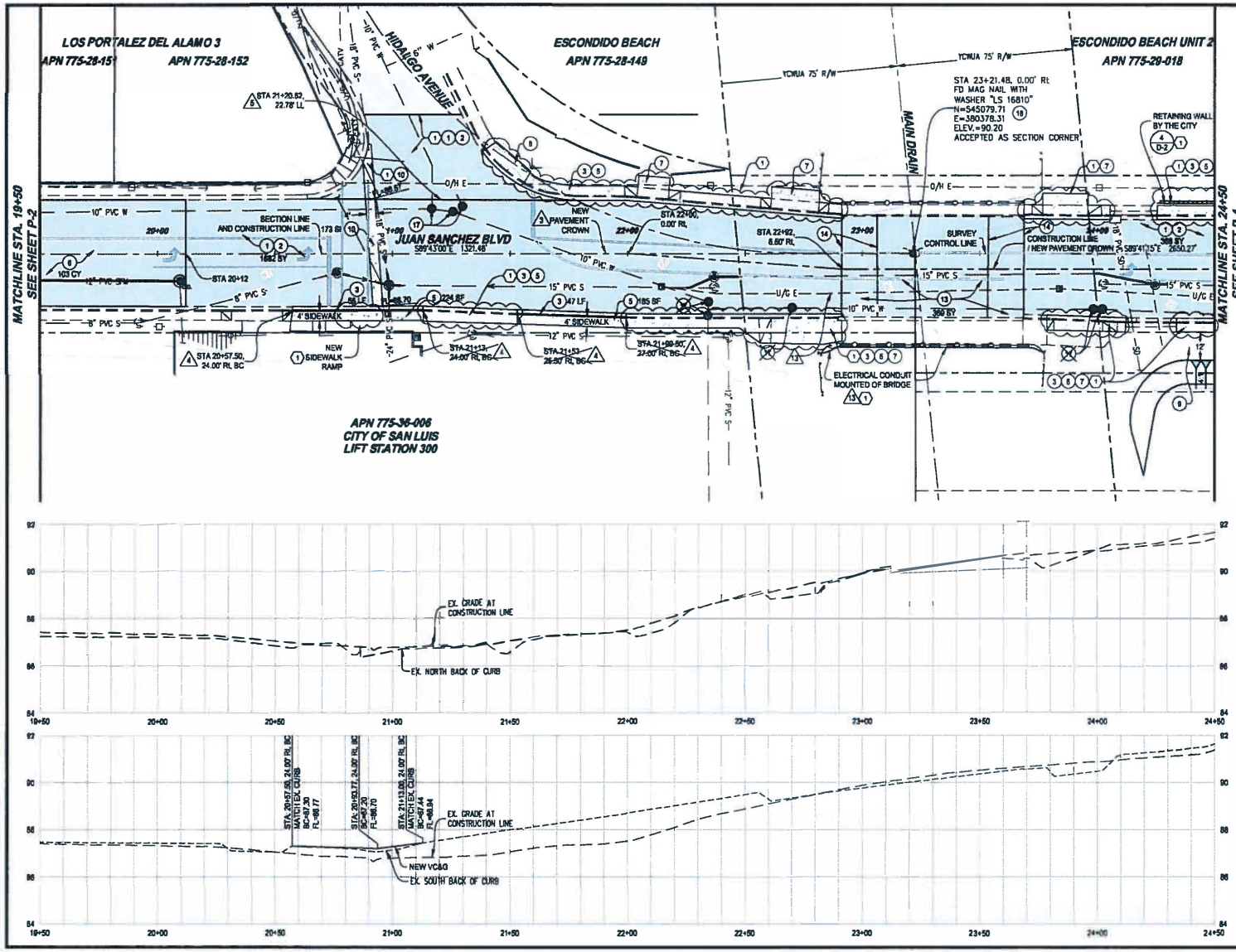
CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

ROADWAY PLAN AND PROFILE
STA 14+50 TO STA 19+50



PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS , AZ 85349
(928) 341-8584

DESIGNED BY: T.S.	
DRAWN BY: O.J.Z.	
APPROVED BY: J.V.D.	
SHEET P-2	
APRIL 21, 2017	



HORIZONTAL SCALE: 1" = 20'
VERTICAL SCALE: 1" = 2'

	CONSTRUCTION NOTES	U/M	QTY
1	ASPHALT PAVEMENT SECTION No. 1 (4" AC / 12" ABC)	SY	2050
2	GRADING FOR PAVEMENT	SY	1681
3	VERTICAL CURB AND GUTTER / 4" ABC (CITY OF YUMA STD. 3-120)	LF	103
5	CONCRETE SIDEWALK / 4" ABC (CITY OF YUMA STD 3-270)	SF	409
9	LIFT STATION #300 GRADING AND ABC PARKWAY (T=6")	LS	1
10	CROSS GUTTER (CITY OF YUMA STD 3-170)	SF	173
13	ASPHALT PAVEMENT SECTION No. 2 (3" AC ON BRIDGE DECK)	SY	389
14	SEAL EXPANSION JOINTS ON BRIDGE DECK (2 / D-1)	LS	1
17	ADJUST EXISTING WATER VALVE WITH NEW FRAME AND COVER (CITY OF YUMA STD. 5-210)	EA	8
18	SURVEY MONUMENT (CITY OF YUMA STD. 4-080)	EA	1
7	DRIVEWAY AND PARKWAY (T=6")	SF	
8	SIDEWALK RAMP (CITY OF YUMA STD. 3-280)	SF	

GENERAL NOTES	
4	PAVEMENT REPLACEMENT SHALL HAVE A 2% MINIMUM CROSS SLOPE WITH A TYPICAL CENTER CROWN.
6	MATCH EXISTING CURB AND SIDEWALK.
8	MATCH EXISTING PAVEMENT.
13	EXISTING UNDER GROUND ELECTRICAL CONDUIT AND CONDUCTORS BETWEEN LIFT STATION #200 AND #300 TO BE RELOCATED BY THE CITY OF SAN LUIS PRIOR TO CONSTRUCTION.

AS-BUILT
SIGNATURE: _____ DATE: 01/26/2018

ARIZONA 811

C8.-19

1 AS-BUILT JANUARY 2018

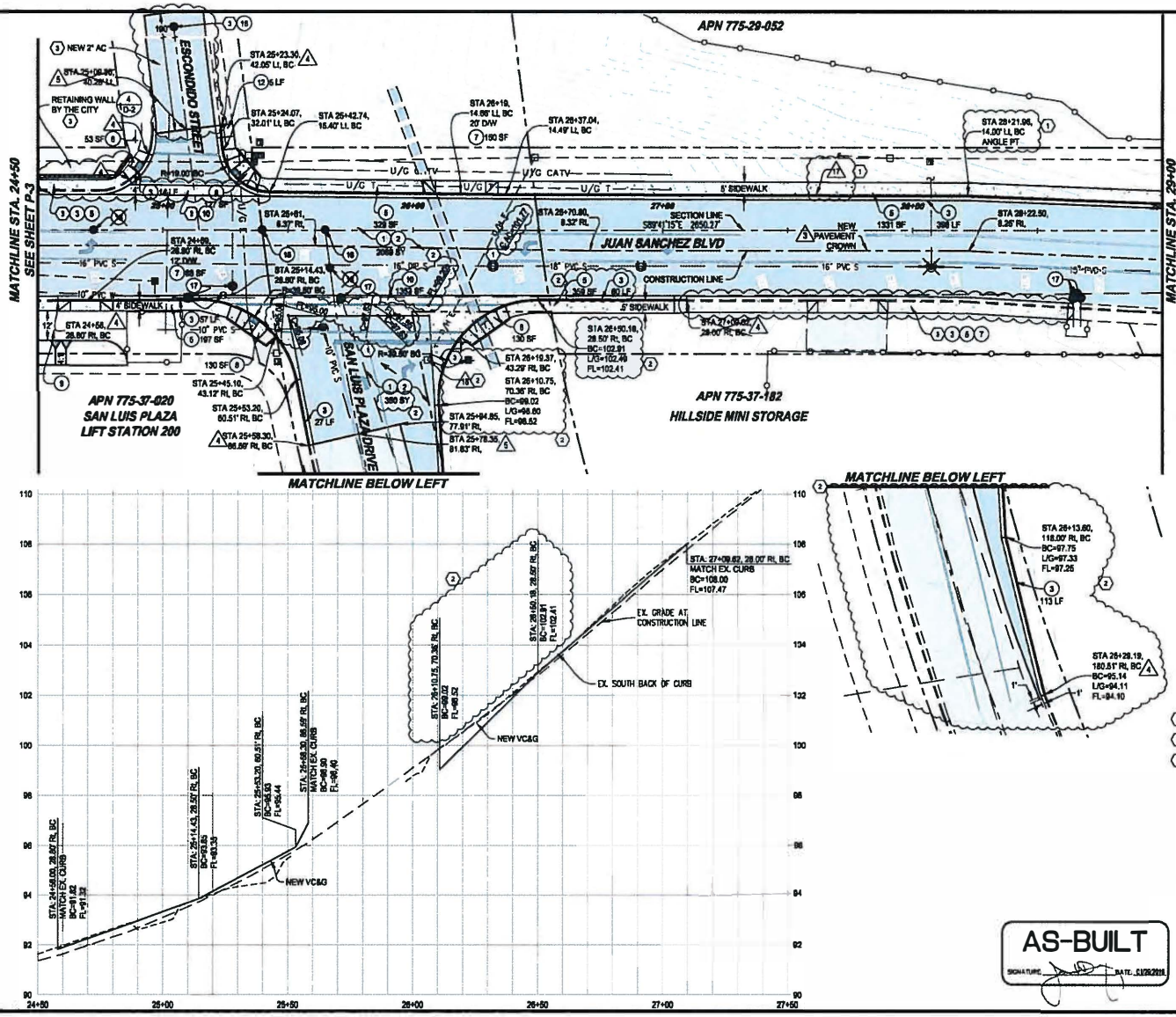
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CONSULTING CIVIL ENGINEERS
1625 W. 24th Street, Ste. #2 - YUMA, AZ 85364 - (928) 782-7826

CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

ROADWAY PLAN AND PROFILE
STA 19+50 TO STA 24+50

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY: T.S.
DRAWN BY: O.J.Z.
APPROVED BY: J.V.D.
SHEET P-3
APRIL 21, 2017



N

0 20' 40'

HORIZONTAL SCALE: 1" = 20'
VERTICAL SCALE: 1" = 2'

	CONSTRUCTION NOTES	UM	QTY
1	ASPHALT PAVEMENT SECTION No. 1 (4" AC / 12" ABC)	SY	2263
2	GRADING FOR PAVEMENT	SY	2263
3	VERTICAL CURB AND GUTTER (7.4" ASC (CITY OF YUMA STD. 3-120)	LF	586
5	CONCRETE SIDEWALK (4" ASC (CITY OF YUMA STD 3-270)	SF	2284
7	DRIVEWAY AND PARKWAY (T=6")	SF	238
8	SIDEWALK RAMP (CITY OF YUMA STD. 3-280)	SF	440
9	LIFT STATION #200 GRADING AND ASC PARKWAY (T=6")	LS	1
10	CROSS GUTTER (CITY OF YUMA STD 3-170)	SF	1401
15	VERTICAL CURB AND GUTTER TO ROLLED CURB TRANSITION	LF	5
17	ADJUST EXISTING WATER VALVE WITH NEW FRAME AND COVER (CITY OF YUMA STD. 5-215)	EA	5
18	SURVEY MONUMENT (CITY OF YUMA STD. 4-080)	EA	4

GENERAL NOTES
1 PAVEMENT REPLACEMENT SHALL HAVE A 2% MINIMUM CROSS SLOPE WITH A TYPICAL CENTER CROWN.
1 MATCH EXISTING CURB AND SIDEWALK.
1 MATCH EXISTING PAVEMENT.
1 2 STA 26+37.04 TO 29+32.40: THE NEW VC&G TO MATCH THE EXISTING SOUTH SIDE VC&G.
2 EXISTING POWER POLE TO BE RELOCATED BY CENTURY LINK.

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

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AS-BUILT

3	AS-BUILT JANUARY 2018
2	REV. 2 - JULY 14, 2017 - SAN LUIS PLAZA DRIVE
1	REV. 1 - MAY 11, 2017 - GRADES

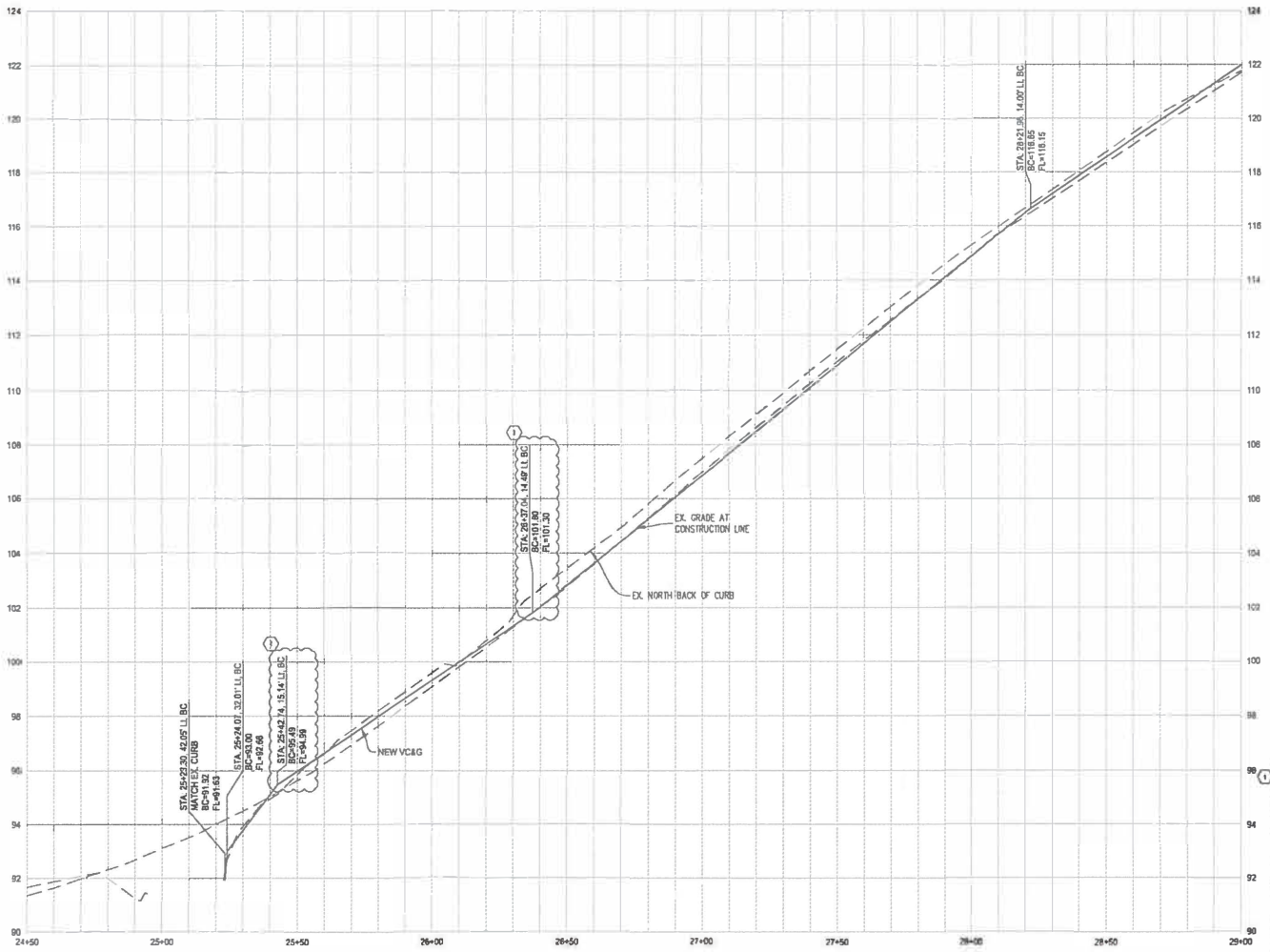
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CONSULTING CIVIL ENGINEERS
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CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

ROADWAY PLAN AND PROFILE
STA 24+50 TO STA 29+00

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY: T.S.	
DRAWN BY: O.J.Z.	
APPROVED BY: J.V.D.	
SHEET P-4	
APRIL 21, 2017	



0 20' 40'

HORIZONTAL SCALE: 1" = 20'
VERTICAL SCALE: 1" = 2'

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1 REV. 1 - MAY 11, 2017 - GRADES

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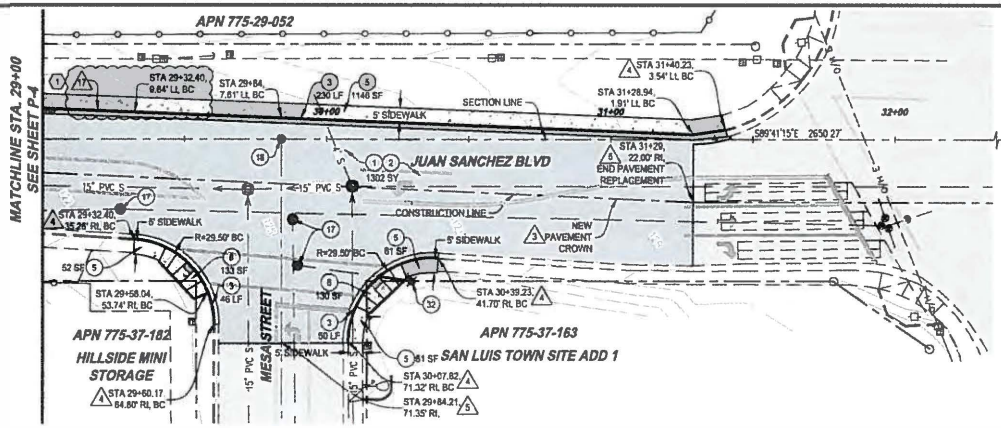
CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

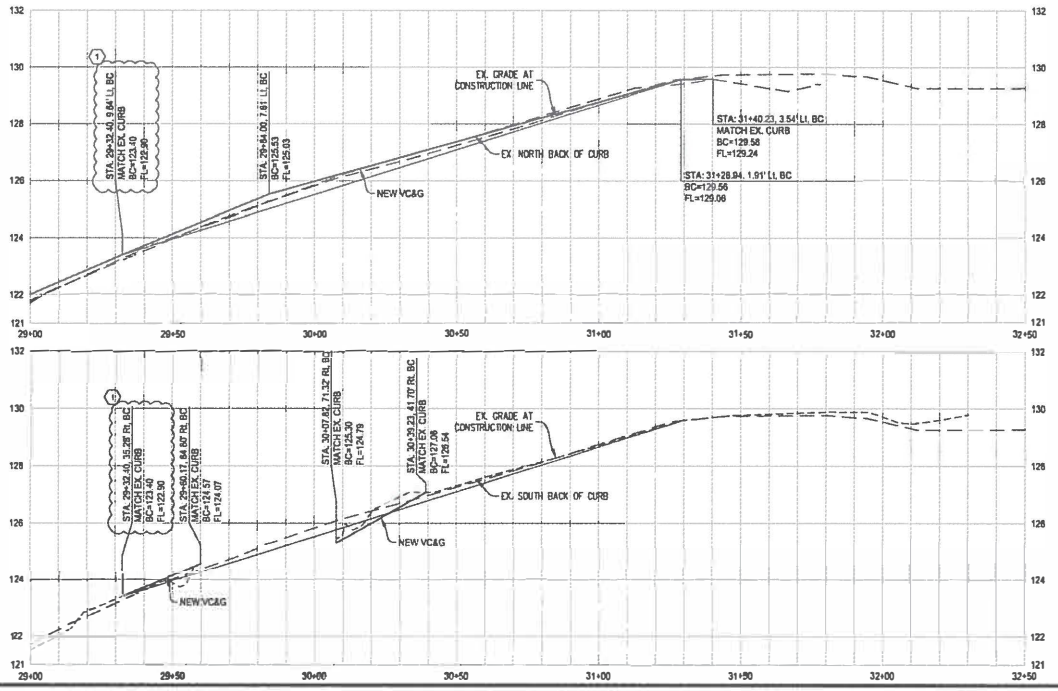
ROADWAY
PROFILE - STA 24+50 TO STA 29+00

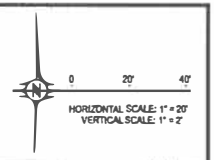
JAMES V. DAVEY — 23052 — REGISTERED PROFESSIONAL ENGINEER — ARIZONA, U.S.A. — Expires 9-30-2017

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY: T.S.	
DRAWN BY: O.J.Z.	
APPROVED BY: J.V.D.	
SHEET: P-4A	
APRIL 21, 2017	







CONSTRUCTION NOTES		UM	QTY
1	ASPHALT PAVEMENT SECTION No. 1 (4" AC / 12" ABC)	SY	1303
2	GRADING FOR PAVEMENT	SY	1303
3	VERTICAL CURB AND GUTTER / 4" ABC (CITY OF YUMA STD. 3- 120)	LF	336
5	CONCRETE SIDEWALK / 4" ABC (CITY OF YUMA STD 3-270)	SF	1326
8	DRIVEWAY RAMP (CITY OF YUMA STD. 3-290)	SF	263
17	ADJUST EXISTING WATER VALVE WITH NEW FRAME AND COVER (CITY OF YUMA STD. 5-210)	EA	3
18	SURVEY MONUMENT (CITY OF YUMA STD. 4-080)	EA	1
32	NEW FIRE HYDRANT, 6" PVC WATER LINE (CITY OF YUMA ST D 5-120)	LS	1

GENERAL NOTES
1 PAVEMENT REPLACEMENT SHALL HAVE A 2% MINIMUM CROSS SLOPE WITH A TYPICAL CENTER CROWN.
2 MATCH EXISTING CURB AND SIDEWALK.
3 MATCH EXISTING PAVEMENT.
1 1 STA 26+37.04 TO 29+32.40: THE NEW VC&G TO MATCH THE EXISTING SOUTH SIDE VC&G.

Call at least two full working days before you begin excavation
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1 REV. 1 - MAY 11, 2017 - GRADES

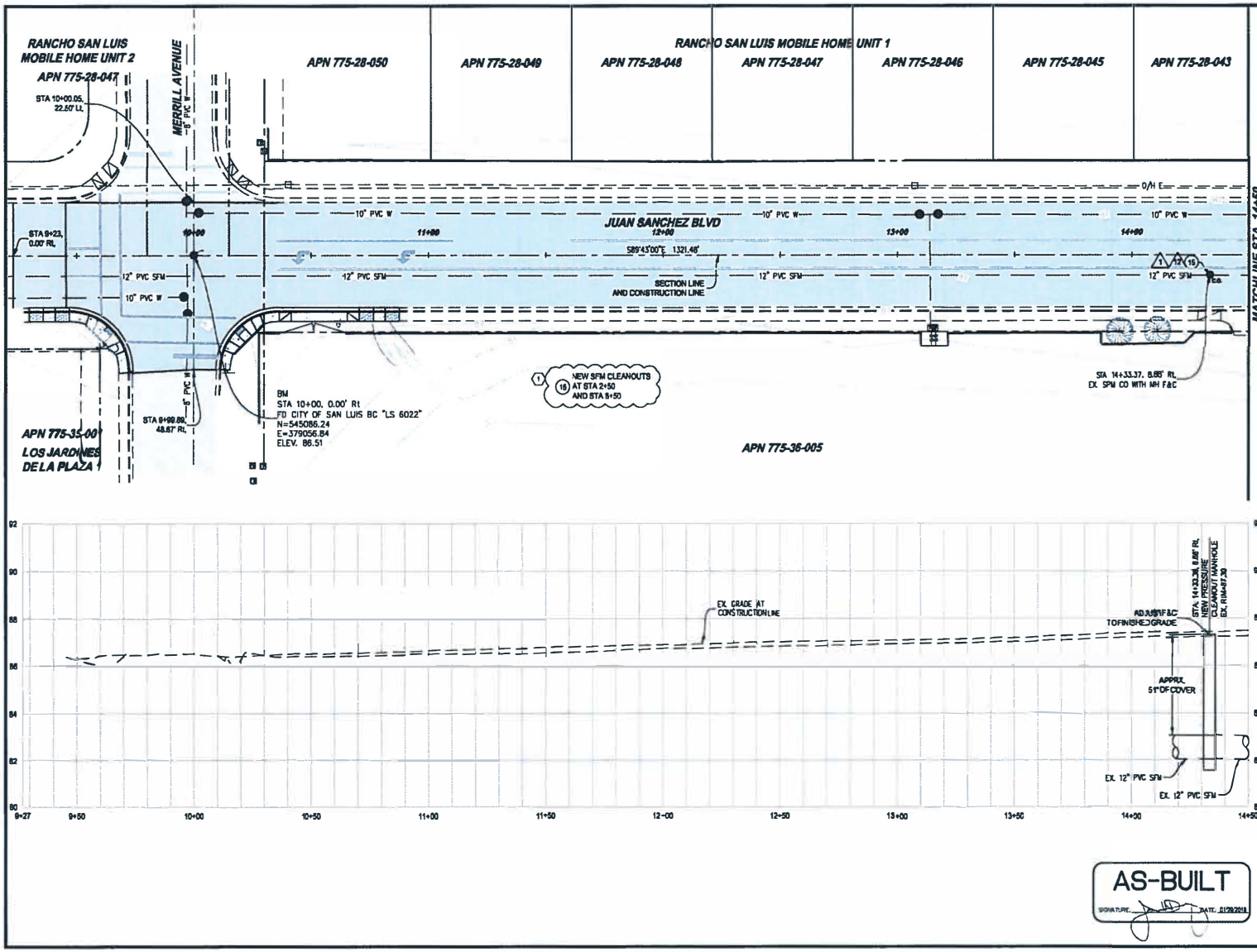
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CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

ROADWAY PLAN AND PROFILE
STA 29+00 TO END PROJECT

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8504

DESIGNED BY: T.S.	
DRAWN BY: O.J.Z.	
APPROVED BY: J.V.D.	
SHEET P-5	
APRIL 21, 2017	



CONSTRUCTION NOTES		U/M	QTY
16	REMOVE AND REPLACE EXISTING SEWER FORCEMAIN PRESSURE CLEANOUT (CITY OF YUMA STD 5-015)	EA	1

HORIZONTAL SCALE, 1" = 20'
VERTICAL SCALE, 1" = 2'

GENERAL NOTES

1. CONTRACTOR WILL BE RESPONSIBLE FOR SEWER FLOWS DURING CONSTRUCTION. CONTRACTOR TO COORDINATE SEWER FLOW OUTAGES WITH THE CITY OF SAN LUIS SEWER COLLECTIONS.
2. SEWERMAIN, FORCEMAIN, MANHOLE AND PRESSURE CLEANOUT MANHOLES BEDDING AND TRENCH BACKFILL SHALL BE PER DETAILS AND 6 ON SHEET D-1
3. CONTRACTOR SHALL VERIFY THE EXISTING SEWER MANHOLE PIPE INVERTS B EFORE EXCAVATING AND REMOVING THE EXISTING MANHOLES. CONTRACTOR SHALL MODIFY OR MAKE MINOR ADJUSTMENTS TO THE NEW POLYURETHANE MANHOLES FURNISHED BY THE CITY OF SAN LUIS IF NECESSARY FOR A COMPLETE MANHOLE INSTALLATION.

Call all local one-call members days before you begin excavation
ARIZONA 811
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In Maricopa County (602) 263-1100

CS:-19

1 AS-BUILT JANUARY 2018
REV. 1 - MAY 4, 2017

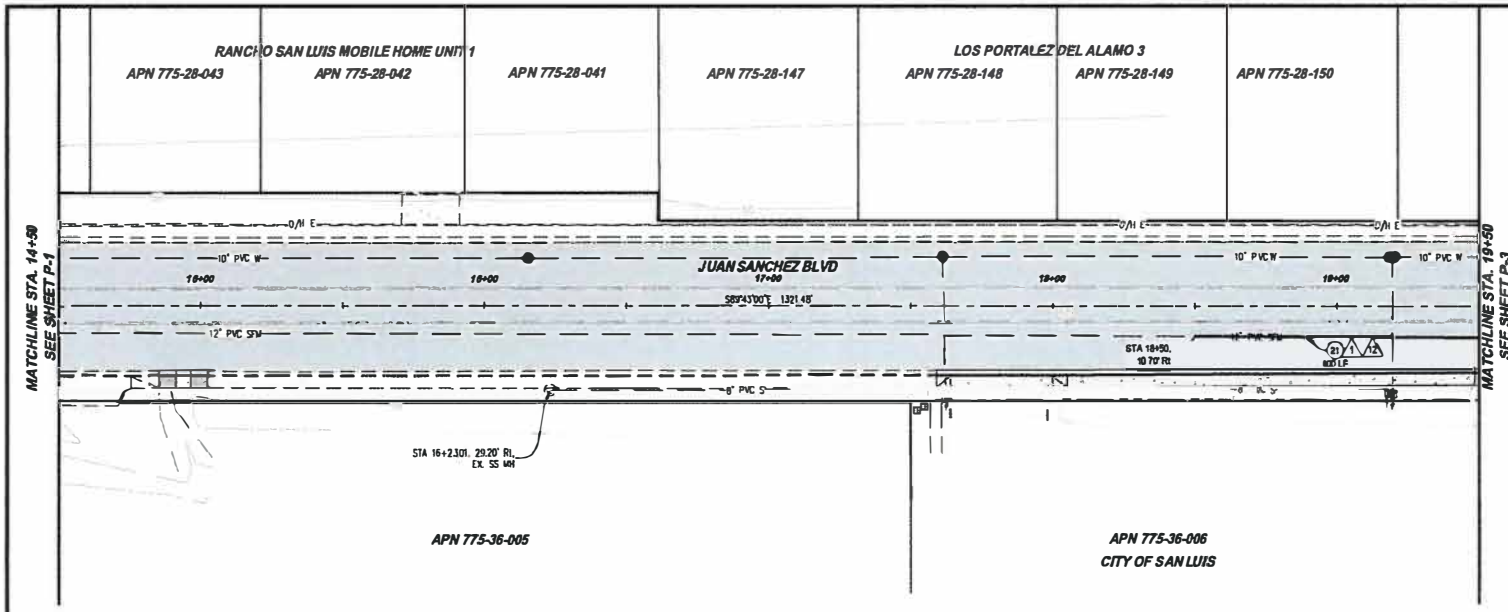
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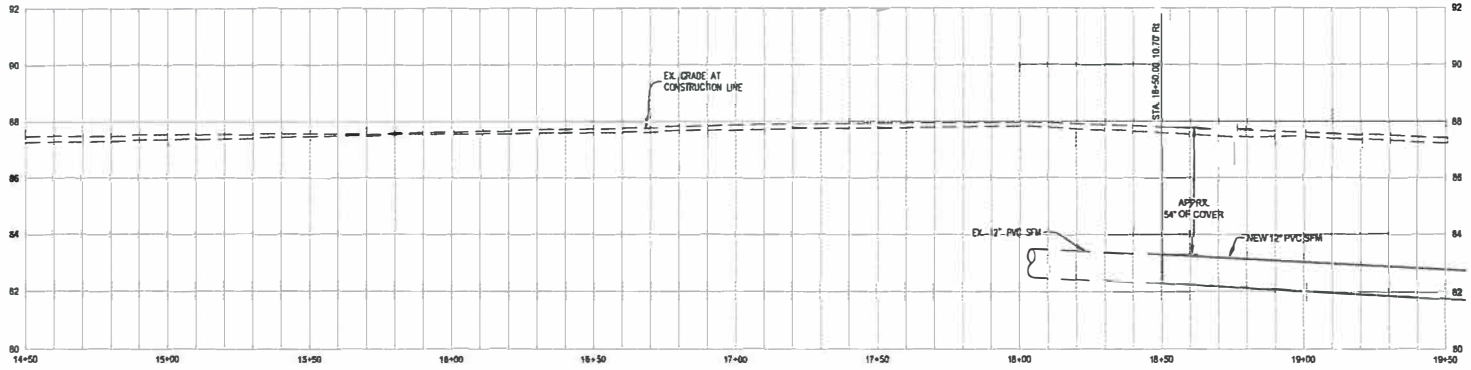
CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT
~~**SEWER PLAN AND PROFILE**~~
BEGIN PROJECT TO STA 14+50

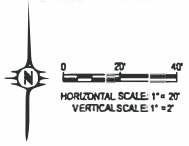
AS-BUILT
SIGNATURE: _____ DATE: 01/29/2018

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY:	T.S.
DRAWN BY:	O.J.Z.
APPROVED BY:	J.V.D.
SHEET	S-1
	APRIL 21, 2017







CONSTRUCTION NOTES		U/M	QTY
21	12" PVC SDR-35, SEWER FORCEMAIN	LF	100

GENERAL NOTES	
1	CONTRACTOR WILL BE RESPONSIBLE FOR SEWER FLOWS DURING CONSTRUCTION. CONTRACTOR TO COORDINATE SEWER FLOW OUTAGES WITH THE CITY OF SAN LUIS SEWER COLLECTIONS.
12	SEWERMAIN, FORCEMAIN, MANHOLE AND PRESSURE CLEANOUT MANHOLE BEDDING AND TRENCH BACKFILL SHALL BE PER DETAIL 3 AND 4 ON SHEET D-1.
18	CONTRACTOR SHALL VERIFY THE EXISTING SEWER MANHOLE PIPE INVERTS BEFORE EXCAVATING AND REMOVING THE EXISTING MANHOLES. CONTRACTOR SHALL MODIFY OR MAKE MINOR ADJUSTMENTS TO THE NEW POLYMER MANHOLES FURNISHED BY THE CITY OF SAN LUIS IF NECESSARY FOR A COMPLETE MANHOLE INSTALLATION.

ARIZONA 811

CSI-19

REV. 1 - MAY 4, 2017

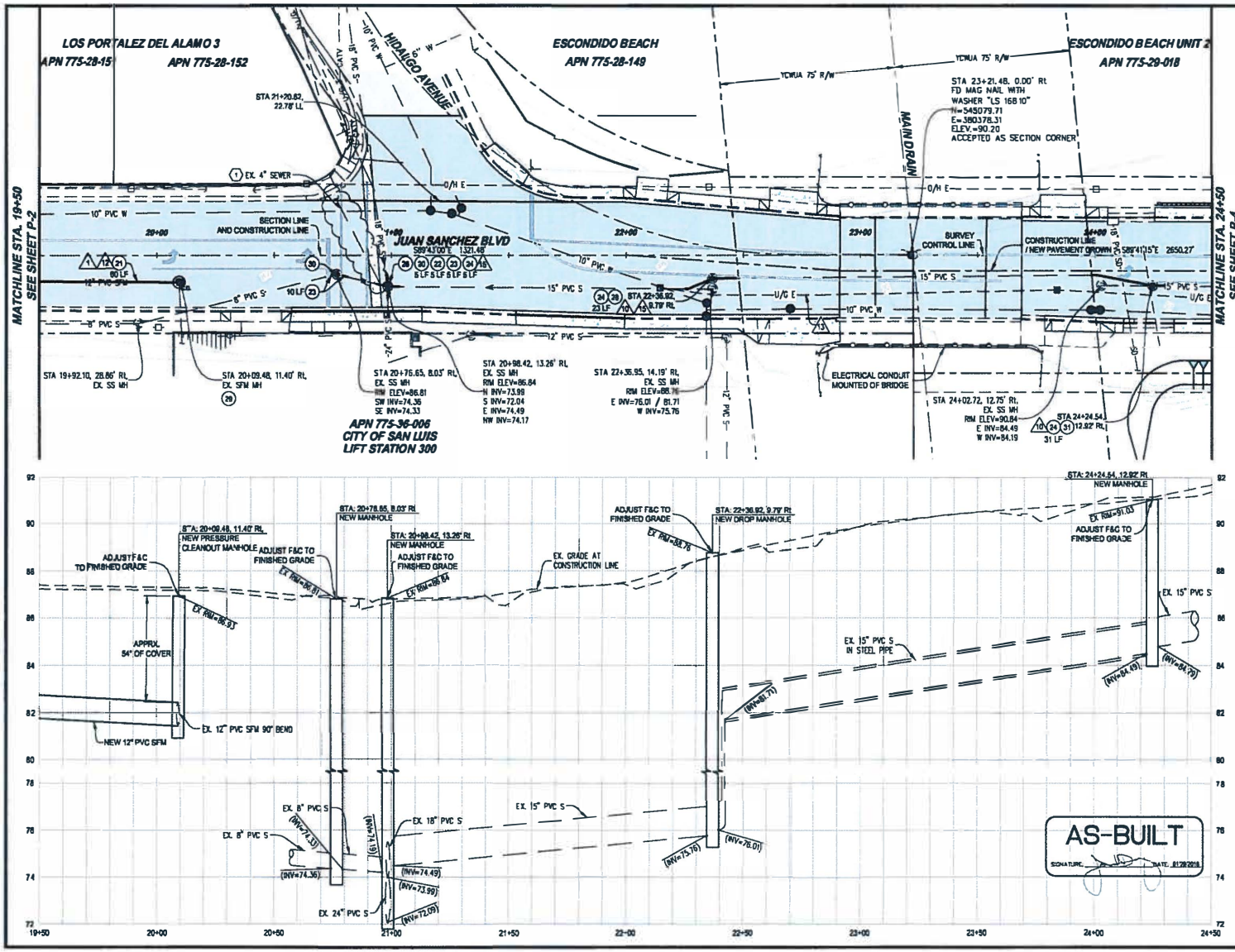
JAMES DAVEY AND ASSOCIATES
CONSULTING CIVIL ENGINEERS
1026 W. 24th Street, Ste. #2 - YUMA, AZ 85364 - (928) 782-7926

CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

SEWER PLAN AND PROFILE STA 14+50 TO STA 19+50

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY: T.S.
DRAWN BY: O.J.Z.
APPROVED BY: J.V.D.
SHEETS-2
APRIL 21, 2017



HORIZONTAL SCALE: 1" = 20'
VERTICAL SCALE: 1" = 2'

	CONSTRUCTION NOTES		U/M	QTY
20	24" PVC SDR-35, SEWERMAIN		LF	5
21	12" PVC SDR-35, SEWER FORCEMAIN		LF	60
22	18" PVC SDR-35, SEWERMAIN		LF	5
23	8" PVC SDR-35, SEWERMAIN		LF	15
24	15" PVC SDR-35, SEWER MAIN		LF	59
26	SANITARY SEWER 5'Ø POLYMER MANHOLE		EA	1
28	SANITARY SEWER 5'Ø POLYMER DROP MANHOLE		EA	1
29	SEWER FORCEMAIN PRESSURE CLEANOUT		EA	1
30	SANITARY SEWER 4'Ø POLYMER MANHOLE		EA	1
31	SANITARY SEWER 5'Ø POLYMER MANHOLE		EA	1

GENERAL NOTES

1. CONTRACTOR WILL BE RESPONSIBLE FOR SEWER FLOWS DURING CONSTRUCTION. CONTRACTOR TO COORDINATE SEWER FLOW OUTAGES WITH THE CITY OF SAN LUIS SEWER COLLECTIONS.
2. EXISTING EAST AND WEST SEWERMAIN HORIZONTAL CENTERLINES ARE OFFSET 4.5' APPROXIMATELY.
3. SEWERMAIN, FORCEMAIN, MANHOLE AND PRESSURE CLEANOUT MANHOLE BEDDING AND TRENCH BACKFILL SHALL BE PER DETAIL 3 AND 4 ON SHEET D-1
4. EXISTING UNDER GROUND ELECTRICAL CONDUIT AND CONDUCTORS BETWEEN LIFT STATION #200 AND #300 TO BE RELOCATED BY THE CITY OF SAN LUIS PRIOR TO CONSTRUCTION.
5. CONNECT THE EXISTING VAPEX ODOR CONTROL 2" PVC PIPE TO THE NEW POLYMER MANHOLE.
6. CONTRACTOR SHALL VERIFY THE EXISTING SEWER MANHOLE PIPE INVERTS BEFORE EXCAVATING AND REMOVING THE EXISTING MANHOLES. CONTRACTOR SHALL MODIFY OR MAKE MINOR ADJUSTMENTS TO THE NEW POLYMER MANHOLES FURNISHED BY THE CITY OF SAN LUIS IF NECESSARY FOR A COMPLETE MANHOLE INSTALLATION.

Call all local two full working days before you begin excavation
ARIZONA 811
CSL-19

1 AS-BUILT JANUARY 2018

REV. 1 - MAY 4, 2017

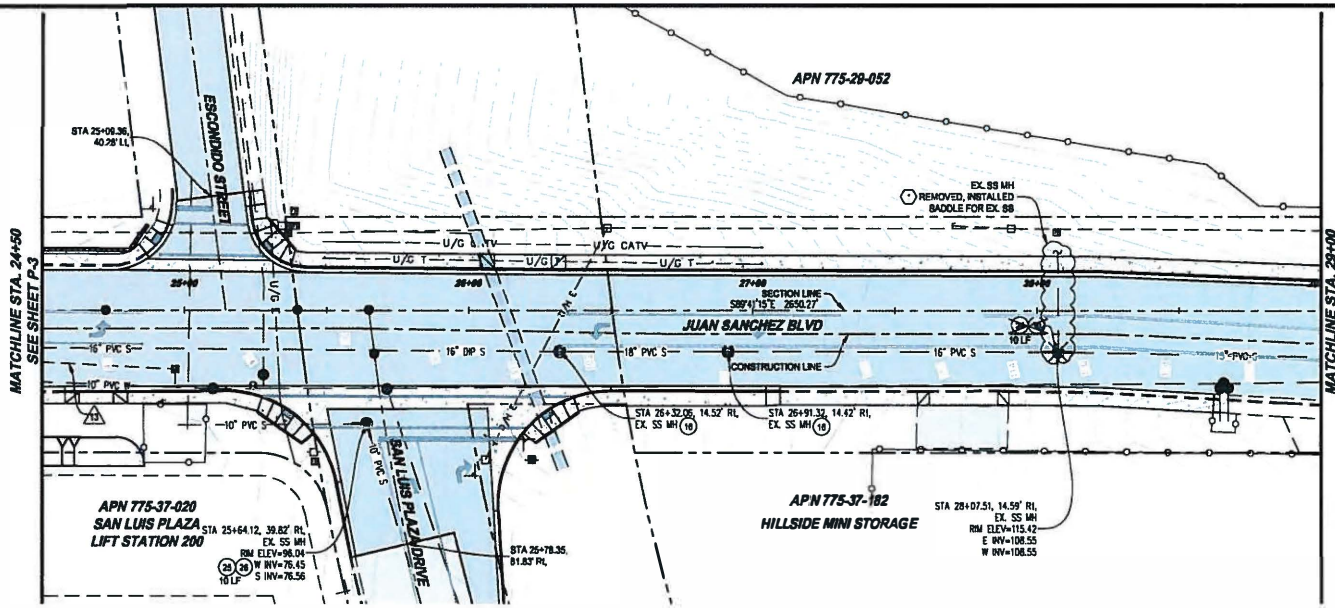
JAMES DAVEY AND ASSOCIATES
CONSULTING CIVIL ENGINEERS
1625 W. 24th Street, Ste. #2 - YUMA, AZ 85364 - (928) 782-7826

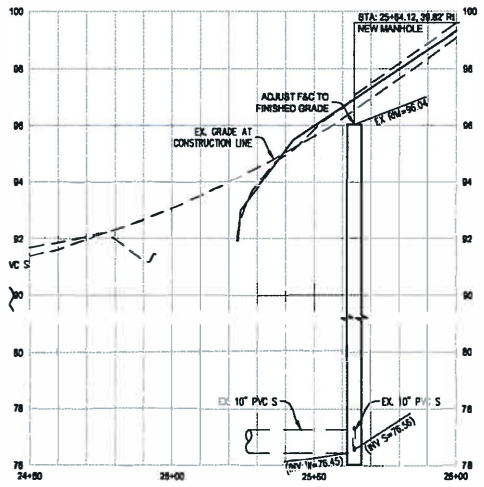
CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

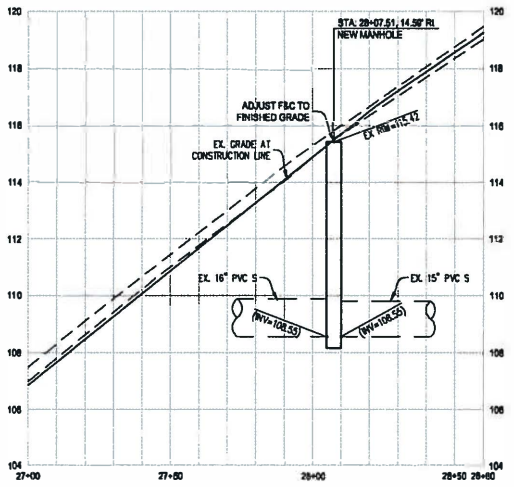
SEWER PLAN AND PROFILE
STA 19+50 TO STA 24+50

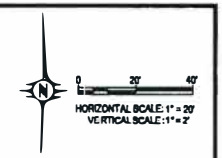
PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY: T.S.
DRAWN BY: O.J.Z.
APPROVED BY: J.V.D.
SHEET 8-3
APRIL 21, 2017









CONSTRUCTION NOTES		UNIT	QTY
18	ADJUST EXISTING MANHOLE WITH NEW FRAME & COVER (CITY OF YUMA STD. 5-025 AND 5-040)	EA	2
34	15" PVC SDR-35, SEWER MAIN	LF	10
75	10" PVC SDR-35, SEWER MAIN	LF	10
26	SANITARY SEWER STD POLYMER MANHOLE	EA	1
35	SANITARY SEWER 4'ID POLYMER MANHOLE	EA	1

AS-BUILT
SIGNATURE _____ DATE: 01/29/2018

GENERAL NOTES	
1	CONTRACTOR WILL BE RESPONSIBLE FOR SEWER FLOWS DURING CONSTRUCTION. CONTRACTOR TO COORDINATE SEWER FLOW OUTAGES WITH THE CITY OF SAN LUIS SEWER COLLECTIONS.
17	S EWER MAIN, FORCEMAIN, MANHOLE AND PRESSURE CLEANOUT MANHOLE BEDDING AND TRENCH BACKFILL SHALL BE PER DETAIL 3 AND 4 ON SHEET D-1.
21	EXISTING UNDERGROUND ELECTRICAL CONDUIT AND CONDUCTORS BETWEEN LIFT STATION #200 AND #300 TO BE RELOCATED BY THE CITY OF SAN LUIS PRIOR TO CONSTRUCTION.
46	CONTRACTOR SHALL VERIFY THE EXISTING SEWER MANHOLE PIPE INVERTS BEFORE EXCAVATING AND REMOVING THE EXISTING MANHOLES. CONTRACTOR SHALL MODIFY OR MAKE MINOR ADJUSTMENTS TO THE NEW POLYMER MANHOLES FURNISHED BY THE CITY OF SAN LUIS IF NECESSARY FOR A COMPLETE MANHOLE INSTALLATION.

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

CSL-19

1 AS-BUILT JANUARY 2018
REV. 1 - MAY 4, 2017

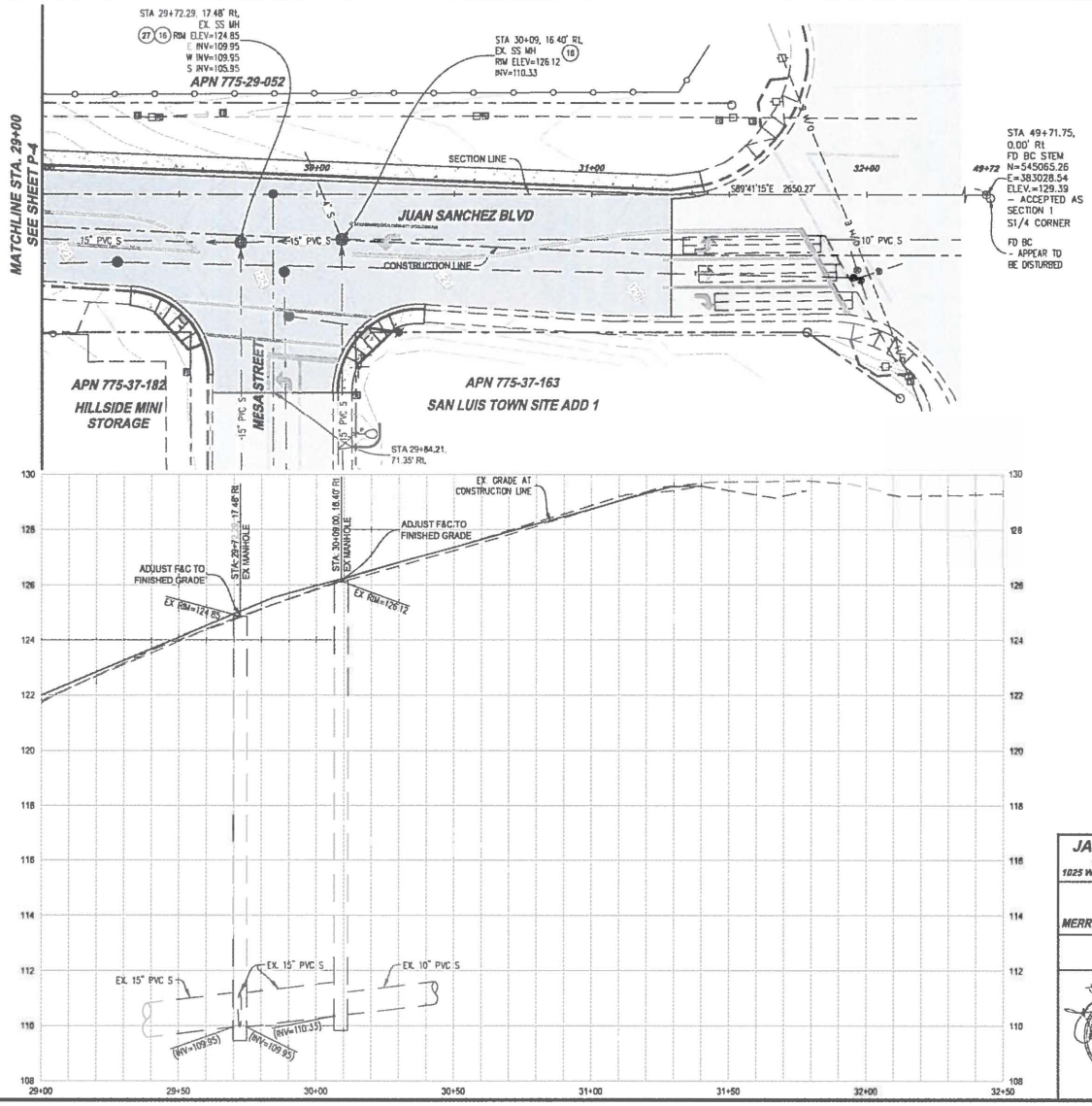
JAMES DAVEY AND ASSOCIATES
CONSULTING CIVIL ENGINEERS
1625 W. 24th Street, Ste. #2 - YUMA, AZ 85364 - (928) 782-7826

CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

SEWER PLAN AND PROFILE
STA 24+50 TO STA 29+00

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY: T.S.	
DRAWN BY: O.J.Z.	
APPROVED BY: J.V.D.	
SHEET B-4	
APRIL 21, 2017	



HORIZONTAL SCALE: 1" = 20'
VERTICAL SCALE: 1" = 2'

CONSTRUCTION NOTES		U/M	QTY
(16)	ADJUST EXISTING MANHOLE WITH NEW FRAME & COVER (CITY OF YUMA STD. S-029 AND S-040)	EA	2
(27)	REPAIR & SEAL EXISTING SANITARY SEWER MANHOLE BASE (CITY OF YUMA STD. S-029)	EA	1

GENERAL NOTES	
1	CONTRACTOR WILL BE RESPONSIBLE FOR SEWER FLOWS DURING CONSTRUCTION. CONTRACTOR TO COORDINATE SEWER FLOW OUTAGES WITH THE CITY OF SAN LUIS SEWER COLLECTIONS.
2	CONTRACTOR SHALL VERIFY THE EXISTING SEWER MANHOLE PIPE INVERTS BEFORE EXCAVATING AND REMOVING THE EXISTING MANHOLES. CONTRACTOR SHALL MODIFY OR MAKE MINOR ADJUSTMENTS TO THE NEW POLYMER MANHOLES FURNISHED BY THE CITY OF SAN LUIS IF NECESSARY FOR A COMPLETE MANHOLE INSTALLATION.

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ARIZONA 811
Dial 8-1-1 or 1-800-STAKE-IT (782-5348)
In Maricopa County (602) 263-1100

CSL-19

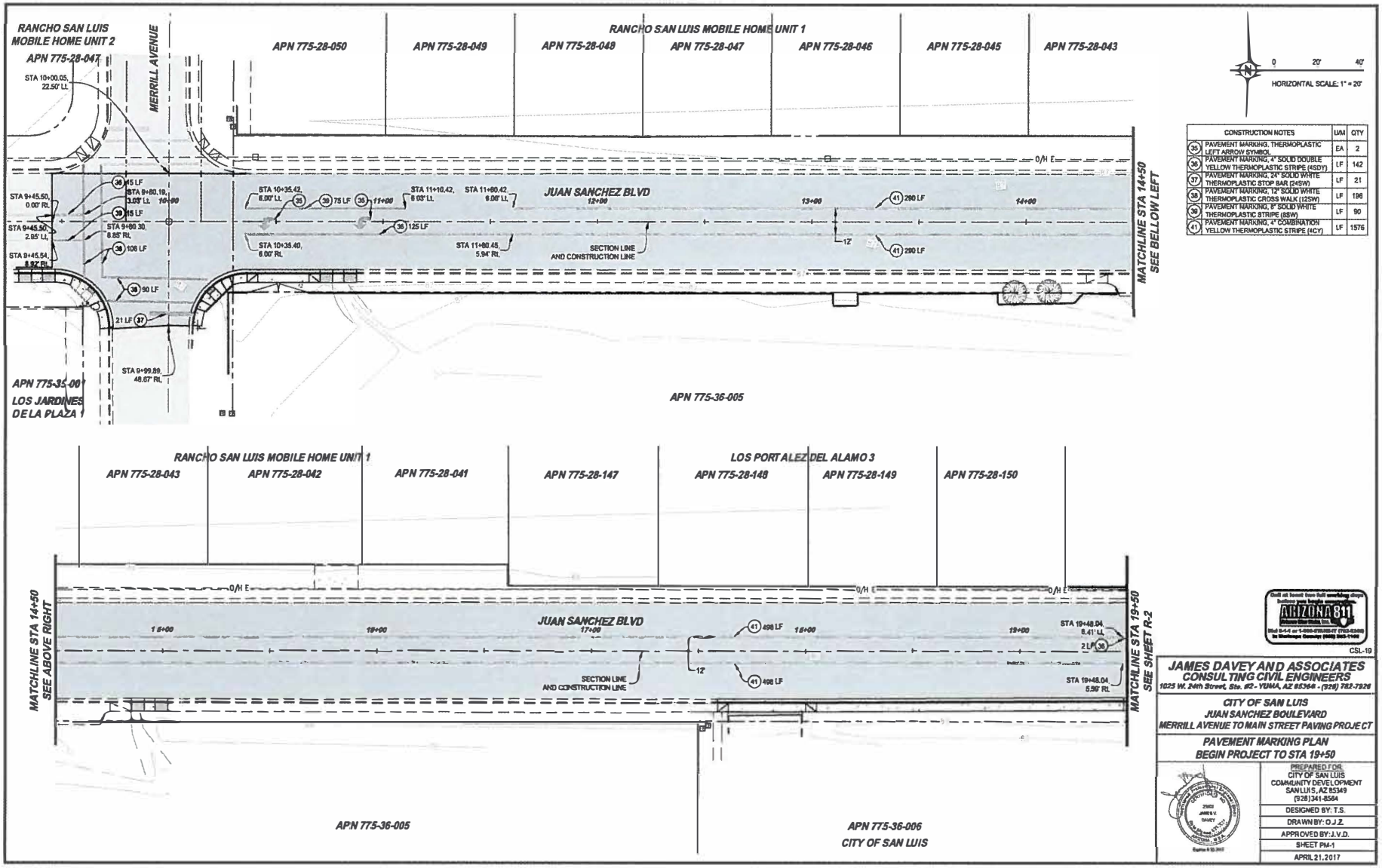
JAMES DAVEY AND ASSOCIATES
CONSULTING CIVIL ENGINEERS
1025 W. 24th Street, Ste. #2 - YUMA, AZ 85364 - (928) 782-7826

CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

SEWER PLAN AND PROFILE
STA 29+00 TO END PROJECT

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY:	T.S.
DRAWN BY:	O.J.Z.
APPROVED BY:	J.V.D.
SHEET	S-5
	APRIL 21, 2017



CONSTRUCTION NOTES		U/M	QTY
35	PAVEMENT MARKING, THERMOPLASTIC LEFT ARROW SYMBOL	EA	2
36	PAVEMENT MARKING, 4" SOLID DOUBLE YELLOW THERMOPLASTIC STRIPE (4SDY)	LF	142
37	PAVEMENT MARKING, 24" SOLID WHITE THERMOPLASTIC STOP BAR (24SW)	LF	21
38	PAVEMENT MARKING, 12" SOLID WHITE THERMOPLASTIC CROSS WALK (12SW)	LF	196
39	PAVEMENT MARKING, 8" SOLID WHITE THERMOPLASTIC STRIPE (8SW)	LF	90
41	PAVEMENT MARKING, 4" COMBINATION YELLOW THERMOPLASTIC STRIPE (4CY)	LF	1576

CSL-19

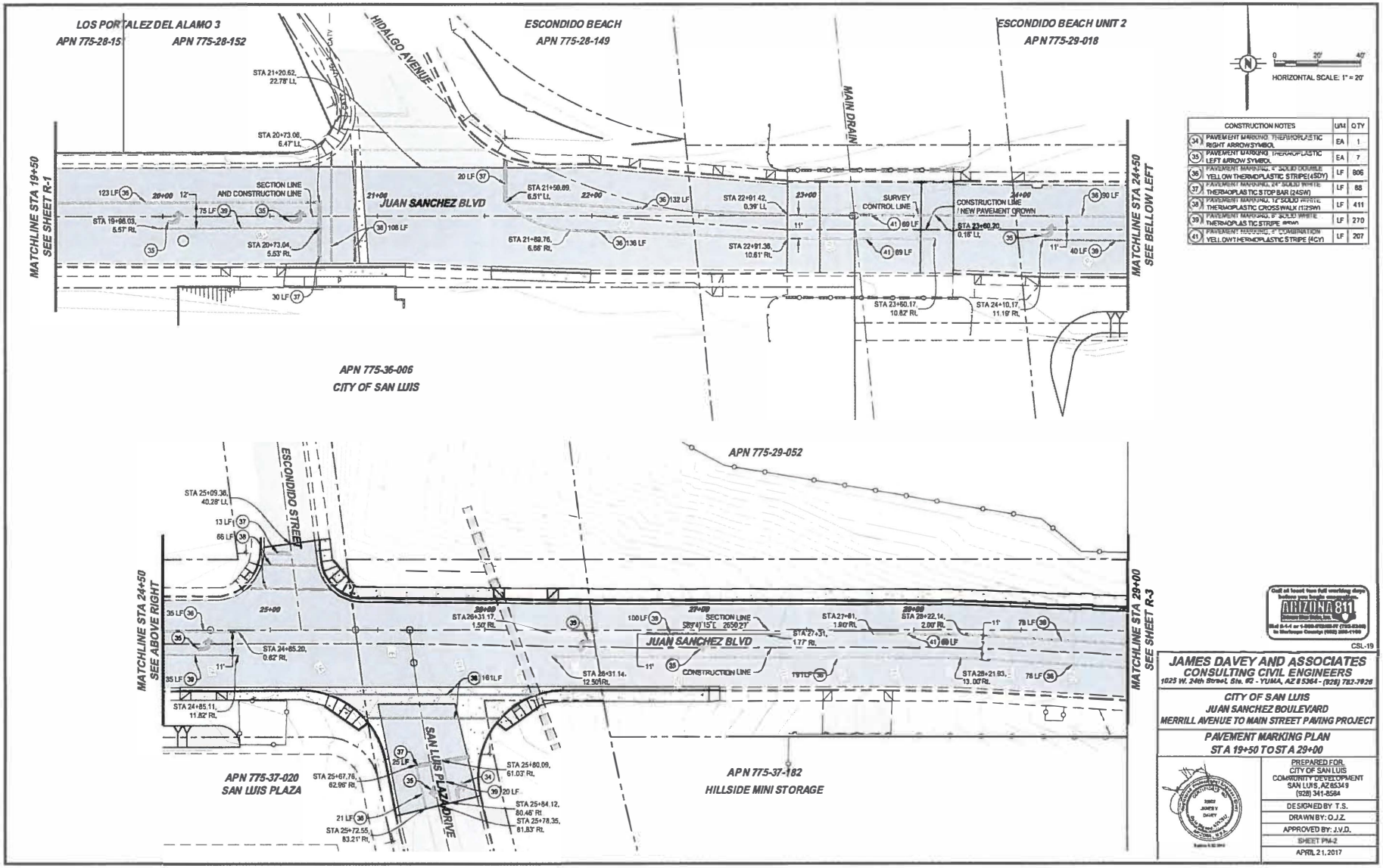
JAMES DAVEY AND ASSOCIATES
CONSULTING CIVIL ENGINEERS
1025 W. 24th Street, Ste. #2 - YUMA, AZ 85364 - (928) 782-7926

CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

PAVEMENT MARKING PLAN
BEGIN PROJECT TO STA 19+50

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928)341-8564

DESIGNED BY: T.S.	
DRAWN BY: O.J.Z.	
APPROVED BY: J.V.D.	
SHEET PM-1	
APRIL 21, 2017	



CONSTRUCTION NOTES	U/M	QTY
(34) PAVEMENT MARKING, THERMOPLASTIC RIGHT ARROW SYMBOL	EA	1
(35) PAVEMENT MARKING THERMOPLASTIC LEFT ARROW SYMBOL	EA	7
(36) PAVEMENT MARKING, 6" SOLID DOUBLE YELLOW THERMOPLASTIC STRIPE(4SDY)	LF	806
(37) PAVEMENT MARKING, 24" SOLID WHITE THERMOPLASTIC STOP BAR (24SW)	LF	88
(38) PAVEMENT MARKING, 12" SOLID WHITE THERMOPLASTIC CROSSWALK (12SW)	LF	411
(39) PAVEMENT MARKING, 6" SOLID WHITE THERMOPLASTIC STRIPE (6SW)	LF	270
(41) PAVEMENT MARKING, 4" COMBINATION YELLOW THERMOPLASTIC STRIPE (4CY)	LF	207

Call at least two full working days before you begin excavation
ARIZONA 811
CSL-19

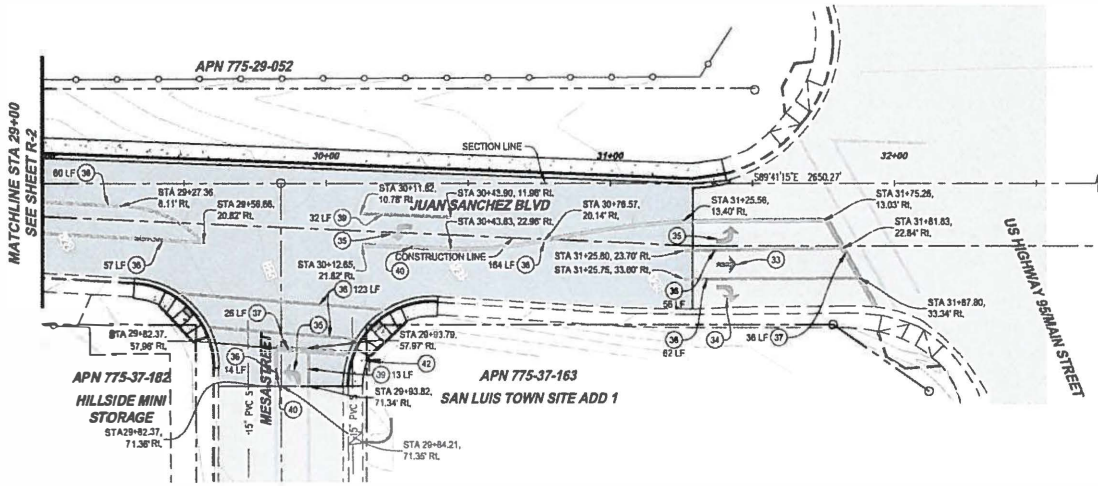
JAMES DAVEY AND ASSOCIATES
CONSULTING CIVIL ENGINEERS
1025 W. 24th Street, Ste. #2 - YUMA, AZ 85364 - (928) 782-7926

CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

PAVEMENT MARKING PLAN
STA 19+50 TO STA 29+00

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY:	T.S.
DRAWN BY:	O.J.Z.
APPROVED BY:	J.V.D.
SHEET PM-2	
APRIL 21, 2017	



N

0 20' 40'

HORIZONTAL SCALE: 1" = 20'

	CONSTRUCTION NOTES	U/M	QTY
33	PAVEMENT MARKING, THERMOPLASTIC THRU ARROW SYMBOL	EA	1
34	PAVEMENT MARKING, THERMOPLASTIC RIGHT ARROW SYMBOL	EA	1
35	PAVEMENT MARKING, THERMOPLASTIC LEFT ARROW SYMBOL	EA	3
36	PAVEMENT MARKING, 4" SOLID DOUBLE YELLOW THERMOPLASTIC STRIPE (4SD(Y)	LF	413
37	PAVEMENT MARKING, 24" SOLID WHITE THERMOPLASTIC STOP BAR (24S(W)	LF	62
38	PAVEMENT MARKING, 12" SOLID WHITE THERMOPLASTIC CROSS WALK (12S(W)	LF	123
39	PAVEMENT MARKING, 8" SOLID WHITE THERMOPLASTIC STRIPE (8S(W)	LF	45
40	RAISED PAVEMENT MARKER, TYPE FRM (BLUE, TWO WAY, REFLECTIVE)	EA	2
42	RELOCATED EXISTING STREET SIGN	EA	1

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

CSL-19

JAMES DAVEY AND ASSOCIATES
CONSULTING CIVIL ENGINEERS
1025 W. 24th Street, Ste. #2 - YUMA, AZ 85364 - (928) 782-7926

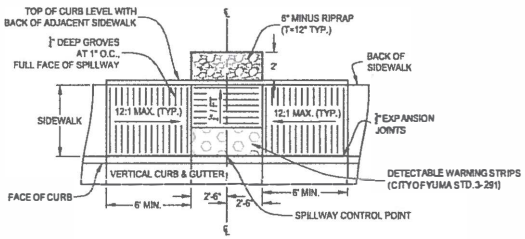
CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

PAVEMENT MARKING PLAN
STA 29+00 TO END PROJECT

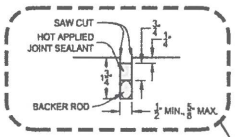
JAMES V. DAVEY
Expires 6-30-2017

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928)341-8504

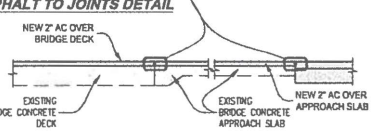
DESIGNED BY: T.S.
DRAWN BY: O.J.Z.
APPROVED BY: J.V.D.
SHEET PM-3
APRIL 21, 2017



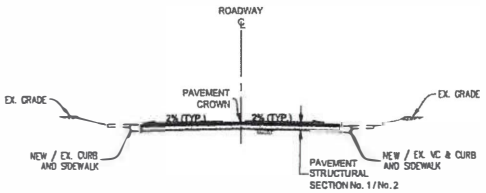
1 STROM DRAIN SPILLWAY DEPRESSED SIDEWALK DETAIL
SCALE: NTS



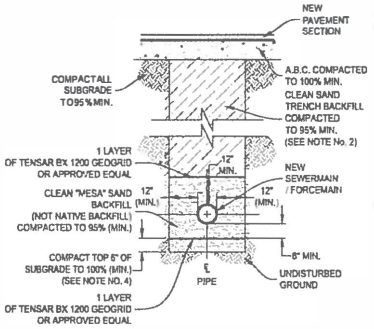
ASPHALT TO JOINTS DETAIL



2 BRIDGE EXPANSION JOINTS DETAIL
SCALE: NTS



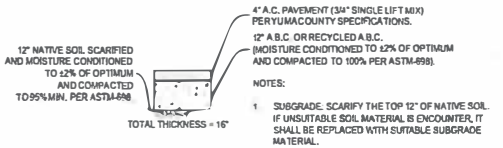
TYPICAL CROSS SECTION
NTS



3 SEWER MAIN AND FORCEMAIN TRENCH BACKFILL
SCALE: NTS

NOTES:

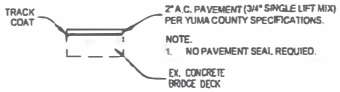
1. DITCH SIDES SHALL BE SLOPED OR SHORED AS REQUIRED PER O.S.H.A. STANDARDS.
2. NATIVE SOIL MAY BE USED FOR BACKFILL WHEN APPROVED BY THE ENGINEER. SHOULD CLAYEY SOIL WITH A PI GREATER THAN 2 BE ENCOUNTERED THE CONTRACTOR SHALL REMOVE SUCH SOIL AND IMPORT CLEAN NON-PLASTIC "MESA" SAND
3. TENSAR BX 1200 GEOGRID, OR AN APPROVED EQUIVALENT, SHALL BE PLACE THE ENTIRE WIDTH OF THE SEWER MAIN AND MANHOLE TRENCH EXCAVATION.
4. SUBGRADE SHALL BE NON-PLASTIC SOIL. IF SOILS WITH PLASTICITY AR E ENCOUNTERED, THE CONTRACTOR SHALL OVER EXCAVATE 6" MIN. AND RECOMPACT WITH CLEAN NON-PLASTIC "MESA" SAND.



NOTES:

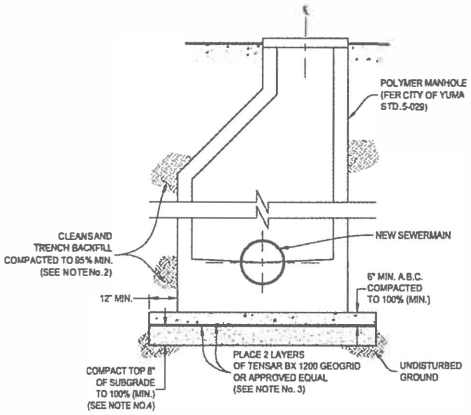
1. SUBGRADE. SCARIFY THE TOP 12" OF NATIVE SOIL. IF UNSUITABLE SOIL MATERIAL IS ENCOUNTER, IT SHALL BE REPLACED WITH SUITABLE SUBGRADE MATERIAL.
2. RECYCLED A.B.C. WILL BE ACCEPTED IN LIEU OF NEW A.B.C. PROVIDED THE RECYCLED A.B.C. MEETS YUMA COUNTY STANDARD 702 - TABLE 702 AND IS ON YUMA COUNTY DDS LATEST APPROVED MIX DESIGN LIST.
3. NO PAVEMENT SEAL REQUIED.

PAVEMENT STRUCTURAL SECTION No. 1
NTS



NOTE.
1. NO PAVEMENT SEAL REQUIED.

PAVEMENT STRUCTURAL SECTION No. 2
NTS



4 MANHOLE TRENCH BACKFILL
SCALE: NTS

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

CSL-19

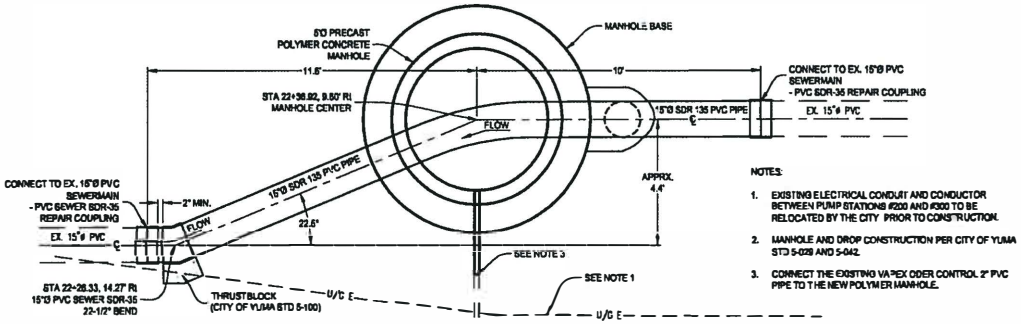
JAMES DAVEY AND ASSOCIATES
CONSULTING CIVIL ENGINEERS
1025 W. 24th Street, Ste. #2 - YUMA, AZ 85364 - (928) 783-7926

CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

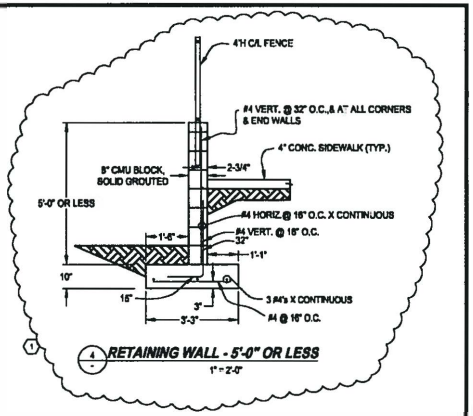
DETAILS

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

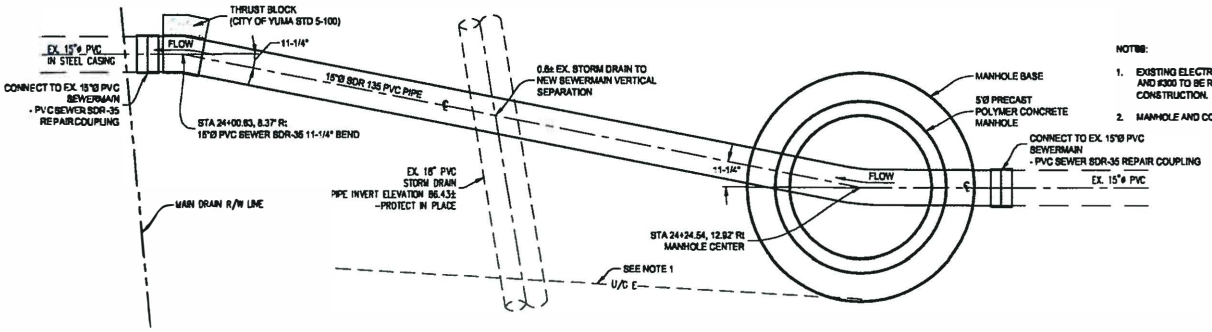
DESIGNED BY: T.S.	
DRAWN BY: O.J.Z.	
APPROVED BY: J.V.D.	
SHEET D-1	
APRIL 21, 2017	



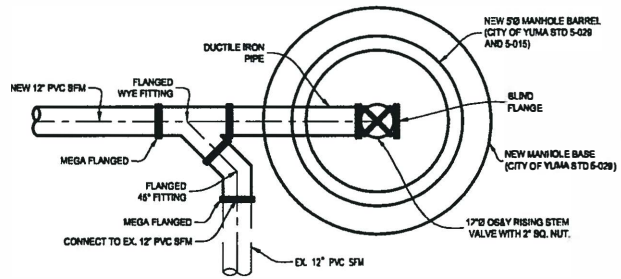
1 - SANITARY SEWER 5'Ø POLYMER DROP MANHOLE DETAIL
SCALE: NTS

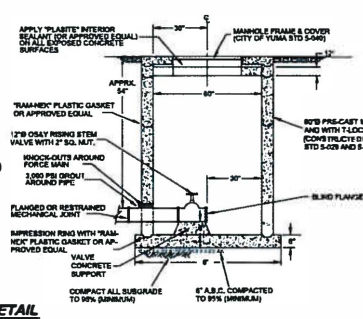


1 - 4 - RETAINING WALL - 5'-0" OR LESS
1" = 1'-0"



2 - SANITARY SEWER 5'Ø POLYMER MANHOLE DETAIL
SCALE: NTS





NOTES
1. All buried ductile iron pipe must be wrapped with 10 mil (minimum) polyethylene plastic wrap.
2. Emphasis shall be placed on the special hardware necessary for use in a pressure system.
3. There shall be no pipe joints within two feet (2') of a manhole's exterior wall face.
4. All valves & fittings to be epoxy lined and rated for sewer service.

3 - SEWER FORCEMAIN PRESSURE CLEANOUT DETAIL
SCALE: NTS

AS-BUILT
SIGNATURE: _____ DATE: 01/26/2018

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

CSL-19

1 AS-BUILT JANUARY 2018
REV. * - MAY 4, 2017

JAMES DAVEY AND ASSOCIATES
CONSULTING CIVIL ENGINEERS
1623 W. 24th Street, Ste. 22 - YUMA, AZ 85364 - (928) 782-7826

CITY OF SAN LUIS
JUAN SANCHEZ BOULEVARD
MERRILL AVENUE TO MAIN STREET PAVING PROJECT

DETAILS

PREPARED FOR:
CITY OF SAN LUIS
COMMUNITY DEVELOPMENT
SAN LUIS, AZ 85349
(928) 341-8584

DESIGNED BY: T.S.
DRAWN BY: O.J.Z.
APPROVED BY: J.V.D.
SHEET D-2
APRIL 21, 2017

LICENSE NO. **017-22-001**

YUMA COUNTY WATER USERS' ASSOCIATION
P. O. BOX 5775
YUMA, AZ 85366-5775

LICENSE FOR ENCROACHMENT AND CONSTRUCTION, INSTALLATION, OPERATION AND MAINTENANCE OF FACILITIES

LICENSEE: **CITY OF SAN LUIS**

LOCATION: **USBR EAST MAIN CANAL & SNYDER DRAIN RIGHTS-OF-WAY LOCATED IN SECTION 1, TOWNSHIP 11 SOUTH, RANGE 25 WEST, GILA & SALT RIVER BASE & MERIDIAN, YUMA COUNTY, ARIZONA.**

1. Authority.

(a) Pursuant to the provisions of United States Department of the Interior, Bureau of Reclamation (the Bureau), Public Notice No. 77 dated February 12, 1960 (the Public Notice), the Yuma County Water Users' Association (Licensor) licenses the above named Licensee to construct, install, operate and maintain facilities encroaching upon rights-of-way of the United States forming part of the Valley Division of the Yuma Project, a reclamation project constructed under the laws of the United States (the Project), but only in strict compliance with the terms of this license.

(b) The Licensor is not authorized to grant or otherwise dispose of any right, title or interest in any land or interest in land owned by the United States, and this license does not constitute a grant or other disposition of any land or interest in land owned by the United States. Requests involving the granting or other disposition of any right, title or interest in any land or interest in land owned by the United States must be submitted to the Bureau as provided in the Public Notice.

(c) The Encroachment authorized by this license is subject to termination as provided in the Public Notice and in this license.

(d) This license is issued with the understanding that the issuance does not involve a substantial adverse change in any of the Project works transferred to the Licensor under the provisions of the Contract for the Care, Operation and Maintenance of Works of the Valley Division, Yuma Project, No. 176r-671, dated June 15, 1951, between the United States of America and the Licensor.

(e) Upon discovery of archaeological or historical cultural resources in the course of constructing the Encroachment, the Licensee shall cease all activity in the area of the discovery and provide immediate telephone notifications of the discovery to the Licensor by directly contacting the Licensor's Manager at 928-627-8824 and the Bureau Archeologist at 928-343-8567, and also make all reasonable efforts to protect the cultural resources discovered. Activity under the license may resume only after the Bureau has authorized it to continue.

2. Description of Encroachment and Applicable Conditions The encroachment proposed by Licensee (the Encroachment) is described as follows:

(i) **CONSTRUCTION, OPERATION AND MAINTENANCE OF THE EXISTING 4TH AVENUE ROADWAY AND APPURTENANCES, EXISTING 12" WATERMAIN, AND NEW STORM DRAIN WORKS ACROSS THE EAST MAIN CANAL APPROXIMATELY 240' SOUTH OF LAS BRISAS BOULEVARD.**

(ii) **CONSTRUCTION, OPERATION AND MAINTENANCE OF A NEW 24" STORM DRAIN PIPE AND APPURTENANCES ACROSS THE SNYDER SPILLWAY PIPE AND APPURTENANCES (ELECTRICAL/SCADA) PARALLELING THE EAST MAIN CANAL ALONG THE NORTH SIDE JUST WEST OF 4TH AVENUE AND APPROXIMATELY 230' SOUTH OF LAS BRISAS BOULEVARD.**

(iii) **INSTALLATION, OPERATION & MAINTENANCE OF THE STORM DRAIN PIPE AND APPURTENANCES SHALL BE IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF THE "YUMA VALLEY DRAIN SYSTEM AGREEMENT" AS EXECUTED BY THE ASSOCIATION, YUMA COUNTY FLOOD CONTROL DISTRICT AND THE USBR, APPROVED 10/25/91.**

(iv) **BY EXECUTION OF THIS LICENSE, THE LICENSOR AGREES THAT THIS ENCROACHMENT DOES NOT HAVE A SUBSTANTIAL ADVERSE IMPACT ON ANY OF THE PROJECT WORKS AS DEFINED IN SECTION 1. (d). HOWEVER, AS THIS LICENSE INVOLVES A DISCHARGE INTO A PROJECT FACILITY, AN ADVANCE ADDITIONAL WRITTEN APPROVAL BY THE USBR AREA MANAGER IS REQUIRED, WITH SUCH APPROVAL DEEMED APPROVED BY THE AREA MANAGER UNLESS THE SAME IS DISAPPROVED IN WRITING TO THE LICENSOR (WITH A COPY TO THE LICENSEE) WITHIN 45 CALENDAR DAYS AFTER THE DATE IT IS FULLY EXECUTED BY THE LICENSOR.**

(v) **A VARIANCE TO THE ASSOCIATION'S NO PARALLEL ENCROACHMENT WITHIN ASSOCIATION'S RIGHTS-OF-WAY IS HEREBY GRANTED, AS THE ENCROACHMENT WILL NOT HINDER THE ASSOCIATION'S OPERATION AND MAINTENANCE RESPONSIBILITIES.**

THIS VARIANCE IS BY NO MEANS A PRECEDENT FOR ANY FUTURE ENCROACHMENTS AND THIS VARIANCE APPLIES ONLY TO THIS ENCROACHMENT.

(vi) **SECTION 3. (a) EXHIBIT "A" IS DEFINED AS FOLLOWS:**

PLANS PREPARED FOR THE CITY OF SAN LUIS, PREPARED BY DAHL, ROBINS & ASSOCIATES, INC., TITLED "CDB VALLEY VIEW APARTMENTS, STAMPED AND SIGNED BY KEVIN A. DAHL ON 03/08/22, SHEETS C2.1-C2.5, C3.1-C3.3.

3. Plans, Specifications; Construction and Inspection.

(a) All structures constructed under this license shall be erected in accordance with plans and specifications approved in writing in advance by Licensor. The approved plans and specifications for the Encroachment contemplated by this license are attached as Exhibit "A" and are incorporated by reference into the terms of this license (the Approved Plans). Any proposed deviation in construction or operations from the Approved Plans must be approved by Licensor in advance in writing before construction or operation of the Encroachment.

(b) All construction shall be completed in a manner so as not to obstruct in any way the flow of water in any canals, laterals, or drain ditches of the Project, or to interfere in any way with the construction, operation and maintenance of any part of the Project by the Licensor or the Bureau.

(c) Within **Sixty** (**60**) calendar days after completion of the Encroachment, Licensee shall submit two (2) copies of as-built drawings to the Licensor. The Licensor shall provide one (1) copy of the as-built drawings, with a cover letter of transmittal, to the Bureau and provide a copy to any other party or entity associated with the Encroachment as determined by the Licensor. As-built drawings are required even in cases where Licensee claims that there have been no changes from the Approved Plans.

(d) Upon receipt of the as-built drawings, the Licensor shall conduct an inspection of the Encroachment to verify that the Encroachment conforms to the as-built drawings and that the as-built drawings conform to the Approved Plans. If the Licensor determines that the Encroachment, as built, does not comply with the Approved Plans,

the Licensee shall, at Licensee's expense, immediately make such changes to the Encroachment as are necessary to make the Encroachment conform to the Approved Plans.

(e) Licensee shall provide Licensor with two (2) working days advance notification before the commencement of construction of Encroachment and any preliminary activity connected with the construction of the Encroachment.

(f) If Licensee does not commence work on the construction of the Encroachment within one (1) year from the date this license is issued, the license shall automatically expire unless extended by the Licensor in writing.

4. Administrative and Inspection Fees.

(a) Licensee shall pay the Licensor, upon submission of its application for the Encroachment, an all inclusive, non-refundable administrative fee of Two Hundred Fifty and No/100 Dollars ($250.00) per encroachment per location.

(b) In addition to the fees required by paragraph 4(a), the Licensee shall reimburse the Licensor all costs incurred by the Licensor in inspecting the Encroachment during and after construction and all costs incurred by the Licensor in causing any changes to the Encroachment necessary to bring the final construction of the Encroachment into accord with the Approved Plans. Licensor's inspection costs will be billed at Licensor's actual costs within forty-five (45) days of completion of the inspection and are due and payable within thirty (30) days after receipt by Licensee of a billing from Licensor.

5. Termination.

(a) As provided in the Public Notice, this license is subject to termination by the Licensor or the Bureau on thirty (30) days notice. Licensor agrees, however, that, except in the case of emergencies, or in cases where Licensor is requested or directed by the Bureau for an earlier termination of the license, or in cases where the Licensee is in default under any term or provision of this license, Licensor will not terminate this license on less than six (6) months prior written notice to the Licensee.

(b) If the Licensee is subject to the provisions of ARS 38-511, the provision of ARS 38-511 shall apply to this license.

(c) On termination of the license, the Licensee shall remove the Encroachment within one hundred eighty (180) days after the date of notice of termination and shall return the rights-of-way affected by this license to their original condition, or a condition acceptable to the Licensor and the Bureau, at Licensee's sole expense and at no expense to the Licensor or the Bureau. If Licensee fails to remove the Encroachment, Licensor may, without liability to Licensee and without further notice to Licensee, remove the Encroachment and charge the Licensee for the cost of

removing the Encroachment and restoring the rights-of-way to their original condition. Payment to the Licensor is due within thirty (30) days after receipt of a statement of the costs incurred by Licensor in the removal of the Encroachment and restoration of the rights-of-way.

6. Increased Operation and Maintenance Expenses. If the construction and placement of the Encroachment increases the cost to Licensor, or its successors, of operation and maintenance functions on the rights-of-way that are affected by the Encroachment, the amount of any increase shall be paid by the Licensee. The amount of any increased operation and maintenance expense charged to the Licensee under this paragraph shall be determined by the Licensor in the Licensor's reasonable discretion. Any dispute between Licensor and Licensee as to the appropriateness or amount of any claimed increase in operation and maintenance charges claimed by the Licensor shall be resolved by the Area Manager. The determination of the Area Manager shall be conclusive and binding upon both parties and shall not be subject to review by any other person, entity or court.

7. Maintenance of Encroachment; Repairs to Damage.

(a) Maintenance of the Encroachment is the complete responsibility of the Licensee. If Licensee fails to perform proper maintenance of the Encroachment within fifteen (15) days after receipt of notice from the Licensor, either orally or in writing, of necessary maintenance to the Encroachment, the Licensor may, but is not obligated to, perform the necessary maintenance and bill Licensee for its costs incurred. Payment to the Licensor is due within thirty (30) days after receipt of statement of the costs incurred by Licensor in performing the necessary maintenance.

(b) If the Encroachment is damaged by the Licensor in the course of performing maintenance and operations on any right-of-way in the Project, the cost of repairing the Encroachment shall be paid by the Licensee unless, and only unless, the damage was caused by the gross (not ordinary) negligence of the Licensor or as a consequence of the Licensor's intentional wrongdoing.

8. Hold Harmless and Indemnification.

(a) To the maximum extent permitted by law, the Licensee agrees to hold forever harmless, indemnify and defend the Licensor and the Bureau, together with all of their respective officers, employees, successors and assigns from and against any and all claims related to or in any way connected with the construction, operation or maintenance of the Encroachment. The Licensee's obligation includes, but is not limited to, the obligation to pay Licensor and the Bureau's attorney fees and costs incurred in connection with any claim whether or not litigation is commenced.

(b) If the Licensee contracts with or employs independent contractors to perform any of the construction of the Encroachment or otherwise provide services to the Licensee in connection with this license, the Licensee agrees to indemnify, defend

and hold the Licensor and the Bureau forever harmless against any and all claims or demands of any nature whatsoever arising out of or in any way connected with the independent contractors retained by Licensee.

9. Covenant Against Contingent Fees. The Licensee warrants that no person or agency has been employed or retained to solicit or secure this license upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial agencies maintained by the Licensee for the purpose of securing business.

10. Assignment and Sublicenses.

(a) The Licensee may not, without the prior written consent of Licensor and the Bureau, assign, sublease or otherwise transfer any interest under this license to any other person or entity. The Licensee may not authorize or permit others to utilize any facility or structure or rights-of-way area which are the subject matter of this license except as expressly authorized by this license or by the Licensor and the Bureau in writing.

(b) If any assignment or sublicense is approved by the Licensor and the Bureau, all of the terms and conditions of this license shall be binding upon the successors and assigns of the Licensee to the full extent those terms and conditions were binding on the Licensee prior to the assignment or sublicense.

(c) For purposes of this license, an annexation of the Encroachment area by any governmental entity from another governmental entity shall constitute an assignment of this license to the annexing governmental entity and the annexing governmental entity shall be bound by all of its terms and conditions to the same extent as the Licensee for so long as the Encroachment remains in place.

11. Disputes, Jurisdiction, Venue and Attorney Fees.

(a) Any action between Licensor and Licensee to interpret or enforce any term of this license shall be commenced and concluded in the Superior Court of the State of Arizona, in Yuma County, Arizona, and not elsewhere. Licensee submits itself to the personal jurisdiction of the Superior Court and waives any objection to venue in Yuma County, Arizona.

(b) In any action to enforce or interpret this license, the prevailing party shall be entitled to recover that party's reasonable attorney fees and costs in an amount fixed by the Court or arbitrator, as the case may be.

IN WITNESS WHEREOF, the parties have signed this License for Encroachment on the dates shown below to be effective as of 3-21-22.

Licensee: **CITY OF SAN LUIS**

s/ _____

By: Lizandro "Louie" Galaviz

Title: Interim City of San Luis Manager

Dated: 3/17/2022

PO Box 1170
San Luis, AZ 85349
Address
928-722-7399
Phone

Approved: **YUMA COUNTY WATER USERS' ASSOCIATION**

s/ _____

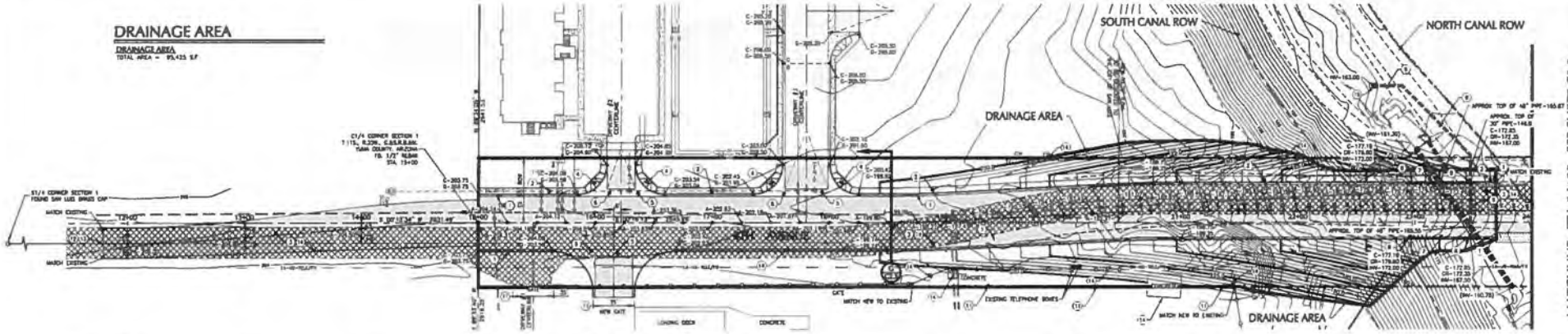
Name: Tom W. Davis

Title: Manager

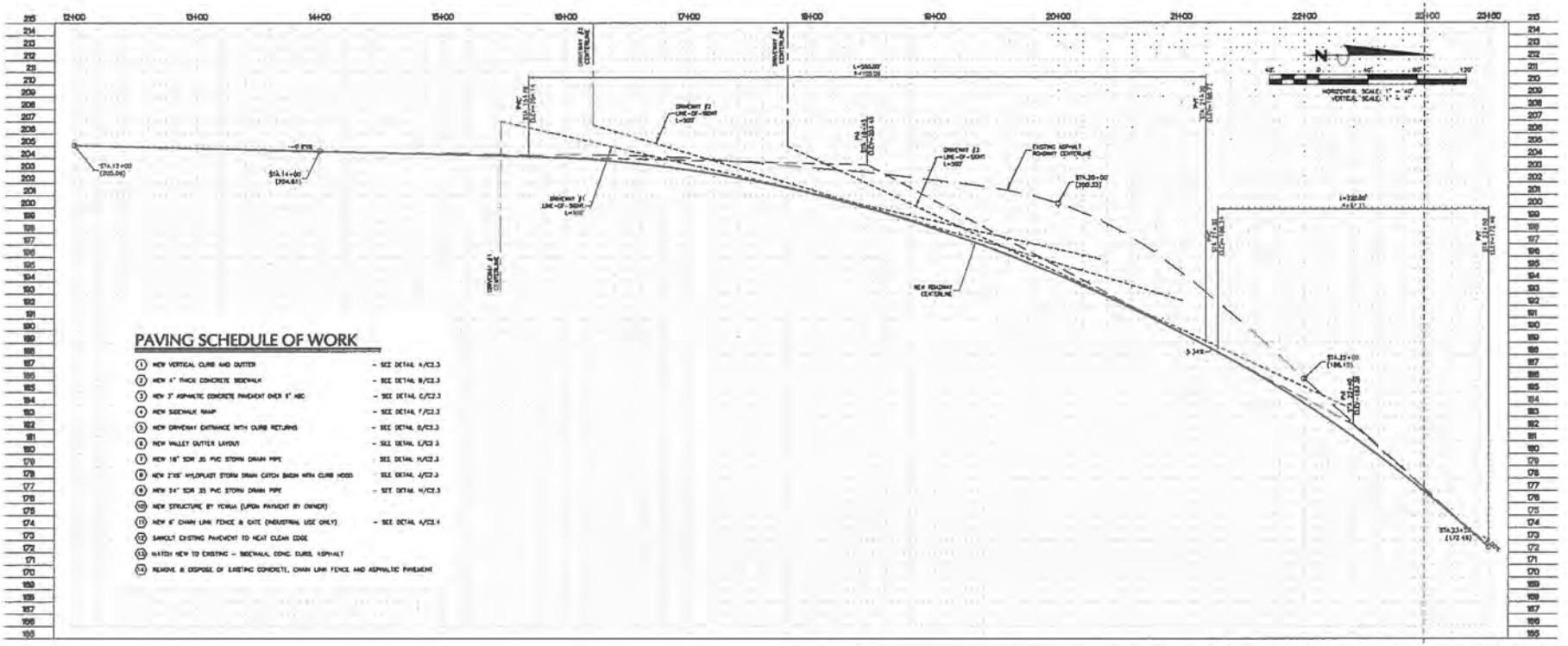
Dated: 3-21-22

DRAINAGE AREA

DRAINAGE AREA
TOTAL AREA = 93,425 S.F.



MATCHLINE - STA 24+00 - SEE SHEET C2.2



PAVING SCHEDULE OF WORK

(1)	NEW VERTICAL CURB AND GUTTER	- SEE DETAIL A/C2.3
(2)	NEW 4" THICK CONCRETE SIDEWALK	- SEE DETAIL B/C2.3
(3)	NEW 3" ASPHALTIC CONCRETE PAVEMENT OVER 8" ABC	- SEE DETAIL C/C2.3
(4)	NEW SIDEWALK RAMP	- SEE DETAIL F/C2.3
(5)	NEW DRIVEWAY ENTRANCE WITH CURB RETURNS	- SEE DETAIL D/C2.3
(6)	NEW VALLEY GUTTER LAYOUT	- SEE DETAIL E/C2.3
(7)	NEW 18" SDR 35 PVC STORM DRAIN PIPE	- SEE DETAIL H/C2.3
(8)	NEW 2'X6" NYLOPLAST STORM DRAIN CATCH BASIN WITH CURB HOOD	- SEE DETAIL J/C2.3
(9)	NEW 24" SDR 35 PVC STORM DRAIN PIPE	- SEE DETAIL H/C2.3
(10)	NEW STRUCTURE BY YUMA (UPON PAVMENT BY OWNER)	
(11)	NEW 6' CHAIN LINK FENCE & GATE (INDUSTRIAL USE ONLY)	- SEE DETAIL K/C2.4
(12)	SAWCUT EXISTING PAVEMENT TO NEAT CLEAN EDGE	
(13)	MATCH NEW TO EXISTING - SIDEWALK, CONC. CURB, ASPHALT	
(14)	REMOVE & DISPOSE OF EXISTING CONCRETE, CHAIN LINK FENCE AND ASPHALTIC PAVEMENT	

UTILITY WARNING

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.

Arizona811 Call 811 or click Arizona811.com

23218 KEVIN A. DAHL

CDB VALLEY VIEW APARTMENTS

4TH AVENUE IMPROVEMENTS
SAN LUIS, ARIZONA

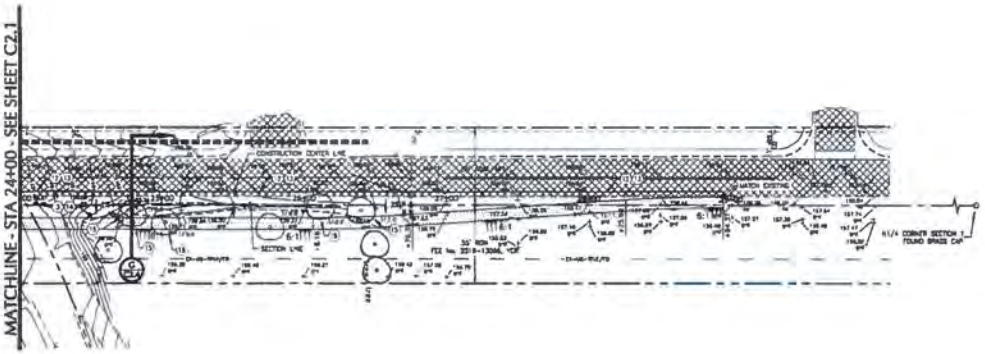
PAVING & GRADING PLAN

DAHL, ROBINS & ASSOCIATES, INC.
1560 S. 8th Avenue
Yuma, AZ 85364
Phone: (928) 819-0825
Fax: (928) 819-0826
www.dahlrobins.com

Z:\Jobs\21\21185\drawings\4th Avenue\21183 4th Avenue Improvements Rev 3 - ABS.dwg 1/6/2022 9:58 AM

DATE	10/5/2021
DESIGNED BY	BAD/KJD
DRAWN BY	VB/MDRA
CHECKED BY	KAD
SURVEYED BY	MAC
PROJECT NO.	21185
SHEET	C2.1

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PAVING SCHEDULE OF WORK

1. NEW VERTICAL CURB AND GUTTER – SEE DETAIL A/C2.1
2. NEW 4" THICK CONCRETE SIDEWALK – SEE DETAIL B/C2.1
3. NEW 3" ASPHALTIC CONCRETE PAVEMENT OVER 6" ABC – SEE DETAIL C/C2.1
4. NEW SIDEWALK RAMP – SEE DETAIL F/C2.1
5. NEW DRIVEWAY ENTRANCE WITH CURB RETURNS – SEE DETAIL D/C2.1
6. NEW VALLEY GUTTER LAYOUT – SEE DETAIL E/C2.1
7. NEW 18" SDR 35 PVC STORM DRAIN PIPE – SEE DETAIL H/C2.1
8. NEW 3'x6' WYLDPLAST STORM DRAIN CATCH BASIN WITH CURB HOOD – SEE DETAIL J/C2.1
9. NEW 24" SDR 35 PVC STORM DRAIN PIPE – SEE DETAIL H/C2.1
10. NEW STRUCTURE BY YCWUA (UPON PAYMENT BY OWNER)
11. NEW 6' CHAIN LINK FENCE & GATE (INDUSTRIAL USE ONLY) – SEE DETAIL K/C2.1
12. SAWCUT EXISTING PAVEMENT TO NEAT CLEAN EDGE.
13. MATCH NEW TO EXISTING – SIDEWALK, CONC. CURB, ASPHALT
14. REMOVE & DISPOSE OF EXISTING CONCRETE, CHAIN LINK FENCE AND ASPHALTIC PAVEMENT.
15. REMOVE & DISPOSE OF EXISTING TREE AND PLANTER.

UTILITY WARNING

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.

Certified Arizona 811 at least two full working days before you begin excavation
ARIZONA811
Call 811 or click Arizona811.com

REGISTERED LAND SURVEYOR
23315
KEVIN A. DAHL
ARIZONA U.S.A.

CDB VALLEY VIEW APARTMENTS

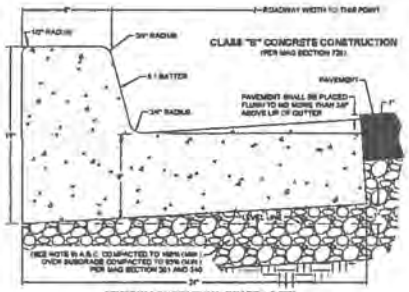
4TH AVENUE IMPROVEMENTS
SAN LUIS, ARIZONA

PAVING & GRADING PLAN

DAHL, ROBINS & ASSOCIATES, INC.
1500 S. 5th Avenue
Yuma, AZ 85364
Phone: (928) 819-0625
Fax: (928) 819-0629
www.dahlrobins.com

DATE	10/5/2021
DESIGNED BY	BM,DRJD
DRAWN BY	V&VIDRA
CHECKED BY	KAD
SURVEYED BY	MAC
PROJECT NO	21185
SHEET	C2.2

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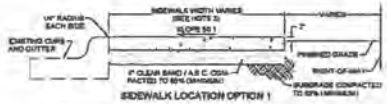


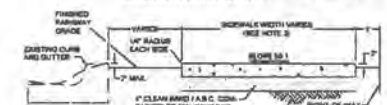
NOTES

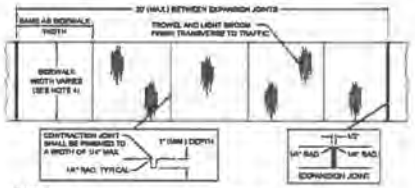
1. Vertical curb & gutter may be constructed by the use of forms or the concrete may be machine extruded.
2. When the pavement slopes away from the gutter, the slope of the gutter shall match the pavement's cross slope. Gutter depression will not be needed.
3. Contraction joint spacing shall be either hand tooled and/or saw cut and shall be placed ten feet (10') apart. Contraction joint shall have a minimum depth of one inch (1").
4. Expansion joint shall be installed at tangent points, in curb returns, at structures and at a max imum of twenty feet (20') intervals. Expansion joint material shall comply with MAG Section 729.
5. Expansion joint material shall be placed in accordance with MAG Section 340.
6. Curb & gutter shall be finished per MAG Section 340. All exposed edges and hand tooled joints shall have a one-quarter inch (1/4") radius unless a larger radius is called for in the construction plans.
7. Vertical curb & gutter shall be used on all city streets unless otherwise approved by the City Engineer.
8. Additional information regarding joint construction can be seen in Standard Detail 3-135
9. ABC thickness per street cross section Standard Details 2-020 to 2-035

VERTICAL CURB AND GUTTER

CITY OF YUMA STANDARD NO. 3-080 — NTS — A / C2.3





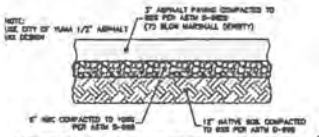


NOTES

1. Expansion joints shall be installed at tangent points, in curb returns, at structures and placed at 20' intervals (maximum). Expansion joint material shall comply with MAG Section 729.
2. Expansion joint material shall be placed in accordance with MAG Section 340.
3. Where the back of the sidewalk abuts a concrete driveway or any other concrete paving or structure, an expansion joint shall be placed between the back of the sidewalk and such driveway or structure.
4. Sidewalk width varies with type of street. See Std. Details 2-010 to 2-025.
5. All sidewalks shall be 4" thick (min.) Class "S" concrete reinforced per MAG Section 725.
6. Sidewalks shall meet MAG Section 340.

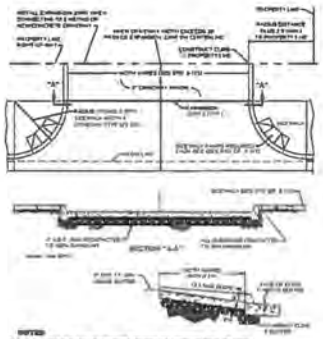
SIDEWALKS

CITY OF YUMA STANDARD NO. 3-100 — NTS — B / C2.3



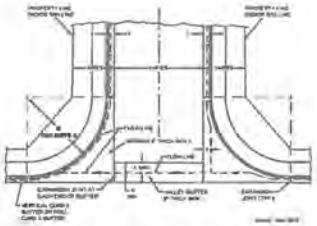
LIGHT DUTY PAVEMENT SECTION

NTS — C / C2.3



DRIVEWAY ENTRANCE WITH CURB RETURNS

CITY OF YUMA STANDARD NO. 3-130 — NTS — D / C2.3



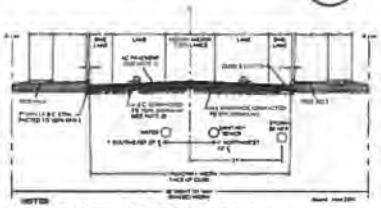
VALLEY GUTTER LAYOUT

CITY OF YUMA STANDARD NO. 3-100 — NTS — E / C2.3



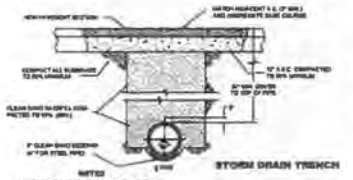
SIDEWALK RAMP

CITY OF YUMA STANDARD NO. 3-110 — NTS — F / C2.3



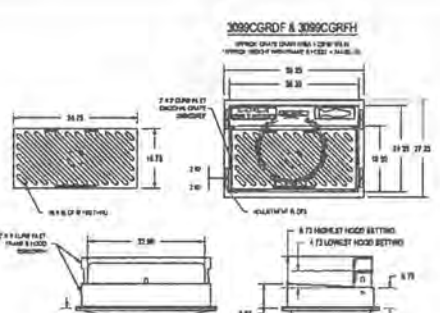
COLLECTOR STREET

CITY OF YUMA STANDARD NO. 3-060 — NTS — G / C2.3



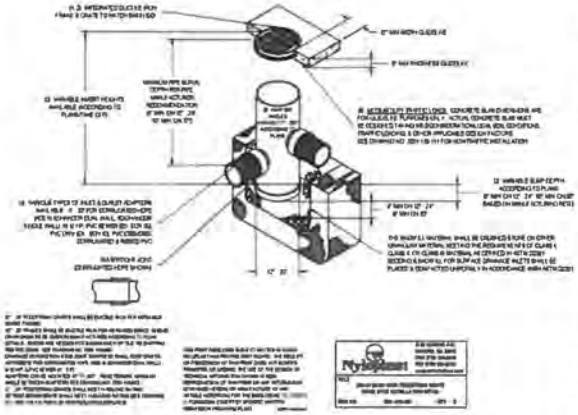
TYP. STORM DRAIN TRENCH BACKFILL

NTS — H / C2.3



INLET GRATE & CURB HOOD

NYLOPLAST DRAIN BASIN WITH PEDESTRIAN GRATE



AREA INLET CATCH BASIN

NTS — J / C2.3

CDB VALLEY VIEW APARTMENTS

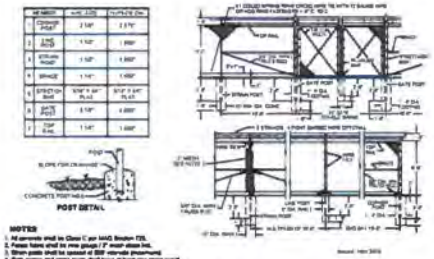
SW CORNER 4TH AVENUE & EAST MAIN CANAL
SAN LUIS, ARIZONA

PAVING DETAILS

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DAHL, ROBINS & ASSOCIATES, INC.

DATE	10/5/2021
DESIGNED BY	BALDWIN
DRAWN BY	VILLEDRA
CHECKED BY	KAD
SURVEYED BY	MAC
PROJECT NO.	21185
SHEET	C2.3

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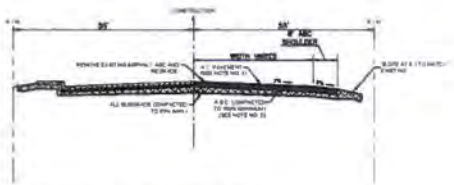


POST DETAIL

NOTES
1. All materials shall be Class C per MAG Section 725.
2. Fence fabric shall be nine gauge / 2" mesh diamond.
3. Chain posts shall be spaced at 500' intervals (maximum).
4. Barb armor and strain posts shall have at least one strain panel.
5. All posts shall be capped and plumb.
6. Fences shall not surround any visibility triangles at offset, driveways and street intersections.
7. If fences built in front yard setbacks shall have a maximum height of three feet (3').
8. Construction and materials shall conform to MAG Sections 725 and 772 respectively.
See MAG Table 772-1 for weight of member

6' CHAIN LINK FENCE & GATE (INDUSTRIAL USE ONLY)

B
C2.4
NTS



NOTES
1. Structural design of completed thickness of base and surface shall be determined by soils test
2. Minimum paving thickness shall be 3" plant hot mixed asphalt surfacing over 6" of A.B.C. compacted to 100% of maximum density as determined by AASHTO T 99 method C or E. See Standard Detail 3-01N for A.B.C. thickness required. A.B.C. shall be per MAG Specifications.
3. Sidewalk location adjacent to curb or as approved by the City Engineer.
4. See Standard Detail 3-02D for grading behind sidewalk.
5. Culvert appliques from source terminals curb & gutter See Standard Detail 3-06D

LOCAL 2 LANE STREET

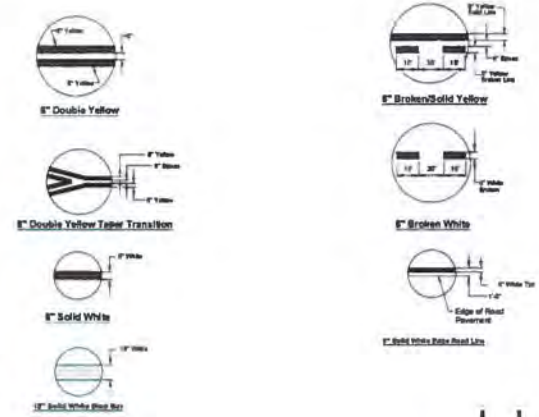
C
C2.4
NTS

PAVEMENT MARKING NOTES:

1. THE CONTRACTOR SHALL BE RESPONSIBLE FOR THE LAYOUT AND INSTALLATION OF PERMANENT PAVEMENT MARKINGS ON THE FINAL SURFACE COURSE, FOLLOWING CONTROL POINTS THAT HAVE BEEN SET NO MORE THAN 30 FEET APART ALONG THE LINES TO BE STRIPED.
2. THE DIMENSIONS SHOWN FOR PAVEMENT STRIPING ARE TO THE CENTER OF THE STRIPING, OR IN THE CASE OF DOUBLE STRIPING TO THE CENTER OF THE DOUBLE STRIPING AND THE FACE OF THE CURB.
3. AT THE COMPLETION OF THE FINAL PAVEMENT SURFACE, CENTER LINES, EDGE LINES AND LANE LINES SHALL BE STRIPED WITH ONE APPLICATION OF STANDARD REFLECTORIZED TRAFFIC PAINT, AT THE LOCATION OF THE PERMANENT STRIPING. THIS APPLICATION SHALL BE PLACED WITHIN 7 DAYS.
4. THE FINAL STRIPING SHALL BE A 0.060 INCH THICKNESS OF HOT-SPRAYED THERMOPLASTIC REFLECTORIZED STRIPING, PLACED BETWEEN 30 AND 60 DAYS AFTER THE INITIAL STRIPING AS DIRECTED BY THE ENGINEER
5. THE CONTRACTOR SHALL CLEAN THE ROADWAY SURFACE TO THE SATISFACTION OF THE ENGINEER, BY SWEEPING AND AIR JET BLOWING, IMMEDIATELY PRIOR TO THE PLACEMENT OF ALL PAVEMENT MARKINGS. THE ROADWAY SURFACE SHALL BE DRY AND THE AIR AND PAVEMENT TEMPERATURES SHALL NOT BE LESS THAN 50 DEGREES F FOR THE PLACEMENT OF THERMOPLASTIC STRIPING.
6. WHEN STRIPE OBLITERATION IS NECESSARY, IT SHALL BE ACCOMPLISHED BY APPROVED METHODS. PAINTING OVER STRIPING DOES NOT CONSTITUTE STRIPE OBLITERATION. TRAFFIC PAINT SHALL BE OBLITERATED BY A METHOD THAT IS IN COMPLIANCE WITH OSHA 29 CFR, PART 1926, LEAD EXPOSURE IN CONSTRUCTION. INTERIM FINAL RULE. SAND BLASTING IS PREFERRED IF LEAD EXPOSURE PREVENTION MEASURES ARE REQUIRED, THE CONTRACTOR SHALL ENSURE THAT ALL PERSONNEL PRESENT ON THE JOB SITE ARE NOTIFIED OF THE ACTIVITY AND ADVISED OF NECESSARY PRECAUTIONS TO BE TAKEN TO AVOID CONTAMINATION BY LEAD COMPOUNDS. THE CONTRACTOR SHALL SUBMIT A LEAD EXPOSURE PREVENTION PLAN TO THE ENGINEER FOR REVIEW, A MINIMUM OF 48 HOURS PRIOR TO THE START OF ANY STRIPING OBLITERATION ACTIVITIES.
7. THE PAVEMENT MARKING DRAWINGS ARE SCHEMATIC ONLY AND NOT TO SCALE. THE CONTRACTOR SHALL FOLLOW ALL DIMENSIONS, DETAILS AND STANDARDS WHEN INSTALLING PAVEMENT STRIPING AND MARKINGS.
8. THE PERMANENT PAVEMENT MARKING PLANS MAY BE MODIFIED AS DIRECTED BY THE ENGINEER
9. ALL PAVEMENT ARROWS AND LEGENDS SHALL BE EXTRUDED THERMOPLASTIC PAVEMENT MARKINGS PER THE SPECIAL PROVISIONS.
10. IT IS THE CONTRACTOR'S RESPONSIBILITY TO ENSURE THAT THE FINAL SURFACE COURSE IS PLACED SO THAT THE STRIPING IS OFFSET ONE FOOT CLEAR OF THE CONSTRUCTION JOINT, UNLESS OTHERWISE DIRECTED BY THE ENGINEER.

SIGNING NOTES:

1. ALL SIGNS SHALL BE IN COMPLIANCE WITH THE LATEST EDITION OF THE MANUAL ON UNIFORM TRAFFIC CONTROL DEVICES (MUTCD), ADOT SIGNING AND MARKING STANDARDS, THE ADOT TRAFFIC ENGINEERING MANUAL OF APPROVED SIGNS, YUMA COUNTY STANDARD PRACTICE, THESE PLANS AND THE SPECIFICATIONS.
2. SIGNING MAY BE MODIFIED AS DIRECTED BY THE ENGINEER.
3. ALL FACE OF BOLTS USED FOR MOUNTING SIGNS SHALL BE PAINTED THE SAME COLOR AS THE SIGN PANEL.
4. ALL STATION LOCATIONS ARE APPROXIMATE. THE CONTRACTOR SHALL VERIFY ACTUAL SIGN LOCATIONS WITH THE ENGINEER PRIOR TO THE INSTALLATION OF ALL SIGNS.
5. ALL SIGNS SHALL BE MADE OF FLAT SHEET ALUMINUM PANELS WITH REFLECTIVE SHEETING AND DIRECT APPLIED CHARACTERS PER SECTIONS 808-2.07 AND 808-2.09 OF THE ADOT STANDARD SPECIFICATIONS.
6. CONTRACTOR SHALL BE RESPONSIBLE FOR SECURING ALL UNDERGROUND UTILITY LOCATIONS WHERE NEW POSTS ARE INSTALLED.
7. NORMAL MOUNTING HEIGHT FOR ALL NEWLY INSTALLED SIGNS SHALL BE 7 FEET MINIMUM ABOVE NEAR EDGE OF PAVEMENT OR TOP OF CURB
8. ALL SIGN POSTS ARE PER YCPW STD 3-390 "U" CHANNEL (3# / FT) POST
9. STREET SIGN BRACKETS TO BE VULCAN MODEL VSB-1/VSI-1UC OR EQUIVALENT AS APPROVED BY THE COUNTY ENGINEER. SIGN BRACKET SLOTS ARE TO BE SIZED FOR EXTRUDED ALUMINUM SIGN BLANKS. SIGN BLANKS ARE TO BE 6"X 24" MINIMUM OF EXTRUDED ALUMINUM. LETTERS ARE TO BE 6" HIGH OF PRISMATIC TYPE 8 GRADE REFLECTIVE WHITE ON PRISMATIC GRADE TYPE 8 REFLECTIVE GREEN BACKGROUND (BOTH SIDES).



PAVEMENT MARKING DETAIL

G
C2.4
NTS

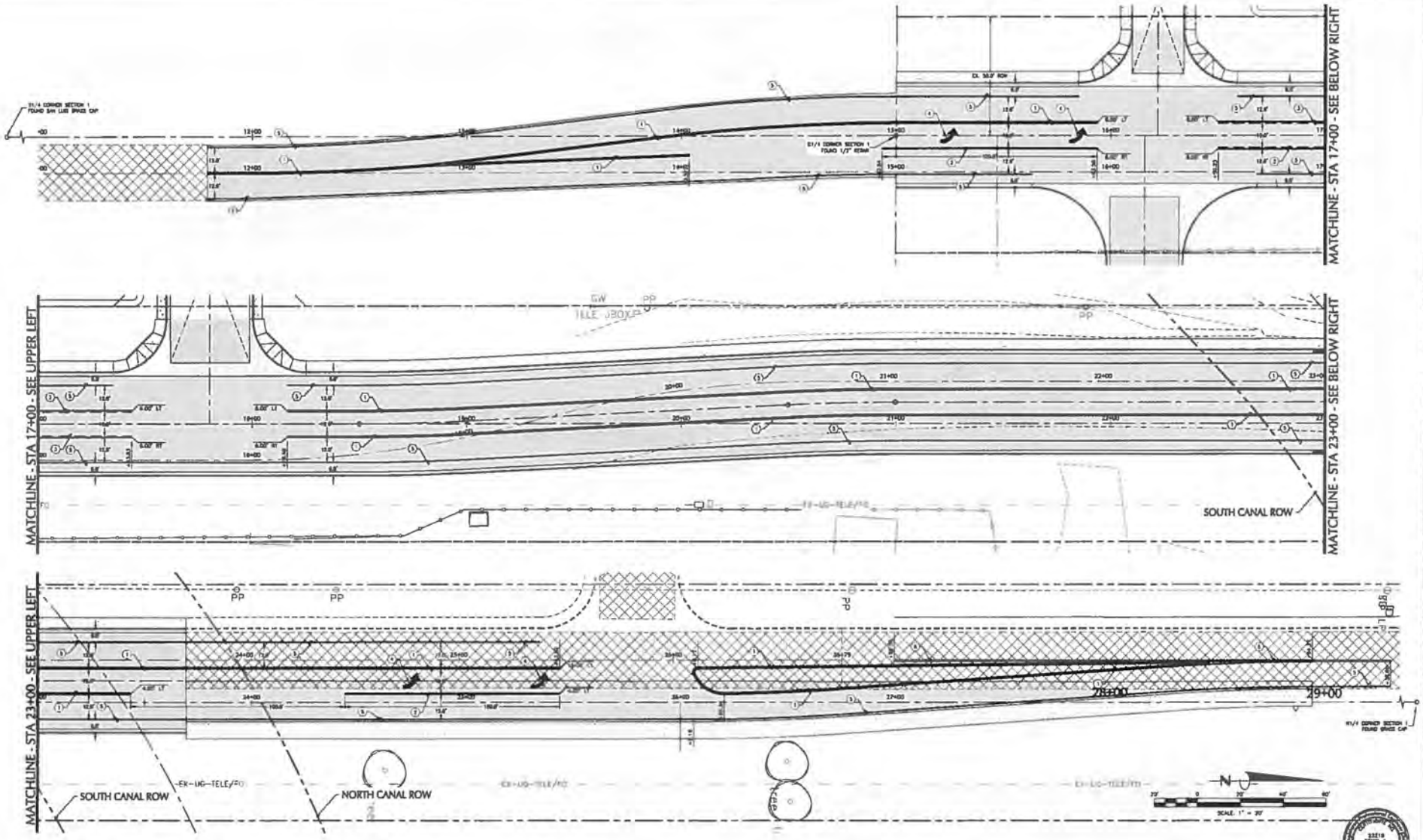
CDB VALLEY VIEW APARTMENTS
SW CORNER 4TH AVENUE & EAST MAIN CANAL
SAN LUIS, ARIZONA

PAVEMENT MARKING / PAVING DETAILS

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3/8/2022 10:07 AM
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DATE	10/5/2021
DESIGNED BY	BK/DJ/KD
DRAWN BY	VB/VD/RA
CHECKED BY	KAD
SURVEYED BY	MAC
PROJECT NO.	21185
SHEET	C2.4

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STRIPING SCHEDULE OF WORK

1. 6" SOLID DOUBLE YELLOW THERMOPLASTIC STRIPE PER COY STANDARD - SEE DETAIL D/C2.3
2. 6" SOLID WHITE THERMOPLASTIC STRIPE PER COY STANDARD - SEE DETAIL D/C2.3
3. 6" COMBINATION YELLOW THERMOPLASTIC STRIPE PER COY STANDARD - SEE DETAIL D/C2.3
4. WHITE PAVEMENT LEGEND ARROW PER COY STANDARD NO. 9-110 - SEE DETAIL D/C2.3
5. 4" SOLID WHITE THERMOPLASTIC STRIPE PER COY STANDARD - SEE DETAIL D/C2.3
6. OBLITERATE EXISTING PAVEMENT MARKING WITH SAND SLURRY MIX

UTILITY WARNING

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.

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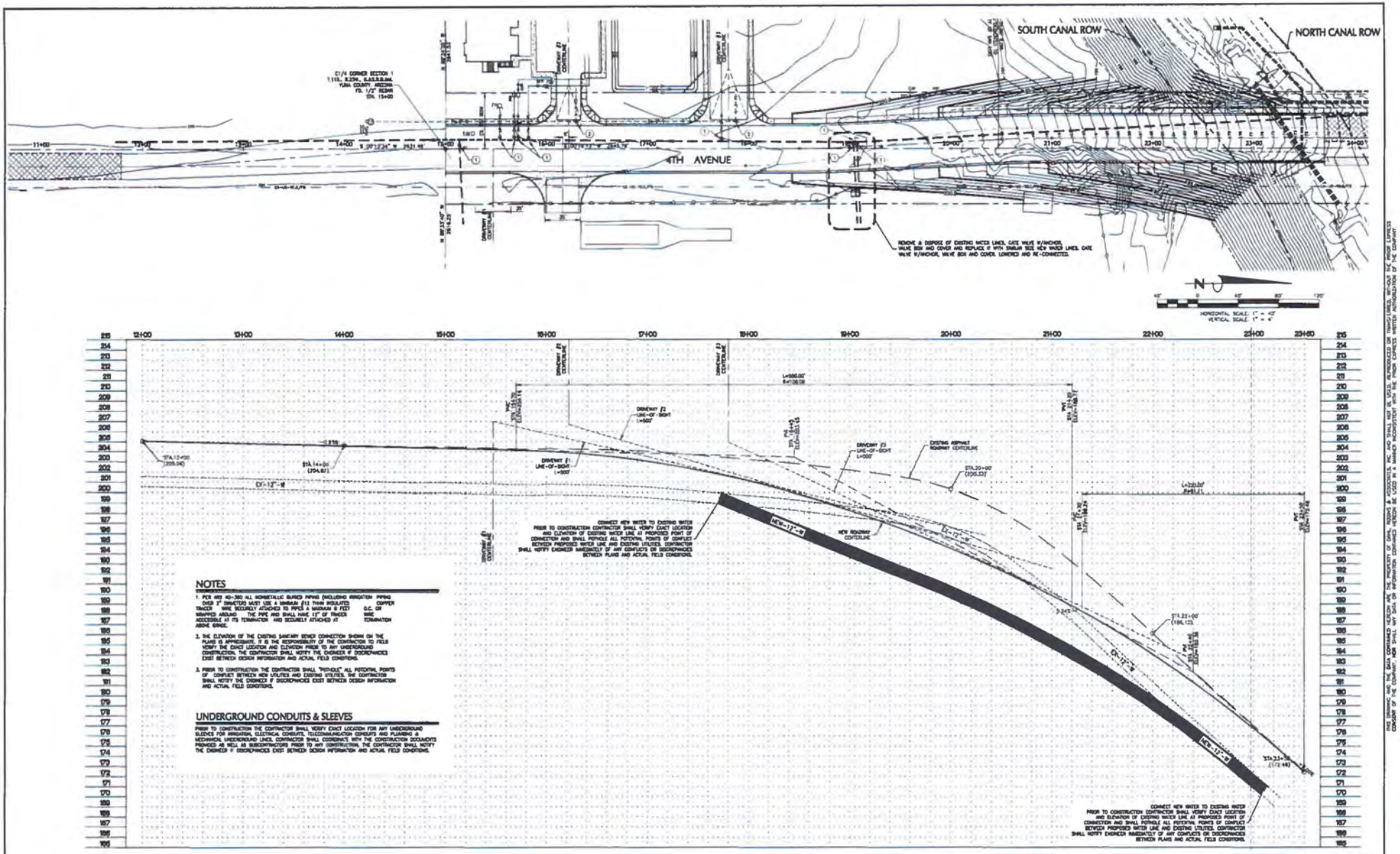
4TH AVENUE IMPROVEMENTS
SAN LUIS, ARIZONA

SREIPING PLAN

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SURVEYED BY	MAC
PROJECT NO.	21185
SHEET	C2.5

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NOTES

1. PER ARS 40-360 ALL NONMETALLIC BURIED PIPING (INCLUDING IRRIGATION PIPING OVER 3" DIAMETER) MUST USE A MINIMUM #12 THHN INSULATED COPPER TRACER WIRE SECURELY ATTACHED TO PIPES A MINIMUM 6 FEET O.C. OR WRAPPED AROUND THE PIPE AND SHALL HAVE 12" OF TRACER WIRE ACCESSIBLE AT ITS TERMINATION AND SECURELY ATTACHED AT TERMINATION ABOVE GRADE.
2. THE ELEVATION OF THE EXISTING SANITARY SEWER CONNECTION SHOWN ON THE PLANS IS APPROXIMATE. IT IS THE RESPONSIBILITY OF THE CONTRACTOR TO FIELD VERIFY THE EXACT LOCATION AND ELEVATION PRIOR TO ANY UNDERGROUND CONSTRUCTION. THE CONTRACTOR SHALL NOTIFY THE ENGINEER IF DISCREPANCIES EXIST BETWEEN DESIGN INFORMATION AND ACTUAL FIELD CONDITIONS.
3. PRIOR TO CONSTRUCTION THE CONTRACTOR SHALL "POTHOLE" ALL POTENTIAL POINTS OF CONFLICT BETWEEN NEW UTILITIES AND EXISTING UTILITIES. THE CONTRACTOR SHALL NOTIFY THE ENGINEER IF DISCREPANCIES EXIST BETWEEN DESIGN INFORMATION AND ACTUAL FIELD CONDITIONS.

UNDERGROUND CONDUITS & SLEEVES

PRIOR TO CONSTRUCTION THE CONTRACTOR SHALL VERIFY EXACT LOCATION FOR ANY UNDERGROUND SLEEVES FOR IRRIGATION, ELECTRICAL CONDUITS, TELECOMMUNICATION CONDUITS AND PLANNING & MECHANICAL UNDERGROUND LINES. CONTRACTOR SHALL COORDINATE WITH THE CONSTRUCTION DOCUMENTS PROVIDED AS WELL AS SUBCONTRACTORS PRIOR TO ANY CONSTRUCTION, THE CONTRACTOR SHALL NOTIFY THE ENGINEER IF DISCREPANCIES EXIST BETWEEN DESIGN INFORMATION AND ACTUAL FIELD CONDITIONS.

WATER SCHEDULE OF WORK

1. ADJUST NEW WATER VALVE BOX FRAME & COVER TO FINISHED GRADE
2. ADJUST NEW SEWER MANHOLE COVER TO FINISHED GRADE

UTILITY WARNING

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.

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23218
KEVIN A.
DAHL

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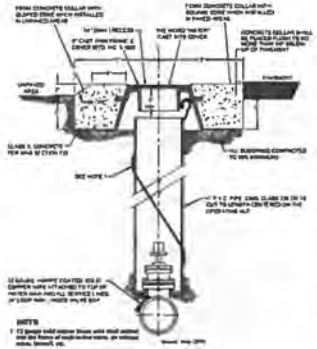
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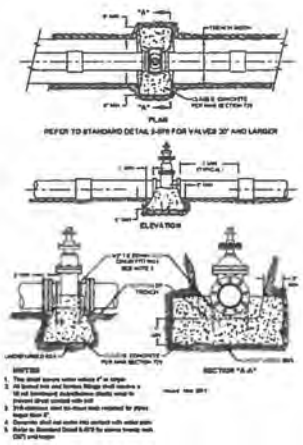
DATE	10/5/2021
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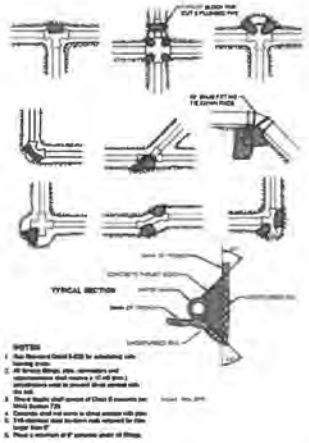
VALVE BOX INSTALLATION

CITY STD 3-073 — NTS — A — C3.2



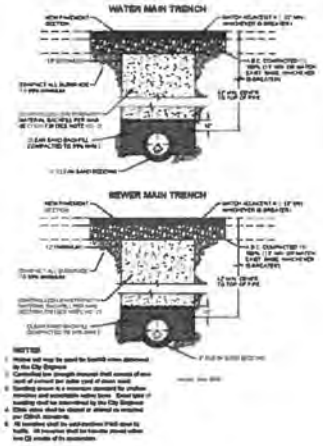
VALVE ANCHORS

CITY STD 3-080 — NTS — C — C3.2



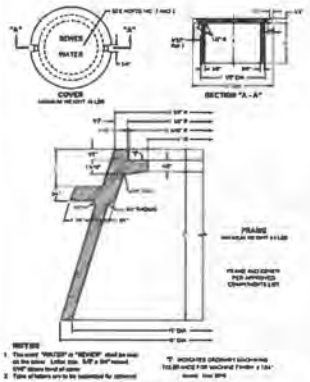
TYPICAL THRUST BLOCK INSTALLATION

CITY STD 3-020 — NTS — E — C3.2



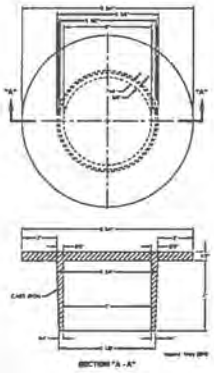
TYPICAL WATER & SEWER MAIN TRENCH BACKFILL

CITY STD 3-010 — NTS — G — C3.2



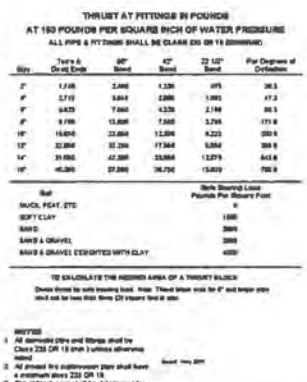
8" CAST IRON FRAME AND COVER

CITY STD 3-100 — NTS — B — C3.2



VALVE BOX COVER, DROP IN

CITY STD 3-090 — NTS — D — C3.2



THRUST AT FITTINGS IN POUNDS
AT 150 POUNDS PER SQUARE INCH OF WATER PRESSURE
ALL PIPE & FITTINGS SHALL BE CLASS 235 OR 18 (DR18/IPS)

Size	Tees & Dead Ends	90° Bend	45° Bend	22 1/2° Bend	Per Degree of Deflection
3"	1,748	2,466	1,329	675	36.5
4"	3,110	4,464	2,406	1,222	47.2
6"	6,673	7,860	4,329	2,198	84.5
8"	9,799	13,808	7,500	3,794	171.6
10"	14,614	22,864	12,376	6,223	283.6
12"	22,854	32,294	17,344	9,054	399.6
14"	31,656	42,385	23,054	12,273	643.6
16"	40,369	57,366	36,736	15,819	700.6

Soil	Safe Bearing Load Pounds Per Square Foot
MUCK, PEAT, ETC	0
SOFT CLAY	1000
SAND	3000
SAND & GRAVEL	3000
SAND & GRAVEL CEMENTED WITH CLAY	4000

TO CALCULATE THE REQUIRED AREA OF A THRUST BLOCK

Divide thrust by safe bearing load. Note: Thrust block ends for 6" and larger pipe shall not be less than 9ms (3) square feet in area.

NOTES
1. All dismantle pipe and fittings shall be Class 235 DR 18 (DR 3 unless otherwise noted
2. All pressure line subdivision plan shall have a minimum class 235 DR 18
3. Thrust block area shall be determined by soil tests for pipe greater in size than 16"
4. Concrete shall not come in direct contact with pipe

THRUST BLOCK DATA

CITY STD 3-030 — NTS — F — C3.2

CDB VALLEY VIEW APARTMENTS

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SURVEYED BY	MAC
PROJECT NO	21185
SHEET	C3.2

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WATER NOTES

1. UNLESS NOTED HEREON OTHERWISE, ALL CONSTRUCTION MATERIALS AND WORKMANSHIP SHALL BE IN ACCORDANCE WITH CITY OF YUMA SPECIFICATIONS AND RECOMMENDED DETAILS AND SHALL, WHERE APPLICABLE, BE IN ACCORDANCE WITH ARIZONA DEPARTMENT OF ENVIRONMENTAL QUALITY REGULATIONS.
2. A MINIMUM OF 7' SHALL BE MAINTAINED BETWEEN PARALLEL WATER AND SEWER LINES.
3. GRAVITY SEWER MAINS AND SERVICES SHALL BE DUCTILE IRON PIPE, CLASS 53 THIRTEEN (DIPRA) EPOXY COATED - THICKNESS OF 80 MILS OR "SEWPER COAT", FOR A PERPENDICULAR DISTANCE OF 7' IN BOTH DIRECTIONS FROM A WATER MAIN OR SERVICE WHEN:
   A. SEWER MAIN OR SERVICE CROSSES LESS THAN 3' BELOW A WATER MAIN OR SERVICE.
   B. WATER MAIN OR SERVICE CROSSES BELOW A SEWER MAIN OR SERVICE. (A MINIMUM OF 3.0' SEPARATION SHALL BE MAINTAINED VERTICALLY BETWEEN WATER AND SEWER MAINS AND SERVICES).

   REFERENCE: A.A.C. R18-4-502(C)
4. ALL FERROUS MATERIAL INCLUDING FLANGE BOLTS, SHALL BE PROTECTED FROM DIRECT CONTACT WITH SOIL BY 10 MIL POLYETHYLENE WRAP.
5. WATER MAINS AND VALVES SHALL BE FLUSHED AND DISINFECTED BY THE "CONSTANT METHOD" AS DESCRIBED IN THE 1976 ARIZONA DEPARTMENT OF HEALTH SERVICES ENGINEERING BULLETIN NO. 8.
6. ENGINEERING PERSONNEL SHALL BE PRESENT WHEN WATER MAINS ARE BOTH FLUSHED AND PRESSURE TESTED.
7. CONTRACTOR SHALL PROVIDE THE ENGINEER AND THE CITY OF YUMA WITH ALL CITY REQUIRED COMPACTION AND CONCRETE TEST RESULTS.
8. ALL PVC WATER DISTRIBUTION PIPES, FITTINGS, AND VALVES SHALL COMPLY WITH NSF STANDARD 61 AND SHALL BEAR THE NSF-PW SEAL FOR POTABLE WATER USE.
9. APPROVED WATER SERVICE COMPONENTS LIST

ITEM/SPECIFICATIONS	MANUFACTURER	MODEL/SERIES
FIRE HYDRANTS		
Dry barrel, traffic model, 3 Hose nozzles/1 Pumper nozzle with 5 1/4" main valve as required by MFMA, Stainless steel upper and lower stems, open left.	American Flow Control	Waterous – Pacer WB-67
	Clow / American AVK / Mueller / East Jordan Iron Works	Medallion Series 2720 Modern / Super Centurion / Water Master
GATE VALVES 4"-48"		
AWWA C515 Resilient wedge valves only. 2" square operating nut, Open left, Non-rising stem, Stainless steel bolts and nuts. Buried valves shall be non-rising stem.	American Flow Control	Series 2500
	Clow / East Jordan Iron Works / American AVK / Mueller	Model 2638 / Flow Master / Series 65 / Series 2500
AIR/VACUUM VALVES		
Note—Valve 250 Isolation Valve	Hydro-Seal (Est Industrial Services)	
COMBINATION AIR/VACUUM VALVES		
Combination air/vacuum valves shall have a Detent isolation valve.	A.R.I. Model D-040 and D-040-C HRAB / APCO Model 145C-4"	Val-Matic 300C.3 – 3"
TURN-OF-MAIN GATE VALVES		
Model and specifications to be determined by the design engineer.	CLA-VAL	
TAPPING SLEEVES		
4" and 6" minimum length 15" / 8" and larger minimum length 20"	Smith-Blair Model / Cascade / JCM	662-663 / CST-SL / A20/A22
TRANSITION COUPLINGS		
Any device used to connect AC pipe to DI or PVC shall require prior approval of the City Engineer. 10" and smaller minimum length 15" 12" and larger minimum length 20".	Smith-Blair	Model 413
	KRAUSZ Hymax	Long Body Coupling
SERVICE CLAMPS		
Full stren stainless steel stamps, Single, double and multi band, 304 Stainless steel bolts w/Thermoplymer covered nuts	Smith-Blair	244, 245, 226, 227, 228
	Ford Meter Box Co. Style F1, F2, F3	
MECHANICAL JOINTS		
Alpha Slide Range Restrained Coupling 4" – 12" / Alpha Slide Range Restrained End Cap 4" – 12" / Alpha Slide Range Restrained Flanged Coupling	Romac Industries	Alpha Series 4" – 12"
WATER METERS		
Contact the Utility Systems Superintendent or Water Services Supervisor for installations before ordering. Meters 2" to 8" must be Badger Meter, Inc. brand. They must have a test port on the body and a dual flange pads strainer or an integral strainer. They must be outfitted with AMR/AMI meter reading capability compatible with Badger BEACON. An HR-E LCD Encoder and an Orion (SE) ARE Endpoint. Additionally a Commercial Meter Mounting Bracket must be ordered for each Endpoint. P/N: 6A38N-033 Note: Endpoint type may change based on system requirements.	Badger Meter Co.	Connect the Utility Systems Superintendent or Water Services Supervisor for customer before ordering.
WATER SERVICE LINE MATERIAL		
1" Sch. 40 PVC / 2" Sch. 40 PVC / 1" and 2" PVC fittings / 1 1/4" PEX-a / 1 1/4" PEX-a	Cresline, Charlotte / Cresline, Charlotte / Generic / Uponor AquaPEX® White / Rehau UNIPEX®	
WATER SERVICE LINE COMPONENTS		
ANGLE STOPS		
ATV 74802-33 (1" ONLY) / KV63-44X9-NL (1" ONLY)	AY MCDONALD AND FORD METER BOX Co ARE ONLY AUTHORIZED MANUFACTURES	244, 245, 226, 227, 228
CURB STOPS		
ATV 74704-33 / F1191-4-NL	IRON PIPE THREAD ONLY	
SERVICE SADDLES		
ATV 3638 FOR AC PIPE / 3609-600-TAP FOR AC PIPE / ATV 3636 FOR C900 PIPE		
AT VALVES		
ATV 781381AW / BF13-7779-NL / ATV 78131 / 611-777-NL / ATV 746842 / BA13-7779-NL		

WATER LINE TESTING PROCEDURE

1. ALL VISIBLE LEAKS SHALL BE REPAIRED REGARDLESS OF THE AMOUNT OF LEAKAGE & REGARDLESS OF WHETHER LEAK DEVELOPS UNDER TEST PRESSURE OR LINE PRESSURE.
2. INITIAL PRESSURES FOR BOTH THE PRESSURE TEST AND ALLOWABLE LEAKAGE TEST SHALL BE A MINIMUM OF 150 PSI FOR WATERLINES AND 200 PSI FOR FIRELINES.
3. A PRESSURE TEST SHALL BE DEEMED AS SUCCESSFUL IF IT PASSES THE CRITERIA SET FORTH BY AWWA C-600, SEC. 4 (LATEST EDITION) AND THAT CRITERIA NOTED ABOVE.
4. SHOULD THE PRESSURE TEST BE UNSUCCESSFUL, THE CONTRACTOR HAS THE OPTION OF ATTEMPTING THE ALLOWABLE LEAKAGE TEST. THIS TEST WILL BE DEEMED SUCCESSFUL IF IT PASSES THE CRITERIA SET FORTH IN AWWA C-600, SEC. 4 (LATEST EDITION) OR AWWA M-23 (LATEST EDITION), WHICHEVER IS MORE RESTRICTIVE AND COMPLIES WITH THAT CRITERIA NOTED ABOVE.

GENERAL NOTES

1. ALL MATERIALS AND CONSTRUCTION HEREON SHALL CONFORM TO CITY OF YUMA STANDARD SPECIFICATIONS AND CONSTRUCTION STANDARDS AND SHALL BE IN ACCORDANCE WITH THE ARIZONA DEPARTMENT OF ENVIRONMENTAL QUALITY REGULATIONS.
2. THE CONTRACTOR SHALL BE RESPONSIBLE FOR THE PREPARATION AND FURNISHING TO THE ENGINEER OF "AS-BUILT" RECORD DRAWINGS. THE CONTRACTOR SHALL OBTAIN ONE SET OF PLANS FROM THE ENGINEER AND SHALL RECORD IN RED COLORED PENCIL ALL CASES WHERE ACTUAL FIELD CONSTRUCTION DIFFERS FROM WORK SHOWN ON PLANS, TO INCLUDE SERVICE LOCATIONS. ALL CONCEALED WORK AND UTILITIES SHALL BE DIMENSIONED.
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 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 (602) 782-3348 AT LEAST FORTY-EIGHT (48) HOURS IN ADVANCE OF CONMENCING 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. 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 MINIMIZE 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 INSURE THE PUBLIC'S HEALTH, WELFARE, AND SAFETY. ALL DEVICES MUST CONFORM TO THE MANUAL ON 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. OCCUPATIONAL SAFETY AND HEALTH ACT (OSHA) STANDARD FOR CONSTRUCTION (TITLE 29), CODE OF FEDERAL REGULATIONS, PART 1926 AS AMENDED) AND CITY OF YUMA SAFETY REGULATIONS ARE APPLICABLE FOR THE COMPLETION OF THE WORK ON THIS PROJECT.
9. 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 THE CITY OF YUMA.
10. CONSTRUCTION STAKING & MATERIALS TESTING WILL BE PROVIDED BY THE OWNER.
11. ANY SURVEY MONUMENT DISTURBED DURING CONSTRUCTION ACTIVITIES SHALL BE REPLACED IN ACCORDANCE WITH CITY OF YUMA 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.
12. ALL WATERLINES WILL BE PRESSURED AND LEAKAGE TESTED TO 150 PSI FOR 2 HOURS. SEE THIS SHEET FOR TEST PROCEDURES.
13. SITE PLUMBING CONTRACTOR TO COORDINATE WITH BUILDING PLUMBING CONTRACTOR TO PROVIDE COMPLETED JOB, READY FOR USE, IN ACCORDANCE WITH PLANS, INCLUDING RAISING ALL VALVE COVERS TO GRADE AFTER PAVING OR LANDSCAPING IS COMPLETED. BUILDING PLUMBING CONTRACTOR SHALL EXTEND WATER AND SEWER APPROXIMATELY 5' FROM THE BUILDING AND MAKE FINAL CONNECTION TO PROPOSED STUBOUTS. STUBOUTS TO BE PROVIDED BY SITE UTILITIES CONTRACTOR.
14. WATER AND SEWER CONTRACTOR SHALL PROVIDE THE ENGINEER WITH A COPY OF THE BACTERIOLOGICAL TEST RESULTS TAKEN ON THE SYSTEM.
15. ALL PVC WATERLINES SMALLER THAN 4" SHALL BE SCHEDULE 40 APPROVED BY NSF AND INSTALLED IN ACCORDANCE WITH CITY OF YUMA STANDARDS.
16. ALL WATERLINES 4" AND LARGER IN DIAMETER SHALL BE PVC COMPLYING WITH ASTM D-1900, CLASS 305 DR18 AND MARKED NSF APPROVED FOR POTABLE WATER.
17. ALL WATER DISTRIBUTION PIPES, WATER SERVICE LINES AND FIRE HYDRANT LEADS SHALL BE INSTALLED WITH TRACER WIRE THAT CONFORMS TO THAT CALLED OUT ON CITY OF YUMA CONSTRUCTION STANDARD NO. S-210.
18. THE ELEVATION OF THE EXISTING SEWER CONNECTION SHOWN ON THE PLANS IS APPROXIMATE. IT IS THE RESPONSIBILITY OF THE CONTRACTOR TO FIELD VERIFY THE EXACT LOCATION AND ELEVATION PRIOR TO ANY UNDERGROUND CONSTRUCTION. THE CONTRACTOR SHALL NOTIFY THE ENGINEER IF DISCREPANCIES EXIST BETWEEN DESIGN INFORMATION AND ACTUAL FIELD CONDITIONS.
19. PRIOR TO CONSTRUCTION THE CONTRACTOR SHALL "POTHOLE" ALL POTENTIAL POINTS OF CONFLICT BETWEEN NEW UTILITIES AND EXISTING UTILITIES. THE CONTRACTOR SHALL NOTIFY THE ENGINEER IF DISCREPANCIES EXIST BETWEEN DESIGN INFORMATION AND ACTUAL FIELD CONDITIONS.
20. BACKFLOW PREVENTION ASSEMBLIES SHALL BE INSPECTED BY THE CITY OF YUMA PUBLIC WORKS DEPARTMENT PRETREATMENT SECTION. PLEASE CONTACT JACKIE COX AT (928) 373-4542 TO REQUEST AN INSPECTION. TESTING OF BACKFLOW DEVICE TO BE DONE BY CERTIFIED TESTER (LIST AVAILABLE ON REQUEST). INSTALLATION AND TESTING TO BE COMPLETED WITHIN ONE WEEK FROM THE TIME THE WATER METER IS SET.

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CDB VALLEY VIEW APARTMENTS
SW CORNER 4TH AVENUE & EAST MAIN CANAL
SAN LUIS, ARIZONA
NOTES

DAHL, ROBINS & ASSOCIATES, INC.
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E:\Dra2021\21185\drawings\4th Avenue\21185 4th Avenue Improvements Rev 5 Detailed 1/5/2022 10:03 AM

DATE	1/05/2021
DESIGNED BY	BAC/JC
DRAWN BY	VM/DRA
CHECKED BY	KAD
SURVEYED BY	MAC
PROJECT NO	21185
SHEET	C3.3

AGENDA ITEM REVIEW FORM

Regular City Council Meeting **5. C.**

Meeting Date: 06/22/2022

Department Head: Maria Munoz, HR Benefits Coordinator, Human Resources Department

Submitted By: Maria Munoz, HR Benefits Coordinator, Human Resources Department

Action Requested: Motion
Order

ITEM:

Discussion and possible action on any and all matters regarding Order No. 2022-09. 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 2022-2023 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. **(Kay Marion Macuil, City Attorney)**

SUMMARY:

The PowerPoint presentation from the Budget Retreat on May 14, 2022 (Budget Retreat presentation 2022), the Benefit Plan Documents, and Summary Plan Descriptions are attached.

Background

Consultant and Benefits Broker Susan Posada negotiated the Employee Benefits Plans for the 2022-2023 Fiscal Year.

At the May 14, 2022, 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 $3,074,310.00

Recommendation of the Trust and City Staff

The final plan went to the San Luis Employees Benefits Trust on April 13, 2022, and the Trustees approved plan changes presented to City Council on May 14, 2022, at the budget meeting.

Staff recommends approval of the employee benefits plans to be administered by the San Luis Employee Benefits Trust and city staff for the Fiscal Year 2022 - 2023 with an effective date of July 1, 2022.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE ORDER NO. 2022-09.

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 $3,074,310.00 to the Trust Fund is to be passed as part of the final budget for the fiscal year 2022-2023. This item is to adopt the benefit plans to be administered by the San Luis Employee Benefits Trust.

Attachments

Order No. 2022-09 Adopt Benefit Plans

Budget Meeting Presentation- May, 142022

US Restated Medical Plan Document and summary plan description - Jul 2021

US Medical Amend 1A - Nov 2021

US Medical Amend 2A - Mar 2022

US Restated Dental Plan Document - Jul 2021

Mexico Only Medical Plan Document and summary plan description - Jul 2021

Mexico Medical Amend 1A - Mar 2022

Mexico Only Restated Dental Plan - Jul 2021

OFFICE OF THE
MAYOR
CITY OF SAN LUIS

Order

No. 2022-09

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 2022-2023 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 22, 2022, City Council estimated the 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 $3,074,310.00 to the San Luis Employee Benefit Trust to implement said employee benefits plans for the fiscal year 2022-2023.

THEREFORE IT IS ORDERED by the City Council of the City of San Luis as follows:

Section 1. Declaring Public Records: The presentation to City Council and the documents making up the Employee Benefits Plan titled:

1. "Budget Management Meeting by Susan Posada"

2. "City of San Luis Employee Benefit Trust, Summary Plan Description and Plan Document, 90 Degree Benefits Group Number SLS001, Effective: July 1, 2018, Revised and Restated July, 2021"

3. "Master Plan Document Amendment #1A" (Effective November 1, 2021)

4. "Master Plan Document Amendment #2A" (Effective March 1, 2022)

5. "City of San Luis Employee Benefit Trust Dental Benefit Plan, Plan Document and Summary Plan Description, 90 Degree Benefits Group Number: SLS0001, Effective: July 1, 2018, Revised and Restated: July 1, 2021"

6. "City of San Luis Employee Benefit Trust – Mexico Coverage, Summary Plan Description and Plan Document, 90 Degree Benefits Group Number SLS001, Effective: July 1, 2018, Revised and Restated: July 1, 2021"

7. "Master Plan Document Amendment #1A" (Mexico Coverage Amended Effective March 1, 2022)

8. "City of San Luis, Employee Benefit Trust Dental Benefit Plan – Mexico Coverage, Plan Document and Summary Plan Description, 90 Degree Benefits Group Number: SLS0001, Effective: July 1, 2018, Revised and Restated: July 1, 2021"

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 2022-2023, 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 the City Council prior to this order in conflict with this order are repealed, effective as of July 1, 2022.

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, 2022.

[Intentionally left blank, signature page follows.]

CITY OF San Luis Arizona

Gateway to the Sea of Cortez

Budget Management Meeting

May 14, 2022

SUSAN POSADA AGENCY

Plan Renewals

- Claims through March 2022 increased 30.54%
- Reimbursements from the Stop Loss $532,642

- Stop Loss Renewal for July 1, 2022, to June 30, 2023
  - Initial Final Renewal 19.81%
  - Final After Negotiation 14.84%
  - Savings of $ $32,379.12





VISION SERVICES PLAN VSP

In Network Benefits	
Eye Exam *	$10 Copay
Contact Lens Exam *	Up to $60 Copay
Prescription Glasses *	$25 Copay
Frames *	$150 Allowance
Contact Lenses *	$130 Allowance
Progressive Lenses *	Covered in Full
* Every 12 Months	

UPRISE HEALTH RENEWAL

EAP (6 Visits per situation)

Uprise Health EAP		EE Count	Rate	Monthly Premium	Annual Premium	Percentage Change
All Employees	Current	243	$2.28	$554.04	$6,648.48	
All Employees	Renewal	243	$2.39	$580.77	$6,969.24	
Difference				**$26.73**	**$320.76**	**4.82%**

Rates good for 2022 - 2023

- 24-Hour Access
- Referrals and Follow-up
- Legal and Financial Services
- Orientation and Training
- Communication Materials
- Utilization Reporting

On-site Service Rates
CISD (Critical Incident Services)
Training, SPV Training

Renewal

- No Plan Changes for the Medical and Dental – Copays, Deductibles and Co-insurance for both US and Mexico Plan
- Pharmacy Change from Magellan to Southern Scripts
- Add Exclusive Mental Health Services – Deductible, Co-insurance waived





Exclusive Mental Health Conditions

- Mental Health Treatment include:
- Chemical Dependency
- Depression
- Alcoholism
- Post-Traumatic Stress Disorder
- Compulsive Gambling
- Spending Addiction
- Anger & Rage
- Obsessive Compulsive Disorder
- ADD/ADHD
- And More conditions .....

EXCLUSIVE BEHAVORIAL HEALTH, LLC

Treatment Modalities Include

- Group Therapy
- Individual Therapy
- Equine Assisted Therapy
- Expressive Arts Groups
- Exercise
- Yoga
- Tai Chi
- Recreation Therapy
- Challenge Course
- Nutrition
- Psychoeducational Lectures
- Trauma Therapy
- Mind-Body Therapy
- Spirituality

Exclusive Mental Health

- Must obtain clinical approval through 90 Degrees
- Centers in Wickenburg and Tucson and others
- Savings to the plan on average of 30%
- No Copay, No Deductible and No Co-insurance
- Initial Enrollment with Exclusive Mental Health of $900 – No PEPM fee
- Renewal Fee $500







Thank You

Susan Posada

SUSAN POSADA
AGENCY



City of San Luis
EMPLOYEE BENEFIT TRUST

SUMMARY PLAN DESCRIPTION AND
PLAN DOCUMENT

90 DEGREE BENEFITS GROUP NUMBER: SLS001

Effective: July 1, 2018

Revised and Restated July 1, 2021

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ESTABLISHMENT OF THE MASTER PLAN DOCUMENT

Effective July 1, 2018, and revised and restated July 1, 2021, 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

90 Degree Benefits, 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.

6/30/21
Date

Signature

Employee Benefit Trust
Maria Saboi, Board Secretary
Print or Type Name and Title

Witness Signature

Sonia Cornelio
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
90 Degree Benefits 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:	90 Degree Benefits, Inc. 215 Stanford Pkwy Findlay, OH 45840 Phone Number 800-558-7798 **Please Note:** 90 Degree Benefits, 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:	$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 90 DEGREE BENEFITS 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.

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.
COVID-19 tests and vaccine administration	100% (Deductible waived	100% (Deductible waived	Includes testing, related services, and vaccine administration to the extent required by law.

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
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	
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	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
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	
Maternity			
Prenatal visits	100% (Deductible and Copays waived)	50% after Deductible	
Hospital Services	80% after Deductible	50% 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	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 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	 50% after Deductible 50% 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	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 Associated Office Visits	 80% after Deductible 100% after a $15 Copay per visit (Deductible waived)	 50% after Deductible 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

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.**

90 DEGREE BENEFITS means 90 Degree Benefits, Inc., formerly EBSO, Inc.

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.

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. 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.

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
90 Degree Benefits, 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
90 Degree Benefits, 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
   90 Degree Benefits, 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, or for missed appointments.

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)
- 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 90 DEGREE BENEFITS 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 or facility
5. Reason for the hospitalization or procedure
6. Date the hospitalization or procedure started or is scheduled
7. Employer's I.D. Number.

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.

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, telehealth 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.

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. **Telehealth Services.** Telehealth services which are Medically Necessary to diagnose or treat an Injury or Sickness.

30. **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.

31. **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, 90 Degree Benefits, 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. 90 Degree Benefits, 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 90 Degree Benefits, 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.**

SECTION R

COVID-19

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

The above benefits are specific to testing/prevention 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.

This Plan shall at all times be in compliance with any required benefits or procedures mandated under the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act), or as later amended, provided the Employer is required to comply with such acts.

MASTER PLAN DOCUMENT AMENDMENT #1A

Effective November 1, 2021, the Master Plan Document and Summary Plan Description for City of San Luis is hereby amended as follows:

SCHEDULE OF COVERAGE, **Section B**, is hereby deleted and replaced with Attachment A

Accepted By:

Maria Jabori Employee Benefits Trust Board Secretary 11/29/21

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 90 DEGREE BENEFITS 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.

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.
COVID-19 tests and vaccine administration	100% (Deductible waived	100% (Deductible waived	Includes testing, related services, and vaccine administration to the extent required by law.

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
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	
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	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
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	
Maternity			
Prenatal visits	100% (Deductible and Copays waived)	50% after Deductible	
Hospital Services	80% after Deductible	50% 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	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 and BCBS AZ lab providers	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 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. Preventive Services not listed will be payable as any other covered illness, subject to applicable cost sharing. 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	 50% after Deductible 50% 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	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 Associated Office Visits	 80% after Deductible 100% after a $15 Copay per visit (Deductible waived)	 50% after Deductible 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

MASTER PLAN DOCUMENT AMENDMENT #2A

Effective March 1, 2022, the Master Plan Document and Summary Plan Description for City of San Luis is hereby amended as follows:

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

COVERED EXPENSES, Item 20.t., page 77, is hereby deleted and replaced with the following:

t. Hearing aids (***LIMITED*** as shown in the Schedule of Coverage).

Accepted By:

Maria Sabori Benefits Trust Board Secretary 3/3/22

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 90 DEGREE BENEFITS 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.

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.
COVID-19 tests and vaccine administration	100% (Deductible waived	100% (Deductible waived	Includes testing, related services, and vaccine administration to the extent required by law.

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies	80% after Deductible	50% after Deductible	
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	
Hearing Aids	100% (Deductible waived	Not covered	***LIMITED*** to 1 per ear, up to a maximum payment of $1,500 in a 3 calendar year period.
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	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Inpatient and Outpatient Physician Services			
Primary Care Physician Office Visits (includes lab and X-ray performed in office)	100% after a $15 Copay per visit (Deductible waived)	50% after Deductible	
Specialist Office Visits (includes lab and X-ray performed in office)	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	
Maternity			
Prenatal visits	100% (Deductible and Copays waived)	50% after Deductible	
Hospital Services	80% after Deductible	50% 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	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 providers	100% (Deductible waived).	Not Applicable	
Standalone providers, including BCBS AZ	100% after a $25 Copay per visit (Deductible waived)	50% after Deductible	
Hospital	80% after Deductible	50% after Deductible	
Other X-rays and Laboratory tests			
Through ESurgeries providers	100% (Deductible waived).	Not Applicable	
Standalone providers, including BCBS AZ	100% after a $25 Copay per visit (Deductible waived)	50% after Deductible	
Hospital	80% after Deductible	50% after Deductible	
Primary care office visit	Included in office visit copay	50% after Deductible	Services provided in the physician's office are included with the applicable office visit copay. For services referred to a hospital or other facility, see above.
Specialist care office visit	Included in office visit copay	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.
Pediatric and Adult Preventive Care	100% (Deductible waived)	80% after Deductible	Preventive Services not listed will be payable as any other covered illness, subject to applicable cost sharing.
Immunizations, inoculations, vaccinations	100% (Deductible waived)	100% after a $20 Copay per visit (Deductible waived)	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.
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

90 DEGREE BENEFITS GROUP NUMBER: SLS0001

Effective: July 1, 2018

Revised and Restated: July 1, 2021

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ESTABLISHMENT OF THE MASTER PLAN DOCUMENT

Effective July 1, 2018, and revised and restated July 1, 2021, 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

90 Degree Benefits, 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.

6/30/21
Date

M Sabori
Signature

Maria Sabori, Employee Benefit Trust Board Secretary
Print or Type Name and Title

Sonia Cornelio
Witness Signature

Sonia Cornelio
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

90 Degree Benefits 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:	90 Degree Benefits, Inc. 215 Stanford Pkwy Findlay, OH 45840 Phone Number 800-558-7798 **Please Note:** 90 Degree Benefits, 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
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.

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.**

90 DEGREE BENEFITS means 90 Degree Benefits, Inc., formerly EBSO, Inc.

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.

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. 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.

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
90 Degree Benefits, 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
90 Degree Benefits, 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
   90 Degree Benefits, 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 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 (established patient)
D0210	lntraoral complete series (including Bitewings)
D0220	lntraoral single/first film
D0230	lntraoral periapical each additional film
D0240	lntraoral 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	Apply 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 surface/permanent or primary
D2150	Amalgam two surface/permanent or primary
D2160	Amalgam three surface/permanent or primary
D2161	Amalgam four surface/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 pulpotomy (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 quadrant
D4240 Gingival flap procedure - four or more contiguous teeth/spaces per quadrant
D4341 Periodontal scaling & root planning per quadrant
D4342 Periodontal scaling and root planing - one to three teeth per quadrant
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 procedure)
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 mol.ar (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 quadrant
D4241	Gingival flap procedure - one to three contiguous teeth/spaces per quadrant
D4249	Clinical crown lengthening - hard tissue
D4260	Osseous surgery- four or more contiguous teeth/spaces per quadrant
D4261	Osseous surgery- one to three contiguous teeth/spaces per quadrant
D4263	Bone replacement graft-retained natural tooth-first site in quadrant.
D4264	Bone replacement graft - multisite
D4273	Subepithelial tissue graft procedure subepithelial
D4321	Provisional splinting-extra coronal
D5110	Complete denture, upper - once every 5 years
D5120	Complete denture, lower - once every 5 years
D5130	Immediate upper dentures - lifetime benefit
D5140	Immediate lower dentures - lifetime benefit
D5211	Maxillary partial denture/resin base
D5212	Mandibular partial denture/resin base
D5213	Upper partial denture/metal frame work w/resin
D5214	Lower partial denture/metal frame work w/resin
D5281	Remove unilat part/one piece cast metal
D5820	Interim partial denture (upper)
D5821	Interim partial denture (lower)
D6242	Pontic - porcelain fused to noble metal
D6740	Crown- porcelain
D6750	Crown - porcelain fused to high noble metal
D6751	Crown - porcelain fused to predominantly base metal
D6752	Crown - porcelain fused to noble metal
D7240	Completely bony impaction
D7241	Removal of impacted tooth - completely bony
D7272	Surgical tooth transplantation

D7286 Biopsy of oral tissue - soft
D7472 Removal of torus palatinus
D7473 Removal of torus mandibular
D7485 Surgical reduction of osseous tuberosity

Class Ill Services -Limitations

- Denture repairs, adjustments, relines or rebase - limited to adjustments made morethan 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 Ill 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.

Carryover Provision

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.

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, 90 Degree Benefits, 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. 90 Degree Benefits, 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 90 Degree Benefits, 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.**

City of San Luis
EMPLOYEE BENEFIT TRUST – Mexico Coverage

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

90 DEGREE BENEFITS GROUP NUMBER: SLS001

Effective: July 1, 2018

Revised and Restated: July 1, 2021

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ESTABLISHMENT OF THE MASTER PLAN DOCUMENT

Effective July 1, 2018, and revised and restated July 1, 2021, 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

90 Degree Benefits, 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.

6/30/21
Date

M Sabori
Signature

Maria Sabori, Employee Benefit Trust Board Secretary
Print or Type Name and Title

Sonia Cornelio
Witness Signature

Sonia Cornelio
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
90 Degree Benefits 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:	90 Degree Benefits, Inc. 215 Stanford Pkwy Findlay, OH 45840 Phone Number 800-558-7798 **Please Note:** 90 Degree Benefits, 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:	$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**
- **Hospice**
- **Home Health Care**
- **Durable Medical Equipment > $750 or when rental exceeds 4 months**
- **Inpatient Rehabilitation/Habilitation services**

FOR PRE-CERTIFICATION CALL 90 DEGREE BENEFITS 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; procedures and services through San Luis Walk in Clinic.

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.

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.
COVID-19 tests and vaccine administration	100%	100%	Includes testing, related services, and vaccine administration to the extent required by law.
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	

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only - Plan Pays	Additional Limitations and Explanations
Inpatient Hospital Services (Non-Emergency)/Outpatient Hospital			Out-of-Network only covered in the case of Emergency.
Visits for more than 12 hours	100% after a $50 Copay per visit	50%	
Outpatient surgery (less than 12 hours)	100% after a $25 Copay per visit	50%	
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	

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only - Plan Pays	Additional Limitations and Explanations
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	
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	

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only - Plan Pays	Additional Limitations and Explanations
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	

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.**

90 DEGREE BENEFITS means 90 Degree Benefits, Inc, formerly EBSO, Inc.

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.

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. 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.

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 times;

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
90 Degree Benefits, 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
90 Degree Benefits, 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
   90 Degree Benefits, 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, or for missed appointments.

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 peripheral vascular 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
- Hospice
- Home Health Care
- Durable Medical Equipment > $750 or when rental exceeds 4 months
- Inpatient Rehabilitation/Habilitation services

For Pre-Certification call 90 Degree Benefits 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 any Deductible or Copay.

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 or facility
5. Reason for the hospitalization or procedure
6. Date the hospitalization or procedure started or is scheduled
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, telehealth 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.

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. **Telehealth Services.** Telehealth services which are Medically Necessary to diagnose or treat an Injury or Sickness.

28. **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.

29. **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, 90 Degree Benefits, 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. 90 Degree Benefits, 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 90 Degree Benefits, 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.**

SECTION Q

COVID-19

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

The above benefits are specific to testing/prevention 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.

This Plan shall at all times be in compliance with any required benefits or procedures mandated under the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act), or as later amended, provided the Employer is required to comply with such acts.

MASTER PLAN DOCUMENT AMENDMENT #1A

Effective March 1, 2022, the Master Plan Document and Summary Plan Description for City of San Luis – Mexico Coverage is hereby amended as follows:

SCHEDULE OF COVERAGE, **SECTION B**, is hereby deleted and replaced with Attachment A

COVERED EXPENSES, Item 17.c., page 71, is hereby deleted and replaced with the following:

c. Hearing aids, ***LIMITED*** as shown in the Schedule of Coverage; and

Accepted By:

Maria Sabori Benefits Trust Board Secretary 3/3/22

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 $9,000 FAMILY	**Out-of-Network:**	$20,000 INDIVIDUAL $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**
- **Hospice**
- **Home Health Care**
- **Durable Medical Equipment > $750 or when rental exceeds 4 months**
- **Inpatient Rehabilitation/Habilitation services**

FOR PRE-CERTIFICATION CALL 90 DEGREE BENEFITS 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; procedures and services through San Luis Walk in Clinic.

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.

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.
COVID-19 tests and vaccine administration	100%	100%	Includes testing, related services, and vaccine administration to the extent required by law.
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	Not Covered	In network covered services only include: • Nebulizer • Breast pump
Emergency Services and Urgent Care Services			In an Emergency, as defined by the Plan, Out-of-Network Covered Expenses will be paid at the Siarmed level.
Emergency visit	100% after a $150 Copay per visit	100% after a $150 Copay per visit	Copay is waived if hospitalized and benefits revert to applicable inpatient hospital benefit.
Urgent Care (visit only)	100% after a $20 Copay per visit	Not Covered	
Hearing Aid Exams	100% after a $5 Copay per visit	80%	Hearing Aids ***LIMITED*** to 1 per ear, to a maximum benefit of $1500 in a 3 calendar year period.
Hearing Aids	100%	80%	

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only - Plan Pays	Additional Limitations and Explanations
Home Health Care	Not Covered	Not Covered	
Inpatient Hospital Services (Non-Emergency)/Outpatient Hospital			Out-of-Network only covered in the case of Emergency.
Visits for more than 12 hours	100% after a $50 Copay per visit	50%	
Outpatient surgery (less than 12 hours)	100% after a $25 Copay per visit	50%	
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	

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only - Plan Pays	Additional Limitations and Explanations
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	
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	

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only - Plan Pays	Additional Limitations and Explanations
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

90 DEGREE BENEFITS GROUP NUMBER: SLS0001

Effective: July 1, 2018

Revised and Restated: July 1, 2021

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ESTABLISHMENT OF THE MASTER PLAN DOCUMENT

Effective July 1, 2018, and revised and restated July 1, 2021, 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

90 Degree Benefits, 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.

6/30/21
Date

M Sabori
Signature

Maria Sabori, Employee Benefit Trust Board Secretary
Print or Type Name and Title

Sonia Cornelio
Witness Signature

Sonia Cornelio
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
90 Degree Benefits 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:	90 Degree Benefits, Inc. 215 Stanford Pkwy Findlay, OH 45840 Phone Number 800-558-7798 **Please Note:** 90 Degree Benefits, 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	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

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.**

90 DEGREE BENEFITS means 90 Degree Benefits, Inc., formerly EBSO, Inc.

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.

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. 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.

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
90 Degree Benefits, 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
90 Degree Benefits, 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
   90 Degree Benefits, 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 and providers.

SECTION H

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.

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, 90 Degree Benefits, 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. 90 Degree Benefits, 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 90 Degree Benefits, 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.**

AGENDA ITEM REVIEW FORM

Regular City Council Meeting **5. D.**

Meeting Date: 06/22/2022

Department Head: Eulogio Vera, Director of Public Works, Public Works Department

Submitted By: Jorge Perez, Assistant Director of Public Works, Public Works Department

Action Requested: Motion
Resolution

ITEM:

Discussion and possible action on any and all matters regarding Resolution No. 2220. A resolution of the Mayor and Council of the City of San Luis, Arizona, authorizing an Intergovernmental Agreement with the Arizona Department of Transportation (ADOT) for the use of Highway Users Revenue Fund (HURF) exchange funding for the construction of County 24th Street. **(Eulogio Vera, Director of Public Works)**

SUMMARY:

The city desires to utilize HURF exchange funding for the construction of roadway grading, roadway base, asphaltic concrete, signage, and marking of the County 24th Street Extension from Avenue F to Avenue H. This project will significantly improve traffic circulation, roadway connectivity, roadway reliability, and a redundant connection between the east and west parts of the city.

County 24th Street is functionally classified as a major collector of the federal aid system. The Yuma Metropolitan Planning Organization (YMPO) has confirmed the Project's eligibility for federal Surface Transportation Block Grant Program (STBGP) funds for areas with a population of 200,000 or less according to the most recent annual population estimates produced by the Arizona Department of Administration. HURF exchange funding will be credited to the applicable Metropolitan Planning Organization at 90% of the amount of the federal Surface Transportation Block Grant Program funds programmed for the Project in the Transportation Improvement Program.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE AND ADOPT RESOLUTION NO. 2220.

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM:	YES
CITY/STATE/FEDERAL FUNDS:	State and Federal
TOTAL:	$1,211,184.00
BUDGETED AMOUNT:	See fiscal impact statement
AVAILABLE AMOUNT TO TRANSFER:	See fiscal impact statement
ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE:	See fiscal impact

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

The city will be entering into an Intergovernmental Agreement (IGA) as part of a HURF Exchange Program to use federal funding from the Surface Transportation Block Grant Program (STBGP). This grant is included in the proposed budget for FY 2023.

Attachments

Proposed Resolution

Proposed IGA with ADOT

IGA Attachment #1

ROW Map

OFFICE OF THE
MAYOR
CITY OF SAN LUIS

Resolution

No. 2220

A RESOLUTION OF THE MAYOR AND CITY COUNCIL OF THE CITY OF SAN LUIS, ARIZONA AUTHORIZING AND DIRECTING THE ENTERING INTO AN INTERGOVERNMENTAL AGREEMENT WITH THE ARIZONA DEPARTMENT OF TRANSPORTATION TO CONSTRUCT WITH FEDERAL FUNDS COUNTY 24TH STREET BETWEEN AVENUES F AND H (ALSO KNOWN AS 10TH AVENUE) IN SAN LUIS, ARIZONA; SUPERSEDING CONFLICTING PROVISIONS; AND PROVIDING FOR SEVERABILITY.

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

Section 1: The Mayor and City Council deem that it is in the best interest of the City of San Luis' residents to contract with the Arizona Department of Transportation to construct County 24th Street from Avenue F to 10th Avenue in San Luis, Arizona.

Section 2: A true copy of the intergovernmental agreement is incorporated into this resolution as though set forth again in full.

Section 3: The Mayor is authorized and directed to execute the said agreement for and on behalf of the City of San Luis.

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

Section 5: If a conflict arises between this resolution and any other ordinance, resolution, regulation, or policy of the City of San Luis, the conflicting provisions are amended, superseded, and replaced, and this resolution shall govern.

Section 6: If any section, subsection, sentence, clause phrase, or a portion of this resolution is held to be invalid or unconstitutional by the final decision of any court of competent jurisdiction, such decision shall not affect the validity of the remaining portion of this resolution.

[Intentionally left blank, signature page follows.]

PASSED, ADOPTED, and APPROVED by the Mayor and City Council of the City of San Luis, Yuma County, Arizona, this ____day of June 2022.

Gerardo Sanchez, Mayor

ATTEST:

Sonia Cornelio, City Clerk

APPROVED AS TO FORM:

Kay Marion Macuil, City Attorney

ADOT CAR No.: IGA 22-0008568-I
AG Contract No.: P001 2022 000724
Project Location/Name: County 24th St Extension; Avenue F - Avenue H
Type of Work: Construct New Road
ADOT Project No.: T0360 01D 01C
TIP/STIP No.: SL22-01C
CFDA No.: 20.205 – Highway Planning and Construction
Budget Source Item No.: HURF Exchange

INTERGOVERNMENTAL AGREEMENT

BETWEEN
THE STATE OF ARIZONA
AND
CITY OF SAN LUIS

THIS AGREEMENT is entered into this date _____, pursuant to the Arizona Revised Statutes §§ 11-951 through 11-954, as amended, between the STATE OF ARIZONA, acting by and through its DEPARTMENT OF TRANSPORTATION (the "State" or "ADOT") and the CITY OF SAN LUIS, acting by and through its MAYOR and CITY COUNCIL (the "City"). The State and the City are collectively referred to as "Parties."

I. RECITALS

1. The State is empowered by Arizona Revised Statutes § 28-334 and § 28-401 to enter into this Agreement and has delegated to the undersigned the authority to execute this Agreement on behalf of the State.

2. The City is empowered by Arizona Revised Statutes § 48-572 to enter into this Agreement and has by resolution, a copy of which is attached hereto and made a part hereof, resolved to enter into this Agreement and has authorized the undersigned to execute this Agreement on behalf of the City.

3. The City desires to utilize HURF Exchange funding for the construction of roadway grading, roadway base, asphaltic concrete, signing and marking of County 24th Street Extension from Avenue F to Avenue H, hereinafter referred to as the "Project." The primary purpose of this Project is the improvement of the efficiency, reliability and safety of the traveling public.

4. The Project is located on a major collector functional classification on the federal aid system. The Yuma Metropolitan Planning Organization (YMPO) has confirmed the Project's eligibility for federal Surface Transportation Block Grant Program (STBGP) funds for areas with population of 200,000 or less according to the most recent annual population estimates produced by the Arizona Department of Administration.

5. All phases of the Project are programmed in the approved, fiscally-constrained portion of the applicable Transportation Improvement Program (TIP) as "HURF Exchange."

6. No phase of the Project has previously been funded with any category of federal aid funding.

7. No phase of the Project is currently programmed with any category of federal aid funding.

8. The City has represented to the State that it will be able to, and will, meet the schedule requirements of this Agreement.

THEREFORE, the Recitals set forth above are incorporated into this Agreement and in consideration of the mutual terms expressed herein, it is agreed as follows:

II. DEFINITIONS AND ACRONYMS

Apportionments	Surface Transportation Block Grant Program funds provided by ADOT on a discretionary basis to Arizona COGs and MPOs.
AFIS	The Arizona Financial Information System administered by the Arizona Department of Administration.
Authorization	The approval by the State of the use of HURF Exchange funding for a Project phase.
Change in Scope	Any change to a Project or Project phase which increases the footprint or adds or decreases features to a Project (for example: pedestrian bridge, roundabout, traffic signal, etc.).
COG	Council of Governments
Date of Authorization	The date on which the State approves the use of HURF Exchange funding for a Project phase. This is also the date on which HURF Exchange funded costs for the Project phase may begin to be incurred.
Eligible Costs	Costs directly associated with the design, acquisition or right of way, and construction of the Project, including necessary safety items. Other items unavoidably required for the primary purpose of the Project, which is to improve the efficiency and safety of motor vehicle travel on the roadway, may be considered part of the eligible costs. These items may include utility relocation, sidewalks, ADA ramps and safety features.
Federal Highway Administration (FHWA)	A division of the US Department of Transportation specializing in highway transportation.
Final Project Phase Amount	Total cost of the Project phase based on the contract, less any ineligible costs but including a reasonable amount for construction engineering and contingency. For Project phases performed using the City's own forces, the Final Project Phase Amount is the amount for the respective phase as estimated in the "Project Cost Estimate" in the HURF Exchange Cost and Schedule tool workbook.

Final Voucher	The final accounting of the Project, prepared by ADOT after the Project is fully complete.
Fully executed IGA	An IGA which has received all required approvals and opinions and has been signed by all parties.
HURF	The state of Arizona taxes motor fuels and collects a variety of fees and charges relating to the registration and operation of motor vehicles on the public highways of the state. These collections include gasoline and use-fuel taxes, motor-carrier taxes, vehicle-license taxes, motor vehicle registration fees and other miscellaneous fees. These revenues are deposited in the Arizona Highway User Revenue Fund (HURF) and are then distributed to the cities, towns and counties and to the State Highway Fund. These taxes represent a primary source of revenues available to the state for highway construction, improvements and other related expenses.
HURF Exchange funding	State Highway Funds which are exchanged for federal Surface Transportation Block Grant Program funds for areas of under 200,000 population and under 5,000 population pursuant to Arizona Revised Statutes §28-6993.G. HURF Exchange funding will be credited to the applicable COG or MPO at 90% of the amount of the federal Surface Transportation Block Grant Program funds programmed for the Project in the TIP.
HURF Exchange Project Forms	The forms in Attachment One, prescribed by ADOT and to be used by the City for HURF Exchange Projects, completed, approved and signed as required. The forms include: • HURF Exchange Project Scoping Form • HURF Exchange Project Cost Estimate • HURF Exchange Project and Draw Schedule • HURF Exchange Draw and Final Reimbursement Invoice
IGA	Intergovernmental agreement
Ineligible costs	Costs which are not eligible. Ineligible costs include, but are not limited to, the following: • Maintenance, which is scheduled or unscheduled work that is performed to preserve existing infrastructure, in reaction to an event (crash) or season (potholes), or work requiring regular reoccurring attention, such as fence repair, culvert cleanouts, etc. • Scoping. • Costs incurred prior to date of finance authorization. • Any items outside of the Project right of way. • Utility relocation which is not directly and unavoidably caused by the HURF Exchange Project.

- Betterments of utilities.
- Any other costs which are not eligible costs as defined above.

LPA	Local Public Agency Section of ADOT
Maintenance	Scheduled or unscheduled work that is performed to preserve existing infrastructure, in reaction to an event (such as an accident) or season (such as potholes), or work requiring regular reoccurring attention, such as fence repair, culvert cleanouts, and other ongoing work.
MPO	Metropolitan Planning Organization
Obligation	The application of State Highway Funds on a Project phase in AFIS.
Obligation Authority (OA)	The amount of apportionments which may be obligated in a federal fiscal year. ADOT provides obligation authority, on a discretionary basis, to COGs/MPOs.
Substantial completion	The Project is substantially complete when all of the following, as applicable, have occurred: (A) All lanes of traffic of the completed Project are finished and accepted and traffic can move unimpeded through the Project at the posted speed; (B) All signage is in place and accepted; (C) All guardrails, drainage devices, ditches, excavation and embankment have been accepted; and (D) The only work left for completion is incidental, away from the paved portion of the road, and does not affect the safety or convenience of the traveling public.
Surface Transportation Block Grant Program (STBGP)	A category of funding under the federal aid highway program. The subcategories of STBGP applicable to the HURF Exchange program are Under 200,000 population and Under 5,000 population. One hundred percent (100%) of the amount of Surface Transportation Block Grant Program apportionments and obligation authority programmed for the Project in the TIP will be charged to the applicable COG or MPO in exchange for HURF Exchange funding.
TIP	Transportation Improvement Program

III. SCOPE OF WORK

1. The City has represented to the State that it will be able to complete the Project phases according to the Funding Transfer and Authorization Schedule table below.

Funding Transfer and Authorization Schedule Table				
Project Phase(s) Programmed in TIP Intended as HURF Exchange	Fiscal Year Programmed	STBGP Apportionments and OA Charged to COG/MPO*	HURF Exchange Funding Credited to COG/MPO	Deadline to Submit Authorization Request to ADOT
Design				
Right of Way				
Construction	2022	$1,345,760.00	$1,211,184.00	5-15-22
Other:				
TOTAL		$1,345,760.00	$1,211,184.00	
*STBGP apportionments and obligation authority will be charged to the COG/MPO at 100% of this amount.				

2. The State will:

   a. Make the following funding transfers prior to the authorization of each Project phase:

      (1) Transfer 100% of the applicable STBGP apportionments and obligation authority for the respective Project phase from the applicable COG/MPO to the State.

      (2) Transfer State Highway Funds to the COG/MPO in the amount of 90% of the applicable STBGP apportionments and obligation authority for the respective Project phase.

      These transfers will be made only after, and are conditioned upon, completion of the prior phase, if any, and receipt of an authorization request and required documents for the phase to which the transfer applies.

   b. After completion of the above transfers for each Project phase, give authorization, obligate State Highway Funds, and notify the City that the phase may be advertised, consultants or contractors may be selected, or work can begin.

   c. After receipt of the final itemized budget and final Project phase amount for each Project phase, review and adjust the amount authorized and obligated in AFIS, as necessary, to be equivalent to the Final Project Phase Amount.

   d. If the Final Project Phase Amount is:

      (1) Less than the amount obligated for that phase, release any excess HURF Exchange funding in AFIS and return it to the COG/MPO for reprogramming.

(2) Greater than the amount of HURF exchange funding obligated, the City is solely responsible for the difference.

e. Pay State Highway Funds to the City for eligible costs for each obligated Project phase as follows:

(1) First 30% - Prior to the start of work and within 30 days approval of an invoice from the City.

(2) Second 30% - Within 30 days of approval of an invoice and copies of Project phase invoices received and paid by the City which demonstrate the work has progressed, or is progressing, to 30% completion.

(3) Third 30% - Within 30 days of approval of an invoice and copies of further Project phase invoices received and paid by the City which demonstrate the work has progressed, or is progressing, to 60% completion.

(4) Final 10% of each phase, except the final phase, will be reimbursed to the City by the State within 30 days of approval of invoice, copies of final Project phase invoices received and paid by the City which demonstrate the phase is completed. For the final phase, the final 10% will be reimbursed within 30 days of the completion of the final voucher. Upon payment of the final 10%, no further invoices will be accepted or paid.

f. After each subsequent phase is authorized and upon payment of the final invoice from the City for the preceding phase, close the preceding phase in AFIS and return any remaining funds to the applicable COG/MPO for reprogramming.

g. After all phases have been completed, conduct a final Project walk-through in conjunction with the City, the applicable COG/MPO and FHWA as required.

h. Prepare a final voucher for the Project upon completion of all phases, and return any remaining funds to the applicable COG/MPO for reprogramming.

3. The City will:

a. Utilize the HURF Exchange funding only for the Project and phase(s) which are the subject of this Agreement.

b. Adhere to the Project schedule in Section III.1.

c. Begin work, initiate selection of consultants or contractors or advertise the Project, as applicable, within 60 days of the date of authorization.

d. Approve and expend any funds required for the Project in excess of the HURF Exchange funding to ensure the Project is successfully completed on schedule.

e. Pay the final 10% of Project costs, to be reimbursed by ADOT within 30 days of the completion of the final voucher.

f. Submit an authorization request for each HURF Exchange Project phase to the ADOT Project Manager (PM) which includes the following documents, updated as necessary for each successive Project phase:

(1) HURF Exchange Project Cost Estimate form;

(2) HURF Exchange Project and Draw Schedule;

(3) A map indicating the location, functional class and limits of the Project;

(4) A copy of the TIP reflecting the HURF Exchange programming; and

(5) Other documents as may be required by the State.

Include an Invoice for first 30% progress payment with the authorization request if the Project phase is being performed with the City's own forces.

g. Within sixty (60) days of the selection of consultant or award of a contract for each Project phase, submit to the ADOT PM:

(1) The final Project phase scope with itemized costs;

(2) The final schedule, including the dates the work will start and end and the anticipated dates of each progress payment request; and

(3) The final itemized budget with Final Project Phase Amount.

h. If the Final Project Phase Amount is greater than the amount of HURF exchange funding obligated, be solely responsible for the difference.

i. Invoice ADOT for eligible costs for each obligated Project phase as follows using the HURF Exchange Draw and Final Reimbursement Invoice:

(1) First 30% - Prior to the start of work.

(2) Second 30% - A minimum of 30 days but not more than 60 days prior to when the funds will be required. The invoice must be accompanied by documents which demonstrate the work has progressed, or is progressing, to 30% completion including:

i. Copies of Project phase invoices, pay requests, estimates and other cost records received by the City and indicating payment status, or, if the City is performing the work with its own forces, a summary of costs expended, and

ii. A status report related to the Project phase schedule.

(3) Third 30% - A minimum of 30 days but not more than 60 days prior to when the funds will be required. The invoice must be accompanied by documents which

demonstrate the work has progressed, or is progressing, to 60% completion, including:

i. Copies of further Project phase invoices, pay requests, estimates and other cost records received by the City and indicating payment status, or if the City is performing the work with its own forces, a summary of costs expended, and

ii. A status report related to the Project phase schedule.

j. After all phases have been completed, participate in the final Project walk-through in conjunction with ADOT, the applicable COG/MPO and FHWA as required.

k. Within 15 business days of substantial completion of the construction phase, notify the ADOT PM to schedule a final Project walk-through.

l. Within 60 days of completion of the construction phase, submit the close out package to the ADOT PM which includes:

(1) An invoice for the final 10%;

(2) Copies of warrants or checks reflecting total costs paid by the City for construction;

(3) The Project Acceptance letter from the City to the contractor; and

(4) A close-out letter to ADOT.

m. Be responsible for complying with any federal requirements applicable to the Project.

n. If the City files a condemnation action, the City shall request an order of immediate possession.

o. Repay all HURF Exchange payments to ADOT if the Project is not constructed within two years of the completion of design and obtaining all rights of possession of right of way parcels. Upon receipt of an invoice from ADOT, the City shall pay the full amount within 30 days, as provided in paragraph III.4.d of this Agreement.

p. After completion and final acceptance of the Project, agree to maintain and assume full responsibility of the Project and all Project components.

4. The Parties agree:

a. The HURF Exchange program is offered at ADOT's discretion. ADOT reserves the right to discontinue the HURF Exchange program at any time. Such termination will not affect the validity of this Agreement.

b. A fully executed IGA does not guarantee funding or constitute permission to begin work. The City must request and receive authorization and a Notice To Proceed from the ADOT PM for each Project phase in advance of starting work.

c. No Change in Scope is authorized under this Agreement. If the City desires a Change in Scope, a formal amendment to the Agreement is required, signed by both Parties.

d. If the construction phase is not complete within two years from the completion of design, or if all phases of the project are not completed within three years from the date of the initial obligation of HURF Exchange funding, whichever is earlier, this Agreement will terminate and the City will be required to repay all HURF Exchange advances and reimbursements received to date. The two year period will be calculated as two years from the date the close out letter for the design phase was received by ADOT. Termination under this section will be executed as follows:

(1) Thirty days prior to termination, the State will send a letter to the City and ADOT Project Manager, indicating:

i. The close out package required in section III.3.n was not received by ADOT within two years of the completion of design or three years from the date of the initial obligation of HURF Exchange funding, whichever is earlier; and

ii. The steps necessary to avoid termination of this Agreement.

(2) If the close out package is not received by ADOT within 30 days of the date of the letter:

i. Any funding remaining on the Project will be de-obligated and returned to the respective COG/MPO for reprogramming on another Project;

ii. No further invoices will be accepted from, and no additional payments will be made to, the City for the Project; and

iii. The City must repay to ADOT all funds which have been previously paid by ADOT under this Agreement, including all current and previous phases.

iv. The State will send an invoice to the City for all HURF Exchange funding advanced or reimbursed for each phase of the Project with the due date by which such funds must be repaid to ADOT.

e. Expenditures incurred prior to the date of authorization of the applicable phase are not eligible for HURF Exchange.

f. The amount obligated for each Project phase will be adjusted to the Final Project Phase Amount.

g. If there is no billing activity in AFIS for 180 days, the City shall provide documentation which justifies the Project phase is still active to the State within 10 days of request. If the City cannot demonstrate such justification, the Project phase will be de-obligated as follows:

(1) Thirty days prior to de-obligation, the State will send an email to the City and ADOT Project Manager, providing notification of the funds available on the Project phase,

number of days since the last billing activity in AFIS and the steps necessary to remove the Project phase from pending de-obligation status.

(2) If the Project phase is not closed or billing activity generated within 30 days of the date of the email, any remaining funding will be de-obligated and returned to the respective COG/MPO for reprogramming on another Project. No further invoices will be accepted from, and no additional payments will be made to, the City for the applicable Project phase.

(3) Upon de-obligation of funds from the inactive Project phase, the ADOT Chief Financial Officer will send a letter to the City with notification of the date of de-obligation, the treatment of the de-obligated funds and, if applicable, an invoice for any funding which must be repaid to ADOT or FHWA with the due date(s).

h. All HURF Exchange submissions and invoices are to be submitted to the assigned ADOT PM.

i. Any HURF Exchange funds de-obligated or released from Project phases will be returned to the applicable COG/MPO for reprogramming.

IV. MISCELLANEOUS PROVISIONS

1. The terms, conditions and provisions of this Agreement shall remain in full force and effect until all payments contemplated under the Agreement have been made, unless specifically otherwise contemplated in this Agreement.

2. This Agreement may be cancelled at any time prior to the exchange of any HURF funds and after 30 days written notice to the other Party. It is understood and agreed that, in the event the City terminates this Agreement, the City shall be responsible for all costs incurred by the State up to the time of termination. It is further understood and agreed that in the event the City terminates this Agreement, HURF Exchange Program will no longer be available for use by the City for this project.

3. The City shall indemnify, defend, and hold harmless the State, any of its departments, agencies, officers or employees (collectively referred to in this paragraph as the "State") from any and all claims, demands, suits, actions, proceedings, loss, cost and damages of every kind and description, including reasonable attorneys' fees and/or litigation expenses (collectively referred to in this paragraph as the "Claims"), which may be brought or made against or incurred by the State on account of loss of or damage to any property or for injuries to or death of any person, to the extent caused by, arising out of, or contributed to, by reasons of any alleged act, omission, professional error, fault, mistake, or negligence of the City, its employees, officers, directors, agents, representatives, or contractors, their employees, agents, or representatives in connection with or incident to the performance of this Agreement. The City's obligations under this paragraph shall not extend to any Claims to the extent caused by the negligence of the State, except the obligation does apply to any negligence of the City which may be legally imputed to the State by virtue of the State's ownership or possession of land. The City's obligations under this paragraph shall survive the termination of this Agreement.

4. ADOT assumes no liability or financial responsibility for HURF Exchange Projects. The City is solely responsible for complying with all applicable laws, rules and regulations, for any additional funding required to complete the Project and for any claims due to delays, change orders or any other circumstances.

5. The City is required to retain all records related to a HURF Exchange Project for a period of five years after the date of the final payment of HURF Exchange funding from ADOT.

6. All HURF Exchange Projects are subject to audit. The State may refer Projects to the State Auditor General or ADOT's Internal Audit unit in cases of suspected misuse of HURF Exchange funding.

7. ADOT reserves the right to refuse to enter into further HURF Exchange transactions with the City if the City owes repayment of previous HURF Exchange funding or has misused HURF Exchange funds.

8. This Agreement shall become effective upon signing and dating of the Determination Letter by the State's Attorney General.

9. The Parties shall comply with all applicable laws, rules, regulations and ordinances, as may be amended.

10. This Agreement may be cancelled in accordance with Arizona Revised Statutes § 38-511.

11. This Agreement is subject to all applicable provisions of the Americans with Disabilities Act (Public Law 101-336, 42 U.S.C. 12101-12213) and all applicable federal regulations under the Act, including 28 CFR Parts 35 and 36. The Parties to this Agreement shall comply with Executive Order Number 2009-09 issued by the Governor of the State of Arizona and incorporated in this Agreement by reference regarding "Non-Discrimination".

12. The City acknowledges and will comply with Title VI of the Civil Rights Act of 1964.

13. Non-Availability of Funds: Every obligation of the State under this Agreement is conditioned upon the availability of funds appropriated or allocated for the fulfillment of such obligations. If funds are not allocated and available for the continuance of this Agreement, this Agreement may be terminated by the State at the end of the period for which the funds are available. No liability shall accrue to the State in the event this provision is exercised, and the State shall not be obligated or liable for any future payments as a result of termination under this paragraph.

14. In the event of any controversy, which may arise out of this Agreement, the Parties agree to abide by arbitration as is set forth for public works contracts if required by Arizona Revised Statutes § 12-1518.

15. The Parties shall comply with the applicable requirements of Arizona Revised Statutes § 41-4401.

16. The City must comply with all applicable anti-discrimination laws and regulations.

17. The Parties shall certify that all contractors comply with the applicable requirements of Arizona Revised Statutes §35-393.01.

18. All notices or demands upon any Party to this Agreement shall be in writing and shall be delivered electronically, in person, or sent by mail, addressed as follows:

For Agreement Administration:

Arizona Department of Transportation
Joint Project Agreement Group
205 S. 17th Avenue, Mail Drop 637E
Phoenix, AZ 85007
JPABranch@azdot.gov

City of San Luis
Attn: Eulogio Vera, Director of Public Works
PO Box 1170
San Luis, AZ 85349
948.341.8577
evera@sanluisaz.gov

For Project Administration:

Arizona Department of Transportation
Local Public Agency Section
205 S. 17th Avenue, Suite 291
Phoenix, AZ 85007
602.712.4173

City of San Luis
Attn: Eulogio Vera, Director of Public Works
PO Box 1170
San Luis, AZ 85349
948.341.8577
evera@sanluisaz.gov

For Financial Administration:

Arizona Department of Transportation
Financial Management Services, Resource Administration
205 S. 17th Avenue, Mail Drop 200B
Phoenix, AZ 85007

City of San Luis
Attn: Monica Castro, Finance Director
PO Box 1170
San Luis, AZ 85349
928.341.8553
mcastro@sanluisaz.gov

19. Any revisions to the names and addresses above may be updated administratively by either Party and shall be in writing.

20. In accordance with Arizona Revised Statutes § 11-952 (D), attached and incorporated in this Agreement is the written determination of each Party's legal counsel that the Parties are authorized under the laws of this State to enter into this Agreement and that the Agreement is in proper form.

IN WITNESS WHEREOF, the Parties have executed this Agreement to be effective upon the signing and dating of all Parties.

CITY OF SAN LUIS

By _____ Date_____
GERARDO SANCHEZ
MAYOR

ATTEST:

By _____ Date_____
SONIA CORNELIO
City Clerk

I have reviewed the above referenced Intergovernmental Agreement between the State of Arizona, acting by and through its DEPARTMENT OF TRANSPORTATION, and the CITY OF SAN LUIS, an agreement among public agencies which, has been reviewed pursuant to Arizona Revised Statutes §§ 11-951 through 11-954 and A.R.S. 48-572 and declare this Agreement to be in proper form and within the powers and authority granted to the City under the laws of the State of Arizona.

No opinion is expressed as to the authority of the State to enter into this Agreement.
Approved as to Form:

By _____ Date_____
City Attorney

ARIZONA DEPARTMENT OF TRANSPORTATION

By _____ Date_____
STEVE BOSCHEN, PE
Division Director

A.G. Contract No. P001 2022 000724 (ADOT IGA 22-0008568-I), an Agreement between public agencies, the State of Arizona and the City of El Mirage, has been reviewed pursuant to A.R.S. §§ 11-951 through 11-954 and A.R.S. § 28-401, by the undersigned Assistant Attorney General who has determined that it is in the proper form and is within the powers and authority granted to the State of Arizona. No opinion is expressed as to the authority of the remaining Parties, other than the State or its agencies, to enter into said Agreement.

By _____ Date_____
Assistant Attorney General

IGA 22-0008568-I

ATTACHMENT ONE
(Cover Sheet)

HURF EXCHANGE PROJECT FORMS

1. HURF Exchange Project Scoping Form
2. HURF Exchange Project Cost Estimate
3. HURF Exchange Project and Draw Schedule
4. HURF Exchange Draw and Final Reimbursement Invoice

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HURF Exchange Project Scoping Form

Note: The Project Scoping Form, Project Cost Estimate and Project and Draw Schedule forms (all contained in this file) must be completed and submitted with the project initiation request. Eash phase requires advanced authorization by ADOT. HURF Exchange funding may not be combined with federal aid.

INSTRUCTIONS: This form is required to accompany a HURF Exchange Project Initiation request.	**Enter information into GREEN CELLS**

PROJECT INFORMATION

(infornation provided in this section will auto-populate to the Project Cost Estimate and Draw Schedule tabs)

Project Sponsor	**City of San Luis**
Sponsor Contact	**Eulogio Vera**
Contact Phone #	**928-341-8577**
Contact Email	evera@sanluisaz.gov
Project Name	**County 24th Extension: Avenue F to Avenue H**
Project Location	**San Luis, AZ**
Functional Classification (select from list)	**Major Collector**
Termini Begin/End	**Avenue F to Avenue H**
ADOT District (select from list)	**Southwest District**

ADOT USE ONLY

ADOT Project Number (5 digit)		**IGA Number**	

Funding Information

COG/MPO (select from list)		**YMPO**		
TIP Information	***Description***	***Design***	***Right of Way***	***Construction***
	Year Programmed	FY2021		FY22
	TIP Number	SAN20-01		SL22-01C
	HURF Exchange Amount			$1,211,184.00
	Sponsor Amount	$50,650.00		$684,052.00
	Phase Total	**$50,650.00**	**$0.00**	**$1,895,236.00**
	Project Total			**$1,945,886.00**

Scope of Work Summary

Delivery Method (select from list)	
Scoping document attached? (select from list)	
Major Items of Work (press Alt-Tab to create a new line; press Alt-Tab-Tab to create a new paragraph)	Roadway Grading, Roadway Base, Asphaltic Concrete, Signing & Marking. Delivery Method: Advertised for Bids.

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HURF Exchange Project Cost Estimate

Note: The Project Scoping Form, Project Cost Estimate and Project and Draw Schedule forms (all contained in this file) must be completed and submitted with the project initiation request. Eash phase requires advanced authorization by ADOT. HURF Exchange funding may not be combined with federal aid.

INSTRUCTIONS: This form is required to accompany a HURF Exchange Project Initiation request. List all items necessary to develop and construct the project. The sponsoring agency is responsible for verifying all costs and their accuracy. Construction cost overruns will be the responsibility of the sponsoring agency.	**Enter values into GREEN CELLS**

PROJECT INFORMATION

(fields below will be populated based on information entered on the Project Scoping Form tab)

Project Sponsor	**City of San Luis**
Sponsor Contact	**Eulogio Vera**
Contact Phone #	**928-341-8577**
Contact Email	**evera@sanluisaz.gov**
Project Name	**County 24th Extension: Avenue F to Avenue H**
Project Location	**San Luis, AZ**
Termini Begin/End	**Avenue F to Avenue H**
COG/MPO	**YMPO**
Design TIP Number	**SAN20-01**
Right of Way TIP Number	**0**
Construction TIP Number	**SL22-01C**

ADOT USE ONLY	ADOT Project Number	**0**

STAGE I – SCOPING (15% Preliminary Design)

NOT ELIGIBLE FOR HURF EXCHANGE FUNDING

STAGES II, III, IV and V - DESIGN

DESIGN COSTS

ITEM DESCRIPTION	UNIT	QUANTITY	UNIT PRICE	TOTAL
PS&E's - Plans, Special Provisions, Cost Estimates & Schedules (10%-20% of construction cost.)	Lump Sum	1	$50,650.00	$50,650.00
GEOTECHNICAL INVESTIGATION (If a report is necessary, anticipate 5% of construction cost) Includes testing, Geotech Report, Materials & Pavement Design Report) ***Enter $0 in Unit Price column if none required.***	Lump Sum	1		$0.00
DRAINAGE REPORT (If a report is necessary, anticipate 5% of construction cost) ***Enter $0 in Unit Price column if none required)***	Lump Sum	1		$0.00
STORM WATER POLLUTION PREVENTION PLAN (Required if there is over 1 acre of total disturbance, 1% of construction cost) ***Enter $0 in Unit Price column if none required.***	Lump Sum	1		$0.00
			SUBTOTAL – PROJECT DESIGN COSTS	**$50,650.00**

RIGHT OF WAY COSTS

ITEM DESCRIPTION	UNIT	QUANTITY	UNIT PRICE	TOTAL
RIGHT OF WAY , Costs for pre-acquisition activities (plans, title reports, appraisals, etc)	Lump Sum	1		$0.00
RIGHT-OF-WAY ACQUISITION (if necessary)	Lump Sum	1		$0.00
			SUBTOTAL – RIGHT OF WAY COSTS	**$0.00**

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STAGE V – CONSTRUCTION				
SITE PREPARATION & HARDSCAPE CONSTRUCTION				
ITEM DESCRIPTION	**UNIT**	**QUANTITY**	**UNIT PRICE**	**TOTAL**
INSTALLATION OF STORMWATER POLLUTION PREVENTION MEASURES (If over 1 acre of disturbance, 5% of construction costs) ***Enter $0 in Unit Price column if area of disturbance is less than one acre.***	Lump Sum	1	$22,000.00	$22,000.00
SITE PREPARATION (Clearing and grubbing, plant salvage)	Lump Sum	1		$0.00
DEMOLITION				
Sawcut	Linear Foot			$0.00
Remove Structures and Obstructions	Lump Sum	1		$0.00
Remove Fencing	Linear Foot			$0.00
Remove Structural Concrete	Cubic Yard			$0.00
Remove Asphaltic Concrete Pavement				$0.00
Remove Concrete Sidewalks, Slabs				$0.00
HAZARDOUS MATERIALS ABATEMENT (If applicable; include heavy metals & asbestos; 5% of construction cost) ***Enter $0 in Unit Price column if none required.***	Lump Sum	1		$0.00
UTILITY RELOCATION (If necessary) Only the cost of utilities needing relocation as a direct result of the HURF Exchange project is eligible for HURF Exchange.	Lump Sum	1		$0.00
RETAINING WALL (Concrete; SF of face above the footing)	Square Footage			$0.00
EARTHWORK				
General Excavation	Cubic Yard			$0.00
Drainage Excavation				$0.00
Structural Excavation				$0.00
Structural Backfill				$0.00
Borrow (In Place)				$0.00
CURB & GUTTER	Linear Foot			$0.00
ROADWAY/PAVING				
Milling	Square Yards			$0.00
Paving	Tons	4,233	$165.00	$698,445.00
AGGREGATE BASE	Cubic Yard	13,782	$45.00	$620,190.00
PATHWAY OR SIDEWALK MATERIALS				
Concrete	Square Foot			$0.00
Colored Concrete				$0.00
Stamped Color Concrete				$0.00
Precast Concrete Pavers				$0.00
Asphaltic Concrete	Tons			$0.00
Polymer or Resin Stabilized Surface	Square Foot			$0.00
CROSSWALK ENHANCEMENT				
Concrete Pavers	Square Foot			$0.00
Stamped Asphalt				$0.00
Stamped Concrete				$0.00
Concrete				$0.00
Integral Color Concrete				$0.00
PEDESTRIAN ADA RAMP	Square Foot			$0.00
CULVERT EXTENSIONS	Linear Foot			$0.00

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SUBTOTAL - SITE PREPARATION & HARDSCAPE CONSTRUCTION	**$1,340,635.00**

OTHER CONSTRUCTION ITEMS (List line items)

ITEM DESCRIPTION	UNIT (Lump Sum, Ton, etc.)	QUANTITY	UNIT PRICE	TOTAL
Removals	LS	1	$15,000.00	$15,000.00
Grading for Paving and Shoulder	LS	1	$200,000.00	$200,000.00
Roadway Signage and Marking	LS	1	$50,000.00	$50,000.00
Street Lights	LS	1	$150,000.00	$150,000.00
				$0.00
				$0.00
				$0.00
				$0.00
SUBTOTAL - OTHER CONSTRUCTION LINE ITEMS				**$415,000.00**

MOBILIZATION AND ADMINISTRATION COSTS

ITEM DESCRIPTION	UNIT	QUANTITY	UNIT PRICE	TOTAL
CONTRACTOR MOBILIZATION (Typically 8% of construction cost)	Lump Sum	1	$22,000.00	$22,000.00
TRAFFIC CONTROL (0-8% of construction cost)	Lump Sum	1	$16,500.00	$16,500.00
CONSTRUCTION SURVEY & LAYOUT (Typically 1% of construction cost)	Lump Sum	1	$27,500.00	$27,500.00
CONSTRUCTION CONTINGENCIES (Typically 5% of construction cost)	Lump Sum	1	$105,000.00	$105,000.00
CONSTRUCTION ADMINISTRATION Typically 20% of construction cost)	Lump Sum	1	$135,000.00	$135,000.00
SUBTOTAL – MOBILIZATION & ADMINISTRATION COSTS				$306,000.00
TOTAL STAGE V COSTS (CONSTRUCTION)				**$2,061,635.00**
TOTAL PROJECT COST				**$2,112,285.00**

SUMMARY OF HURF EXCHANGE AND SPONSOR FUNDS

The data below is automatically calculated based on the information entered above and the amount programmed in the TIP as entered on the Project Scoping Form.

PHASE	HURF EXCHANGE FUNDS IN TIP	SPONSOR FUNDS	TOTAL
~~TOTAL DESIGN~~	$0.00	$50,650.00	$50,650.00
TOTAL RIGHT OF WAY	$0.00	$0.00	$0.00
TOTAL CONSTRUCTION	$1,211,184.00	$850,451.00	$2,061,635.00
TOTALS	$1,211,184.00	$901,101.00	**$2,112,285.00**

Prepared by:
Name Eulogio Vera
Title Public Works Director
Company City of San Luis
Phone 928-341-8577
Email evera@sanluisaz.gov

DocuSign Envelope ID: A1A0EDC6-7015-4ADB-80F1-0456432DE6DE

HURF Exchange Project and Draw Schedules

Note: The Project Scoping Form, Project Cost Estimate and Project and Draw Schedule forms (all contained in this file) must be completed and submitted with the project initiation request. Eash phase requires advanced authorization by ADOT. HURF Exchange funding may not be combined with federal aid.

INSTRUCTIONS: This form is required to accompany a HURF Exchange Project Initiation request. Enter the Estimated Completion Dates as requested for each Stage of Development and Construction. Also enter the Expected Draw Dates for these phases. Draw amounts for each phase are auto-calculated based on the amount programmed in the TIP as entered on the Project Scoping Form.

Enter dates into GREEN CELLS

Project Information

(fields below will be populated based on information entered on the Project Scoping Form tab)

Project Sponsor	**#NAME?**
Sponsor Contact	**Eulogio Vera**
Contact Phone #	**928-341-8577**
Contact Email	**evera@sanluisaz.gov**
Project Name	**County 24th Extension: Avenue F to Avenue H**
Project Location	**San Luis, AZ**
Termini Begin/End	**Avenue F to Avenue H**
COG/MPO	**YMPO**
Design TIP Number	**SAN20-01**
Right of Way TIP Number	**0**
Construction TIP Number	**SL22-01C**
ADOT USE ONLY	**ADOT Project Number**

Project Development

Development Schedule

Stage	Estimated Completion Date
Project Initiation	3/31/2022
IGA Executed	6/17/2022
Request for Authorization to ADOT	6/24/2022
Authorization/Start of Phase Work	
Stage II	3/12022
Stage III	4/1/2020
Stage IV	7/1/2020
Bid Ready	10/1/2020

HURF Exchange Funding Draw Schedule

Draw %	Amount	Expected Draw Date
30%	$ -	
30%	$ -	
30%	$ -	
10%	$ -	
Total	$ -	

Right of Way

Acquisition Schedule

Activity	Estimated Completion Date
Request for Authorization to ADOT	
Authorization/Start of Phase Work	
All Parcels Acquired By	

HURF Exchange Funding Draw Schedule

Draw %	Amount	Expected Draw Date
30%	$ -	
30%	$ -	
30%	$ -	
10%	$ -	
Total	$ -	

Construction

Construction Schedule

Activity	Estimated Completion Date
Request for Authorization to ADOT	6/24/2022
Authorization/Start of Phase Work	6/30/2022
Bid Advertisement	7/7/2022
Bid Opening	8/9/2022
Bid Award	8/25/2022
Notice to Proceed to Contractor	9/5/2022
Substantial Completion	12/22/2022
Final Project Walk-through	1/5/2023
Final Acceptance	1/19/2023

HURF Exchange Funding Draw Schedule

Draw %	Amount	Expected Draw Date
30%	$ 363,355.20	6/30/2022
30%	$ 363,355.20	11/10/2022
30%	$ 363,355.20	12/2/2022
10%	$ 121,118.40	1/19/2023
Total	$ 1,211,184.00	

The Final 10% is reimbursed to the Sponsor as follows:

- For projects involving multiple phases funded with HURF Exchange - the final 10% for each phase, except for the last, will be reimbursed within 30 days of the receipt and approval of an invoice and documentation demonstrating the phase is complete.
- At final Project completion - the final 10% will be reimbursed upon completion of the project final voucher by ADOT.

ARIZONA DEPARTMENT OF TRANSPORTATION
HURF EXCHANGE DRAW AND FINAL REIMBURSEMENT INVOICE

COG/MPO:		**Project Phase:**	
Local Entity:			
TIP ID Number:			
Project Number:			
Project Name/Location Desciption:			
REMIT PAYMENT TO: (Entity Name and Address Project Sponsor)			
Date Started:	**Estimated Completion Date:**	**% Billed:**	**% Complete:**

	Expected Draw Date	Actual Draw Date	Actual Invoice Amount	Estimated Draw Amount	Actual Draw Amount
Draw # 1 (30%)					
Draw # 2 (30%)					
Draw # 3 (30%)					
Draw # 4 (10% - Final Reimbursement)					

SUMMARY OF WORK FOR WHICH PAYMENT IS REQUESTED

Items	Description	Previous Accumulative Amount	Current Month	Accumulative Amount
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00

Submitted By:	Date:	Total To Date	$0.00
Approved By:	Date:	Total Previous Report	$0.00
ADOT Project Manager			
Approved By:	Date:	Current Report	**$0.00**
FMS Resource Admin			

Attachments:

Invoices
Status Reports

County 24th Street - 10th Avenue to Avenue F-1/4 Roadway Project
Location Map for Existing and New Road Right-of-Way Across USA Lands

147760502601
USA
641.2 Acres

8

1477701029
USA
391.24 Acres

9

7

EXISTING 66' WIDE ROAD RIGHT-OF-WAY
- Area Covered by 2009 Cultural Resource Survey -

NEW 33' WIDE x 660' LONG
ROAD RIGHT-OF-WAY

10TH AVENUE (AVENUE H)

AVENUE F-1/2

COUNTY 24TH ST

147765015
STATE OF ARIZONA
87.32 Acres

AVENUE H

147820502602
USA
302.84 Acres

17

1478301030
USA
231.38 Acres

16

1478301008
USA
282.93 Acres

bing

AGENDA ITEM REVIEW FORM

Regular City Council Meeting **5. E.**

Meeting Date: 06/22/2022

Department Head: Monica Castro, Director of Finance, Finance Department

Submitted By: Roula Encinas, Accountant, Finance Department

Action Requested: Motion
Public Hearing
Resolution

ITEM:

Public hearing followed by discussion and possible action on any and all matters regarding Resolution No. 2221. A resolution of the Mayor and City Council of the City of San Luis, Arizona, adopting the budget for Fiscal Year 2022-2023. **(Monica Castro, Director of Finance)**

A. Open Public Hearing
   1. Staff Presentation
   2. Call to the public on this item
B. Close Public Hearing
C. Action on Resolution No. 2221

SUMMARY:

Pursuant to state statute, the City Council is required to hold a public hearing before adopting the final budget that will establish the maximum ceiling for the city's budget.

Budget preparation workshops were held during the months of April and May, followed by the submission of a tentative recommended budget that was provided to the City Council on June 8, 2022. At this point, staff has reviewed, revised, and compiled the data from all the work sessions for the expected Fiscal Year 2022-2023 revenues and expenditures. Therefore, staff is submitting the final budget to the council for acceptance and adoption.

RECOMMENDATION / SUGGESTED MOTION:

A. I MOVE TO OPEN THE PUBLIC HEARING
   1. Presentation by staff
   2. Call to the public on this item
B. I MOVE TO CLOSE THE PUBLIC HEARING
C. I MOVE TO APPROVE AND ADOPT RESOLUTION NO. 2221.

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):

There is no fiscal impact associated with this item.

Attachments

Resolution No. 2221

Schedule A- FY2023

OFFICE OF THE
MAYOR
CITY OF SAN LUIS

Resolution

NO. 2221

A RESOLUTION OF THE MAYOR AND CITY COUNCIL OF THE CITY OF SAN LUIS, ARIZONA ADOPTING THE BUDGET FOR THE FISCAL YEAR 2022 - 2023.

WHEREAS, in accordance with the provisions of Title 42, Chapter 17, Articles 1-5, Arizona Revised Statutes (A.R.S.), the City Council did, on June 22, 2022, make an estimate of the different amounts required to meet the public expenditures/expenses for the ensuing year, also an estimate of revenues from sources other than direct taxation, and

WHEREAS, in accordance with said chapter of said title, and following due public notice, the Council met on June 22, 2022, at which meeting any taxpayer was privileged to appear and be heard in favor of or against any of the proposed expenditures/expenses, and

WHEREAS, it appears that publication has been duly made as required by law, of said estimates together with a notice that the City Council would meet on June 22, 2022, at the office of the Council for the purpose of hearing taxpayer, therefore be it

RESOLVED, that the said estimates of revenues and expenditures/expenses shown on the accompanying schedules, as now increased, reduced, or changed, are hereby adopted as the budget of the City of San Luis for the fiscal year 2022-2023.

PASSED AND ADOPTED by the San Luis City Council, this 22nd day of June 2022, in the City of San Luis, Arizona.

Gerardo Sanchez, Mayor

ATTEST:

Sonia Cornelio, City Clerk

APPROVED AS TO FORM:

Kay Macuil, City Attorney

City of San Luis
Summary Schedule of estimated revenues and expenditures/expenses
Fiscal year 2023

Fiscal Year		Sch		Funds						
				General Fund	Special Revenue Fund	Debt Service Fund	Capital Projects Fund	Enterprise Funds Available	Internal Service Funds	Total all funds
2022	Adopted/adjusted budgeted expenditures/expenses*	E	1	27,233,036	13,541,147	26,256,150	1,643,700	17,939,594	2,917,110	89,530,737
2022	Actual expenditures/expenses**	E	2	22,308,760	4,570,070	25,310,870	251,610	12,910,570	2,917,110	68,268,990
2023	Beginning fund balance/(deficit) or net position/(deficit) at July 1***		3	30,862,034	3,924,594	29,768	2,877,918	39,819,603	4,292,018	81,805,935
2023	Secondary property tax levy	B	5		642,640					642,640
2023	Estimated revenues other than property taxes	C	6	28,416,480	21,816,184	25,000,800	804,030	14,940,480	3,074,310	94,052,284
2023	Other financing sources	D	7	0	0	0	0	0	0	0
2023	Other financing (uses)	D	8	0	0	0	0	0	0	0
2023	Interfund transfers in	D	9	0	4,827,397	1,629,630	0	576,890	0	7,033,917
2023	Interfund Transfers (out)	D	10	4,003,810	2,880,107	0	150,000	0	0	7,033,917
2023	Line 11: Reduction for fund balance reserved for future budget year expenditures		11							
	Maintained for future debt retirement			2,162,440			109,790	3,099,535		5,371,765
	Maintained for future capital projects			5,000,000				14,450,000		19,450,000
	Maintained for future financial stability	0		13,470,248	1,245,740			4,413,390	1,537,155	20,666,533
										0
										0
2023	Total financial resources available		12	34,642,016	27,084,968	26,660,198	3,422,158	33,374,048	5,829,173	131,012,561
2023	Budgeted expenditures/expenses	E	13	26,830,093	26,002,564	26,630,430	2,316,364	18,783,064	3,074,310	103,636,825

	Expenditure limitation comparison	2022	2023
1	Budgeted expenditures/expenses	$ 89,530,737	$ 103,636,825
2	Add/subtract: estimated net reconciling items		
3	Budgeted expenditures/expenses adjusted for reconciling items	89,530,737	103,636,825
4	Less: estimated exclusions	39,816,118	55,123,848
5	Amount subject to the expenditure limitation	$ 49,714,619	$ 48,512,977
6	EEC expenditure limitation	$ 54,011,497	$ 51,226,925

* Includes expenditure/expense adjustments approved in the current year from Schedule E.

** Includes actual amounts as of the date the proposed budget was prepared, adjusted for estimated activity for the remainder of the fiscal year.

*** Amounts on this line represent beginning fund balance/(deficit) or net position/(deficit) amounts except for nonspendable amounts (e.g., prepaids and inventories) or amounts legally or contractually required to be maintained intact (e.g., principal of a permanent fund).

AGENDA ITEM REVIEW FORM

Regular City Council Meeting **5. F.**

Meeting Date: 06/22/2022

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

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

Action Requested: Motion
Resolution

ITEM:

Discussion and possible action on any and all matters regarding Resolution No. 2222. A resolution of the Mayor and City Council of the City of San Luis, Arizona, approving the entering into a Pledgehold Agreement with Riedel Holdings to post land for assurances to construct a wastewater lift station and other commitments related to Los Mezquites Subdivision. **(Glenn Gimbut, Assistant City Attorney)**

SUMMARY:

Background

On December 21, 2021, City Council approved Resolution 2204 authorizing a Development Agreement with Riedel Holdings, LLC, for Los Mezquites Subdivision (the second attachment to this agenda item). Under Section 2.2 of that agreement, Riedel Holdings, LLC agreed to improvements needed at the discretion of the city's Public Works director. One of the listed improvements is a wastewater lift station, which is needed. Los Mezquites is phased out into 4 units. The lift station serves all units in addition to Von Verde and state lands to the south. The lift station is known as the Los Mezquites/Von Verde Lift Station, located on Avenue D between County 23½ Street and County 24th Street.

Summary of Pledgehold Agreement

Assurance for a Lift Station

The Pledgehold Agreement allows for other construction of Units 3 and 4 to go forward in exchange, the city has a guarantee of land it can sell to pay for building the lift station if Riedel Holdings were not to construct it for any reason.
Chicago Title Company will hold Los Mezquites Unit 4 (about 74.8 acres) as collateral under this Pledgehold Agreement.

Assurance for Los Mezquites Unit 2

Public Works has approved an Engineers Cost Estimate of $3,473,505.85 for the construction of Los Mezquites Unit 2. (The cost estimate is the third attachment to this Agenda Item). A letter of credit in the amount of $3,370,612.00 will be finalized upon the signing of the Pledgehold Agreement. The Pledgehold Agreement provides for another $250,000 of additional assurances for Los Mezquites Unit 2, which more than covers the shortfall from the Engineer's Cost Estimate.

Assurance for Los Mezquites Units 1 and 2 Road and Intersection Improvements

The Pledgehold Agreement assures the city that Riedel Holdings will construct the road and intersection improvements required by the traffic study that are related to Los Mezquites Units 1 and 2. The city will be responsible for right-of-way acquisition. Riedel Holdings will be responsible for the construction.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE AND ADOPT RESOLUTION NO. 2222 AND THE PLEDGEHOLD AGREEMENT.

Fiscal Impact

IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM:	See fiscal impact statement
CITY/STATE/FEDERAL FUNDS:	See fiscal impact statement
TOTAL:	See fiscal impact statement
BUDGETED AMOUNT:	See fiscal impact statement
AVAILABLE AMOUNT TO TRANSFER:	See fiscal impact statement
ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE:	See fiscal impact statement

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

There is no fiscal impact. If Los Mezquites were abandoned before the completion of the infrastructure construction, the city would sell the land at auction to pay for the completion of the subdivision. The Engineer's estimates of cost is under today's best estimate given that Riedel Holdings purchased materials months ago at better prices. So, if the city were to complete the subdivision, it is possible that the land sale would not pay for all the costs.

Attachments

Resolution No. 2222

Resolution 2204

Engineer's Cost Estimate

OFFICE OF THE
MAYOR
CITY OF SAN LUIS

Resolution

No. 2222

A RESOLUTION OF THE MAYOR AND CITY COUNCIL OF THE CITY OF SAN LUIS, ARIZONA, APPROVING THE ENTERING INTO A PLEDGEHOLD AGREEMENT WITH RIEDEL HOLDINGS, LLC TO POST LAND FOR ASSURANCES TO CONSTRUCT A WASTEWATER LIFT STATION AND OTHER COMMITMENTS RELATED TO LOS MEZQUITES SUBDIVISION.

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

Section 1: The attached Pledgehold Agreement and its Exhibit are hereby approved.

Section 2: City officers and employees are authorized and directed to perform all acts necessary or desirable to give effect to the Pledgehold Agreement.

Section 3: If a conflict arises between the provisions of this resolution and any other ordinance, resolution, regulation, or policy of the City of San Luis, the conflicting provisions are amended, superseded, and replaced, and this resolution shall govern.

Section 4: If any section, subsection, sentence, clause phrase, or a portion of this resolution is held to be invalid or unconstitutional by the final decision of any court of competent jurisdiction, such decision shall not affect the validity of the remaining portion of this resolution.

PASSED, ADOPTED, and APPROVED by the Mayor and City Council of the City of San Luis, Yuma County, Arizona, this ____day of June 2022.

_____
Gerardo Sanchez, Mayor

ATTEST:

_____
Sonia Cornelio, City Clerk

APPROVED AS TO FORM:

_____
Kay Marion Macuil, City Attorney

PLEDGEHOLD AGREEMENT

This PLEDGEHOLD AGREEMENT ("Agreement") is entered into on this ___ day of June 2022, by and between RIEDEL HOLDINGS, L.L.C. ("Pledgor"), and the CITY OF SAN LUIS, Arizona ("Pledgee" or "City"); and CHICAGO TITLE INSURANCE COMPANY, Inc., an Arizona corporation ("Pledgeholder"). Pledgor, Pledgee or City, and Pledgeholder may be referred to collectively as the "Parties" and individually as the "Party."

WITNESSETH:

WHEREAS, Pledgor, as Guarantor, to induce Pledgee to allow for the continued construction of the Los Mezquites Units 2, 3 and 4 by RIEDEL HOLDINGS, L.L.C. ("RIEDEL HOLDINGS") under that certain Development Agreement dated December 21, 2021, and recorded with the Yuma County Recorder's Office at Fee #2021-47097, desires to pledge certain Collateral, as defined, to Pledgee to secure the construction of a lift station known as the Los Mezquites/Von Verde Lift Station ("Lift Station") located on Avenue D between County 23½ Street and County 24th Street in San Luis, Arizona, as well as pledge said Collateral to secure construction of Improvements for the subdivision known as Los Mezquites II and secure the performance of construction of signalization at County 24th Street and Ave. E and County 23 ½ and Ave. E in San Luis, Arizona;

NOW, THEREFORE, for good and valuable consideration, the receipt of which is hereby acknowledged by Pledgor, the Parties hereby agree as follows:

Section 1. Definitions. The terms defined in this Section shall have such defined meanings for all purposes of this Agreement unless the context otherwise requires:

(a) "Borrower" shall mean RIEDEL HOLDINGS, L.L.C.

(b) "Collateral" shall mean all of Pledgor's interest in the following real property:

See Exhibit A attached hereto.

(Collectively referred to as the "Property" or "Collateral").

(c) "Event of Default" shall have the meaning(s) ascribed to such term in this Agreement.

(d) "Development Agreement" shall mean that certain Development Agreement between the Pledgor and Pledgee dated December 21, 2021, and recorded with the Yuma County Recorder's Office at Fee #2021-47097.

(e) "Improvements" means the Los Mezquites/Von Verde Lift Station ("Lift Station") and related infrastructure located on Avenue D between County 23½ Street and County 24th Street in San Luis, Arizona. "Improvements" shall also include all streets, roads, sidewalks, easements, drainage, utility mains and lines, and all other infrastructure of every nature, kind, or description, whatsoever, known or unknown, for the subdivision known as Los Mezquites II. "Improvements" shall additionally include any and all design, development and construction of signalization at the intersections of County 24th and Ave. E and County 23 ½ and Ave. E to the Public Works Standards of the City and the Standards of the Arizona Department of Transportation, hereinafter referred to as "Signalization Projects".

(f) "Obligations" shall mean all promises, duties, and/or responsibilities arising from the Development Agreement, and in specific the construction of the Los Mezquites/Von Verde Lift Station located on Avenue D between County 23½ Street and County 24th Street in San Luis, Arizona, the construction of Los Mezquites II Subdivision, and the design, development, and construction of the Signalization Projects.

(g) "Pledged Collateral" shall mean that Warranty Deed delivered to Pledgeholder and endorsed in blank pursuant to the terms and conditions of this Agreement, conveying all Pledgor's interest in the Property, as Collateral in favor of Pledgee.

(h) "Pledgeholder" shall mean Chicago Title Insurance Company or its successors or assigns.

(i) "Related Agreements" shall mean that certain Development Agreement, as defined herein, and any other agreement affecting the Improvements and Obligations as are defined in Section 1 (e) and (f) of whatsoever kind, nature or description..

Section 2. Security Interest in Collateral; Power of Attorney. To secure the construction of the Obligations, Pledgor hereby pledges to Pledgee and grants to Pledgee, and Pledgee agrees to accept the Pledged Collateral. Pledgor hereby represents that it is the owner of the Collateral in fee simple free and clear of all liens or restrictions of any kind, and agrees to sign and execute, alone or with Pledgee, and agrees to the filing of any financing statement(s) or other document or procure any document and pay all necessary costs to perfect (and continuously perfect) the security interest granted hereunder and to protect the security interest against the interest of third persons. Pledgor will pay the costs of filing the same in all public offices wherever filing is deemed by Pledgee to be necessary or desirable. Pledgee is hereby appointed Pledgor's attorney-in-fact to do all acts and things which Pledgee may deem necessary to perfect and/or continue the perfection of the security interest created by this Agreement and to protect the Collateral. Pledgor further agrees to pay all costs and fees for filing any termination statements. Pledgor hereby ratifies all acts that such attorney-in-fact shall lawfully do or cause to be done by virtue hereof. This power of attorney is coupled with an interest and shall be irrevocable. The grant of this power of attorney shall not be construed to limit the powers of Pledgee to take actions otherwise permitted by the Agreement, as may be amended from time to time, any other agreement between the Parties hereto, the Uniform Commercial Code, or other law to take actions. Pledgor further agrees to indemnify, defend at his sole cost, and hold Pledgee harmless from any and against any and all claims, demands,

damages, liabilities, and expenses (including attorneys' fees and costs) arising from or in any way related to any act or omission of Pledgee or Pledgor, or the exercise of Pledgee's rights, remedies, or powers under this Section 2 or Related Agreements.

Section 3. **Representations.** Pledgor represents that the Collateral is and will remain owned by Pledgor free and clear of any adverse claims or interests, liens, security interests, or encumbrances of any other person, except liens hereunder in favor of Pledgee during the term of this Agreement.

Section 4. **Delivery of Warranty Deed.** Pledgor agrees to deliver a fully executed Warranty Deed to the Collateral to Pledgeholder immediately upon the execution of this Agreement, to be held for the purposes and subject to the terms and conditions set forth in this Agreement.

Section 5. **Duties of Pledgeholder.** Pledgeholder agrees as follows:

(a) To take custody of the Pledged Collateral;

(b) To retain possession of the Pledged Collateral for as long as the Obligations remain outstanding, subject to subsections (c), (d), and (e) hereof;

(c) To return the Pledged Collateral to Pledgor if, and only if, the Obligations are fully and timely satisfied and Pledgor is not otherwise in default of this Agreement or the Related Agreements, and Pledgeholder receives a signed and written confirmation from Pledgee of such satisfaction and absence of defaults;

(d) If Pledgor fails to complete the Obligations to Pledgeholder (as account servicing agent for Pledgee) when due and in a timely manner, Pledgor and Pledgee irrevocably instruct Pledgeholder to deliver the Pledged Collateral to Pledgee without further notice to either Party. Upon delivery of the Pledged Collateral to Pledgee (or the proceeds of the sale of such Collateral by Pledgeholder), Pledgee shall complete the Pledgor's Obligations to complete the Los Mezquites/Von Verde Lift Station located on Avenue D between County 23½ Street and County 24th Street in San Luis, Arizona, and/or the Improvements for Los Mesquites II Subdivision, and/or the Signalization Projects; and

(e) To deliver or otherwise dispose of the Pledged Collateral, as otherwise directed by Pledgee and Pledgor in a signed written instruction to Pledgeholder, or by final, non-appealable court order, judgment, or decree; provided, however, that neither of the events described in subsection (c) or (d) has occurred first.

Section 6. **Compensation to Pledgeholder.** The fees charged by Pledgeholder for its services hereunder shall be borne solely by Pledgor.

Section 7. **Termination of Duties of Pledgeholder.** Pledgeholder's duties hereunder cease upon surrendering possession of the Pledged Collateral, as provided in Section 5(c), (d), or (e).

Section 8. **Indemnity and Release Agreement.** Pledgor and Pledgee agree to indemnify, release, and hold harmless Pledgeholder and all its respective officers, directors, members, managers, shareholders, partners, employees, agents, contractors, and affiliates (collectively "Indemnified Parties") from and against any and all legal claims or causes of action (including all resulting damages, expenses, costs, and reasonable attorneys' fees) arising from, or related to, the performance of Pledgeholder's duties hereunder, except for any intentional act or omission of Pledgeholder, Pledgeholder's gross negligence, or Pledgeholder's default hereunder.

Section 9. **Obligations secured by Pledge.** The purpose of this Pledgehold Agreement is to provide financial assurances for the construction of the Los Mezquites/Von Verde Lift Station ("Lift Station") as heretofore referenced in compliance with Section 6.2 of the Subdivision Regulations of the City of San Luis and to secure up to $250,000.00 of Improvements for the Subdivision known as Los Mezquites II in addition to all other sums, instruments, letters of credit, or other arrangements, whatsoever, for financial assurances posted or pledged to the City for completion of said Improvements. The purpose shall additionally include provision of financial assurances that Pledgor will develop, design, and construct all infrastructure needed for the Signalization Projects The pledge of $250,000 for Improvements of Los Mezquites II is the net sum of money as generated after the City takes such actions as may be appropriate, in its sole discretion, to sell or otherwise dispose of the Collateral. This Agreement shall remain in force until: 1) all Improvements for the Lift Station, Los Mezquites II, and Signalization Projects have been satisfactorily completed and accepted by the City; 2) final acceptance of all projects have been made by the City; and 3) the two (2) year warranty period as required by the Subdivision Regulations has been satisfied, or an alternate form of assurance has been provided to and accepted by City, pursuant to the terms as set forth below.

If Improvements are not satisfactorily completed or corrected, City may, without notice, sell the Collateral and use the proceeds from the sale to complete or correct all or part of the required Improvements and Obligations secured hereunder.

After completion of the Lift Station, Los Mezquites II, and the Signalization Projects, the Parties agree to release the Collateral and accept another form of Collateral that is an amount representing not less than ten percent (10%) of any assurance, pursuant to the Subdivision Regulations of City and shall be retained by the Pledgeholder for a period of two (2) years after completion and inspection of all Improvements for all projects to insure that all work and materials are adequate and in satisfactory condition, or an alternate form of assurance has been provided to and accepted by City. If Collateral is pledged, at the end of the two (2) year period, all remaining Collateral shall be returned to Pledgor.

Section 10. **Events of Default.** A Party shall be in default of this Agreement upon the occurrence of any of the following events:

(a) Failure of a Party to perform as required by this Agreement, or the breach of any other covenant or representation of this Agreement;

(b) The occurrence of an Event of Default under any of the Related Agreements;

(c) If a petition or action is filed or taken by or against either Party under any law dealing with insolvency, bankruptcy, or suspension of payment;

(d) If a Receiver is appointed over the assets or undertaking of either Party (or any part of them);

(e) If either Party enters into a deed or arrangement or makes an assignment for the benefit of creditors; or

(f) If either Party ceases to function as a going concern or an order is made, or a resolution passed to that effect except for the purposes of amalgamation or reorganization; or

(g) Failure to perform any or all of Pledgor's Obligations or failure to complete construction and development of all or part of the Improvements and related infrastructure.

Section 11. General Provisions.

(a) *Use of Collateral.* Pledgor shall be entitled to exercise its dominion, right, and control and other powers, if any, relating to or arising from the Collateral or any purpose consistent with the terms of this Agreement or any other instrument, document, or Agreement executed and delivered by Pledgor to Pledgee, until and unless the Collateral is delivered to Pledgee in accordance with this Agreement or Pledgor commits an Event of Default. Upon the occurrence and during the continuation of an Event of Default, all rights of Pledgor to exercise its dominion, right, and control, and other powers pursuant to the foregoing provisions shall cease.

(b) *Remedies Upon Default.*

(i) If an Event of Default shall exist (a) under this Agreement; (b) Pledgee may exercise any rights and remedies available to it, including the right to dispose of the Collateral, and (c) Pledgee shall have the right, for and in the name, place, and stead of Pledgor, to execute endorsements, assignments, and other instruments of conveyance or transfer with respect to all or any of the Collateral. If any notification or intended disposition of any of the Collateral shall be given by Pledgee to Pledgor, such notification shall be deemed reasonably and properly given if mailed or faxed at least ten (10) business days before such disposition, postage prepaid, addressed, or transmitted to Pledgor at its address or number set forth herein, or at such other address or number as Pledgor may specify by notice received by Pledgee. Any proceeds of any disposition of Collateral may be applied by Pledgee to payment of expenses in connection with the Collateral, including, without limitation, reasonable attorneys' fees and legal expenses, and any balance of such proceeds may be applied by

Pledgee toward the completion of such of the Obligations. All rights and remedies of Pledgee expressed hereunder are in addition to all other rights and remedies possessed by it.

(ii) Pledgor agrees that in any sale of any of the Collateral, Pledgee is hereby authorized to comply with any limitation or restriction in connection with such sale as it may be advised by its counsel is necessary in order to avoid any violation of applicable law, or in order to obtain any required approval of the sale or of the purchase by any governmental regulatory authority or official, and Pledgor further agrees that such compliance shall not result in such sale being considered or deemed not to have been made in a commercially reasonable manner, nor shall Pledgee be liable or accountable to Pledgor for any discount allowed by reason of the fact that such Collateral is sold in compliance with any such limitation or restriction.

(c) *Complete Agreement; Amendment.* This Agreement, along with the Related Agreements, contains the entire Agreement between the Parties hereto with respect to the matters covered herein and, except as specifically provided in this Agreement and Related Agreements, supersedes and merges all prior and contemporaneous oral and written agreements, discussions, and understandings between the Parties. No other agreements, representations, warranties, or other matters, oral or written, shall be deemed to bind the Parties hereto with respect to the subject matter hereof. This Agreement may be amended only by a written document signed by the Pledgor and Pledgee.

(d) *Binding Effect.* The provisions of this Agreement shall be binding on and inure to the benefit of each Party and its administrators, representatives, successors, assigns, transferees, grantees, and any other person or entity acting on the Party's behalf, except to the extent modified herein.

(e) *Advice of Counsel.* Each Party agrees that he, she, or it is signing this Agreement of his, her, or its own free will, after consideration with counsel or an opportunity to seek the assistance of counsel such that no presumptions of interpretation shall apply.

(f) *Execution in Counterparts.* This Agreement may be executed in one or more counterparts and by the Parties hereto in separate counterparts, each of which will be deemed to be an original but all of which, taken together, shall constitute one in the same Agreement.

(g) *Notices.* Unless otherwise provided herein, any notice, request, instruction, or other document to be given hereunder by any Party to the other shall be in writing and delivered in person or by courier, telegraphed, telexed, or by facsimile transmission or mailed by registered or certified mail, postage prepaid, as follows:

Pledgor:

Riedel Holdings, L.L.C.
P.O. Box 1649 (U.S. Postal Service)
San Luis, Arizona 85349

Pledgee:

City of San Luis
Attn: City Manager
P.O. Box 1170 (U.S. Postal Service)

Email: nieves@riedelholdings.com
Fax: (928) 627-4750

(Physical Address)

1964 E. Cesar Chavez Blvd., Suite 1
San Luis, Arizona 85336

San Luis, Arizona 85349
Email: lgalaviz@Sanluisaz.gov
Fax: (928) 341-8539

(Physical Address)

1090 East Union Street
San Luis, Arizona 85336

With a copy to:

Arturo I. Villarreal, Esq.
Garcia & Villarreal, P.L.C.
241 S. Main Street
Yuma, Arizona 85364
avillarreal@gkvlaw.com
Fax: (928) 276-4861

With a copy to:

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

Pledgeholder:

Martha Ulloa,
Commercial Escrow Officer
Chicago Title Insurance Company, Inc.
963 East B Street
San Luis, Arizona 85349
(928) 304-0594
Fax: (928) 569-3817
Martha.Ulloa@CTT.com

(h) *Severability.* If any one or more of the provisions of this Agreement is found to be illegal or unenforceable, then notwithstanding the same, this Agreement shall remain in full force and effect, and such term or provision shall be deemed severed.

(i) *No Waiver.* Neither Party's right to require performance of the other Party's obligations under this Agreement shall be affected by any previous waiver, forbearance, or course of dealing.

(j) *Relationship of the Parties.* No agency, partnership, joint venture, franchise, other joint relationship, or any business organization of any kind is created by this Agreement, and the agents of neither Party shall have authority of any kind to bind the other Party in any respect whatsoever, except as expressly provided herein to the contrary.

(k) *Attorneys' Fees.* In the event, suit is brought, or an attorney is retained by any Party to this Agreement to seek interpretation or construction of any term or provision of this Agreement, to enforce the terms of this Agreement, to collect any money due, or to obtain any money damages or equitable relief for breach, or to seek recourse in a bankruptcy proceeding, the prevailing Party shall be entitled to recover, in addition to any other available remedy, reimbursement for reasonable attorneys' fees for representation in the court (including, without limitation, bankruptcy court), court costs, costs of investigation, and other related expenses.

(l) *Governing Law; Forum Selection Clause.* This Agreement shall be interpreted and governed by the laws of the State of Arizona. The Parties agree that any action, at law or in equity, arising out of the terms, conditions, performance, termination, default, and/or breach of this Agreement, including, but not limited to, any tortious conduct, shall be instituted and litigated in the courts within Yuma County, State of Arizona, and in no other. In accordance therewith, the Parties irrevocably submit and consent to the jurisdiction and venue of the courts of Yuma County, State of Arizona. This Agreement is subject to the cancellation provisions of A.R.S. § 38-511.

(m) *Assignment Prohibited.* Neither this Agreement nor any interest in or claim under this Agreement shall be assigned or otherwise transferred by Borrower to another person or entity without the prior written consent of the secured Party, which consent may be withheld in the secured Party's sole and absolute discretion.

(n) *No Third-Party Rights.* No term or provision of this Agreement is intended to be, nor shall any such term or provision be construed to be, for the benefit of any person, firm, corporation, or other entity other than the Parties hereto, and no such person, firm, corporation, or other entity shall have any right or cause of action hereunder.

(o) *Identity of Pledgeholder.* Following Pledgor and Pledgee's execution of this Agreement, the Parties agree to amend this Agreement to substitute Pledgeholder should the Pledgeholder designated herein fail or refuse to execute this Agreement; in such event, the effectiveness of this Agreement shall remain unimpaired.

(p) *Time is of the Essence.* Time is of the essence as to each and every provision of this Agreement.

[THE REMAINDER OF THIS PAGE LEFT BLANK INTENTIONALLY]

[SIGNATURE PAGE TO FOLLOW]

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

"PLEDGEE":

THE CITY OF SAN LUIS, ARIZONA

ATTEST:

By: Melissa Lopez, Deputy City Clerk

By: Gerardo Sanchez
Its: Mayor

Approved as to form

By: Kay Marion Macuil, City Attorney

"PLEDGOR":

RIEDEL HOLDINGS, L.L.C.

By: Nieves G. Riedel
Its: Manager and Member

[REMAINDER OF THIS PAGE IS LEFT BLANK INTENTIONALLY]

[SIGNATURE PAGE TO FOLLOW]

"PLEDGEHOLDER":

Chicago Title Insurance Company, Inc.

_____

By: Martha Ulloa
Its: Commercial Escrow Officer

Exhibit A

LEGAL DESCRIPTION
LOS MEZQUITES UNIT 4

A PORTION OF THE SOUTH HALF OF SECTION 11, TOWNSHIP 11 SOUTH, RANGE 24 WEST, GILA AND SALT RIVER BASE AND MERIDIAN, YUMA COUNTY, ARIZONA, MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BEGINNING AT THE WEST QUARTER CORNER OF SAID SECTION 11;

THENCE: S89°28'41"E, ALONG THE EAST-WEST MID SECTION LINE OF SAID SECTION 11, A DISTANCE OF 2640.29 FEET **TO THE TRUE POINT OF BEGINNING**;

THENCE: S89°28'51"E, CONTINUING ALONG THE EAST-WEST MID SECTION LINE OF SAID SECTION 11, A DISTANCE OF 1888.44 TO A POINT;

THENCE: S00°27'24"W, A DISTANCE OF 1449.58 FEET TO A POINT;

THENCE: N89°28'51"W, A DISTANCE OF 901.55 FEET TO A POINT;

THENCE: S00°27'17"W, A DISTANCE OF 528.22 FEET TO A POINT;

THENCE: N89°31'14"W, A DISTANCE OF 986.38FEET TO A POINT;

THENCE: N00°26'29"E, A DISTANCE OF 1978.69 FEET **TO THE TRUE POINT OF BEGINNING;;**

CONTAINING 74.8125 ACRES MORE OR LESS

2021-47097 RESOLUTION
12/22/2021 09:51:20 AM Pages: 13 Fees: $15.00
Requested By:CITY OF SAN LUIS
Recorded By: arios
Robyn Stallworth Pouquette County Recorder, YUMA County AZ

WHEN RECORDED MAIL TO:

CITY OF SAN LUIS
ATTN: CITY CLERK
P.O. BOX 1170
SAN LUIS, ARIZONA 85349

The above area is to be reserved for recording information

****

CAPTION HEADING:

Resolution
Resolution No. 2204
Riedel Holdings, L.L.C.
Los Mezquites Development Agreement

OFFICE OF THE
MAYOR
CITY OF SAN LUIS

Resolution

NO. 2204

A RESOLUTION OF THE MAYOR AND CITY COUNCIL OF THE CITY OF SAN LUIS, ARIZONA AUTHORIZING AND DIRECTING THE ENTERING INTO A DEVELOPMENT AGREEMENT DEVELOPMENT BETWEEN THE CITY OF SAN LUIS, ARIZONA AND RIEDEL HOLDINGS, AZ LLC.

WHEREAS, Nieves Riedel, Riedel Holdings, L.L.C.; Owner, desires to enter into a development agreement for Los Mezquites project to be located in San Luis, Arizona; and

WHEREAS, A.R.S. § 9-500.05 grants power to a municipality to enter into development agreements; and

WHEREAS, the parties desire to enter into such agreement; and

WHEREAS, the applicant and the city staff agreed to all matters in the City's proposed development agreement; and

NOW, THEREFORE, BE IT RESOLVED by the Mayor and Council of the City of San Luis, State of Arizona, as follows:

SECTION 1. That the development agreement proposed by the staff of the City of San Luis, Arizona attached hereto as Exhibit "A", is hereby approved;

PASSED AND ADOPTED by the Mayor and City Council of the City of San Luis, Arizona, this 21st day of December 2021.

APPROVED:

Africa Luna-Carrasco, Vice-Mayor

ATTEST:

for Sonia Cornelio, City Clerk

APPROVED AS TO FORM:

Kay Marion Macuil, City Attorney

LOS MEZQUITES DEVELOPMENT AGREEMENT

THIS DEVELOPMENT AGREEMENT (the "**Agreement**") is entered into as of 21st day of December, 2021 ("**Effective Date**") by and between the City of San Luis an Arizona municipal corporation (the "**City**") and Riedel Holdings, AZ LLC, (the "**Owner**"). This Agreement is entered into pursuant to City Resolution Number 2204.

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, Owner, owns real property located in the municipal limits of the City which is legally described on Exhibit 1 (the **"Property")** and is currently being developed for a commercial shopping center ("**Shopping Center**") and residential housing ("**Housing**"), and

C. WHEREAS, Owner has applied for a rezoning and lot split in order to develop the aforementioned Shopping Center and Housing Projects;

D. WHEREAS, A.R.S. § 9-500.05 provides, in part, that a development agreement can provide for the permitted uses of land; the density and intensity of uses; reservation or dedication of land for public purposes; conditions, terms, restrictions and requirements for public infrastructure; conditions, terms, restrictions and requirements relating to the governing body's intent to form a special taxing district pursuant to title 48; and any other matters relating to the development of the property; and

E. WHEREAS, the City and Owner desire to enter into an agreement to provide for the rezoning and the splitting of land and provide for the lands future development; and

F. WHEREAS, the City's governing body has authorized execution of this Agreement by Resolution No. 2204;

NOW, THEREFORE, the parties agree as follows:

AGREEMENT

DEFINITIONS

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

Agreement shall mean this development agreement.

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

Owner shall mean and refer to Riedel Holdings LLC, and any successor in ownership.

Property as used in this Agreement shall mean and refer to all of the real Property, which is legally described in Exhibit 1.

ARTICLE 1. DEVELOPMENT PLAN

1.1. Duration of Development Agreement. The term of this Agreement shall be for a period of five (5) years from date of execution.

1.2 Failure of Timely Performance. In the event that either party hereto fails to perform any of its obligations which are set forth in or contemplated by this Agreement in a timely manner, and should such failure not otherwise be excused by agreement of the parties or by the terms of this Agreement, such failure shall be considered to be a breach of this Agreement and the nonbreaching party shall have their respective remedies set forth in Section 5.3 of this Agreement.

1.3.Review Process. The City acknowledges the necessity for expeditious review by the City of all plans and other materials ("**Submitted Materials**") submitted by the Owner to the City hereunder or under any zoning procedure, permit procedure, or other governmental procedure pertaining to the development of the Property and agrees to use its reasonable efforts accomplish such an expeditious review of the Submitted Materials whenever possible.

ARTICLE 2. SPECIAL PROVISIONS FOR DEVELOPMENT

2.1 Dedication of Right of Way. At present time Owners shall dedicate appropriate right-of-way to the City along County 23 ½ Street and Avenue D ½ alignments in accordance with the updated standards for right-of-way as provided by Public Works Department. Dedication of right of way on County 24th shall be 62 feet from center of alignment and 130 feet within 300 feet of the intersection. Dedication of said right-of-way shall occur at such time and in such manner as required by the City in its sole discretion.

2.2 Development of Improvements. At such time that any lot created by City Lot Split Case Number 2021-0387 or any lot within the Rezoning Case No. 2021-0693 is developed, public improvements, including but not limited to streets, roads, retention basins, utility extensions, utility mains, including pumping stations, lift stations, force mains, traffic signalization, and other off-site public improvements will be made pursuant to City standards as may be required by the Public Works Director of City in his sole discretion. The location of such improvements and/or its development is not confined to the lot being developed, but rather may be located on any portion of the entire Property (Exhibit 1) that is the subject of this agreement. Owner agrees to make such

dedications of property as may be needed or necessary for such development in the discretion of the Public Works Director. Such dedications and the development of such improvements as described above shall be a condition of the issuance of any building permit(s) or other use permit(s) for the development of any such lot or portion of such lot.

2.3 Street Lights. At such time that any lot created by City Lot Split Case Number 2021-0387 or any lot within Rezoning Case No. 2021-0693 is developed, the Public Works Director may require, in his sole discretion, that the development of street lights in the public right-of-way is needed or desired, the development of such street lighting in the manner and at the locations as may be determined by the Public Works Director, in his sole discretion, shall be a condition of the issuance of building permit(s) or other use permit(s) for the development of any such lot.

2.4 Residential Development. Developer is requesting Rezoning Case No. 2021-0693 to change Assessor Parcel Number 227-11-004 and portion of parcel 227-11-005 to Medium Density Residential (R1-6) to allow for single-family development. At such time as any portion of the property is developed with single family homes, the development will be of lots no less in size of 6,000 square feet, amending the lot size requirement and removing the minimum home size on Resolution No. 933.

2.5 Traffic Light Contribution. 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.

2.6 Waste Water Treatment Plant. Developer agrees to execute, record, and deliver such agreements, easements, and/or covenants conditions and restrictions that run with the land which is the subject of this development agreement for the benefit of the City of San Luis that will allow the real property of Developer that is the subject of this agreement to be used for fumes or odors from its wastewater treatment operations located at 358 N. Avenue D, and to waive any claims for any damages that might arise from wastewater treatment operations, whatsoever, and agree to indemnify and hold the City of San Luis and its officers, agents, and employees harmless from any and all claims, whatsoever, known or unknown, emanating from wastewater treatment operations including, but not limited to, claims arising from fumes or odors.

2.7 Land Dedication for Park. Owner wishes to donate to the City, and City agrees to accept from Owner, certain land within the Property, containing 5 gross acres of buildable land in addition to the open space requirement. Owner agrees to convey to the City by executing a Deed, free and clear of all liens and encumbrances.

2.8 Covenants Conditions and Restrictions. For any lot developed or to be developed as other than residential development, Owner shall record a covenant, condition and restriction to run with the land prohibiting the development and use of the property as a school, public or private, of any kind nature, or description.

2.9 Special Taxing Districts. Owner agrees to agree to the formation of a street lighting improvement district, a community facilities district and any enhanced municipal district needed.

2.10 Regulations. The terms of this Agreement are in addition to City codes, rules, fees, and regulations that are applicable to this action.

2.11 Buffer. Developer agrees to build an 8 foot cmu wall along the entire property line along the Detention Center and the East Waste Water Treatment Plant. Including as a buffer, a 30 feet wide green area and the residential street, totaling 82 feet.

ARTICLE 3. INDEMNIFICATION

3.1. Owner agrees to defend, indemnity and hold harmless City, its officers, officials and employees ("**Indemnified Group**") for liability from and against claims, damages, losses and expenses of any nature whatsoever (including but not limited to reasonable attorney fees, court costs, the costs of appellate proceedings, and all claim adjusting and handling expense), relating to, arising out of, resulting from or alleged to have resulted from the Owner's acts, errors, mistakes or omissions relating to any action or inaction of the Owner under this Agreement, including but not limited to work or services in the performance of this Agreement by any subcontractor or anyone directly or indirectly employed by or contracting with the Owner or a subcontractor or anyone for whose acts any of them may be liable.

3.2. If any claim, action or proceeding is brought against the Indemnified Group, by reason of any event that is the subject of this agreement, Owner (at its sole cost and expense) shall pay, resist or defend such claim or action on behalf of the Indemnified Group by the attorney of the Owner, or if covered by insurance, Owner's insurer, all of which must be approved by City, which approval shall not be unreasonably withheld or delayed. The City shall cooperate with all reasonable efforts in the handling and defense of such claim. Notwithstanding the foregoing, the City may engage its own attorney to defend or assist in its defense, and the Owner shall pay the reasonable costs and expenses thereof.

3.3. Any settlement of claims must fully release and discharge the Indemnified Group from any liability for such claims. The release and discharge shall be in writing and shall be subject to approval by the City, which approval shall not be unreasonably withheld or delayed. If Owner neglects or refuses to defend any of the Indemnified Group as required by this Agreement, any recovery or judgment against the Indemnified Group for a claim covered by this Agreement shall conclusively establish Owner's liability to the Indemnified Group in connection with such recovery or judgment. If the City desires to settle such dispute, the City shall be entitled to settle such dispute in good faith and Owner shall be liable for the amount of such settlement, and all expenses in connection with such settlement.

3.4. The indemnity provisions of this Agreement shall survive the termination of this Agreement.

ARTICLE 4. MEDIATION AND DEFAULT

4.1. Representatives. To further the cooperation of the parties in implementing this Agreement, the City and Owner each shall designate and appoint a representative to act as a liaison between the City and its various departments and the Owner. The initial representative for the City (the "**City Representative**") shall be the City Manager, and the initial representative for the Owner shall be its project manager, as identified by the Owner from time to time (the "**Developer Representative**"). The representatives shall be available at all reasonable times to discuss and review the performance of the parties to this Agreement and the development of the Property.

4.2. Mediation. In the event that there is a dispute hereunder which the parties cannot resolve between themselves, the parties agree that there shall be a forty-five (45) day moratorium on litigation during which time the parties agree to attempt to settle the dispute by nonbinding mediation before commencement of litigation. In the event that the parties cannot agree upon the selection of a mediator within seven (7) days, either party may request the presiding judge of the Superior Court of Yuma County to assign a mediator from a list of mediators maintained by the Arizona Municipal Risk Retention Pool.

4.3. Default. Failure or unreasonable delay be any party to perform any term or provision of this Agreement for a period of ten (10) days after written notice thereof from another party shall constitute a default under this Agreement. If the default is of a nature which is not capable of being cured within ten (10) days, the cure shall be commenced within such period, and diligently pursued to completion. The notice shall specify the nature of the alleged default and the manner in which the default may be satisfactorily cured. In the event of a default hereunder by any party, the non-defaulting party shall be entitled to all remedies at both law and in equity, including, without limitation, specific performance and the right to perform the obligation(s) of which the defaulting party is in default and to immediately seek reimbursement from the defaulting party of all sums expended in order to cure such default, together with interest on all such sums from the date said sums are expended by the non-defaulting party for the purpose of curing the default to the date such sums are paid in full.

ARTICLE 5. CONFLICT OF INTEREST; REPRESENTATIVES NOT INDIVIDUALLY LIABLE

5.1. Conflict of Interest. Pursuant to Arizona law, rules and regulations, no member, official or employee of the City shall have any personal interest, direct or indirect, in this Agreement, nor shall any such member, official or employee participate in any decision relating to this Agreement which affects his or her personal interest or

the interest of any corporation, partnership or association in which he or she is, directly or indirectly, interested. This agreement is subject to the provisions of A.R.S. §38-511.

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

ARTICLE 6. MISCELLANOUS PROVISIONS

6.1. Notices. All notices and communications provided for herein, or given in connection herewith, 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:
City Manager
City of San Luis
P.O. Box 1170
1090 E. Union Street
San Luis, Arizona 85349

If to the Owner:
Nieves Riedel, Riedel Holdings, L.L.C.
1964 E. Cesar Chavez Blvd., Suite 1
P O Box 1649
San Luis, Arizona 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 given by mail shall be deemed delivered 72 hours following deposit in the United States Postal Service in the manner set forth above.

6.2. Waiver. No delay in exercising any right or remedy shall constitute a waiver thereof, and no waiver by the parties of the breach of any provision of this Agreement shall be construed as a waiver of any preceding or succeeding breach of the same or of any other provision of this Agreement.

6.3. 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.

6.4. 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 Owner represents and warrants that it is duly formed and validly existing under the laws of the State of Arizona and that it is duly qualified to do business in the State of Arizona and is in good standing

under applicable state laws. The Owner and the City warrant to each other that the individuals executing this Agreement on behalf of their respective parties are authorized and empowered to bind the party on whose behalf each individual is signing. The Owner represents to the City that by entering into this Agreement, the Owner has bound the Property and all persons and entities having any legal or equitable interest therein to the terms of the Agreement.

6.5. 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.

6.6. 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.

6.7. Governing Law. The laws of the State of Arizona shall govern the interpretation and enforcement of this Agreement. The parties agree that venue for any action commenced in connection with this Agreement shall be proper only in a court of competent jurisdiction located in Yuma County, Arizona, and the parties hereby waive any right to object to such venue.

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

6.9. 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.

6.10. Notice of Conveyance or Assignment. The Owner 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.

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

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

6.13. 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 Owner, or any successor in interest, in the event of any default or breach by the

City or for any amount that may become due to the Owner or successor, or under any obligation under the terms of this Agreement.

6.14. Employment Eligibility, E-Verify

1. The Owner warrants his compliance with all federal immigration laws and regulations that relate to its employees and its compliance with A.R.S. § 23214, subsection A.
2. A breach of a warranty under paragraph 1 shall be deemed a material breach of the Agreement that is subject to penalties up to and including termination of the contract.
3. That the City retains the legal right to inspect the papers of any contractor or subcontractor employee who work on the Agreement to ensure that the contractor or subcontractor is complying with the warranty under paragraph 1.

6.15. Time is of the Essence. Time is of the essence of this agreement.

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

THE CITY OF SAN LUIS,
an Arizona municipal corporation

By: _____
Vice Mayor

KMM

ATTEST:

By: _____, Deputy City Clerk
City Clerk

APPROVED AS TO FORM:

_____
City Attorney

THE OWNER, Riedel Holding, L.L.C.

By: _____
Its: President

STATE OF ARIZONA)
) ss.
County of Yuma)

The foregoing instrument was acknowledged before me this 21st day of December 2021, by Africa Luna-Carrasco, Vice-Mayor of the City of San Luis, Arizona, a municipal corporation.

Angelica Cifuentes
Notary Public

My Commission Expires: 05-11-2023

Angelica Cifuentes
Notary Public - Arizona
Yuma County
Commission Number 562004
My Comm. Exp. 5/11/2023

STATE OF ARIZONA)
) ss.
County of Yuma)

The foregoing instrument was acknowledged before me this 22ND day of DECEMBER 2021, by NIEVES RIEDEL, on behalf of Riedel Holdings L.L.C., an Arizona Limited Liability Corporation.

Janet Taylor
Notary Public

My Commission Expires: 09/28/2025

Janet Taylor
Notary Public - Arizona
Yuma County
Commission Number 613060
My Comm. Exp. 9/28/2025

Exhibit 1

Los Mezquites Development Agreement

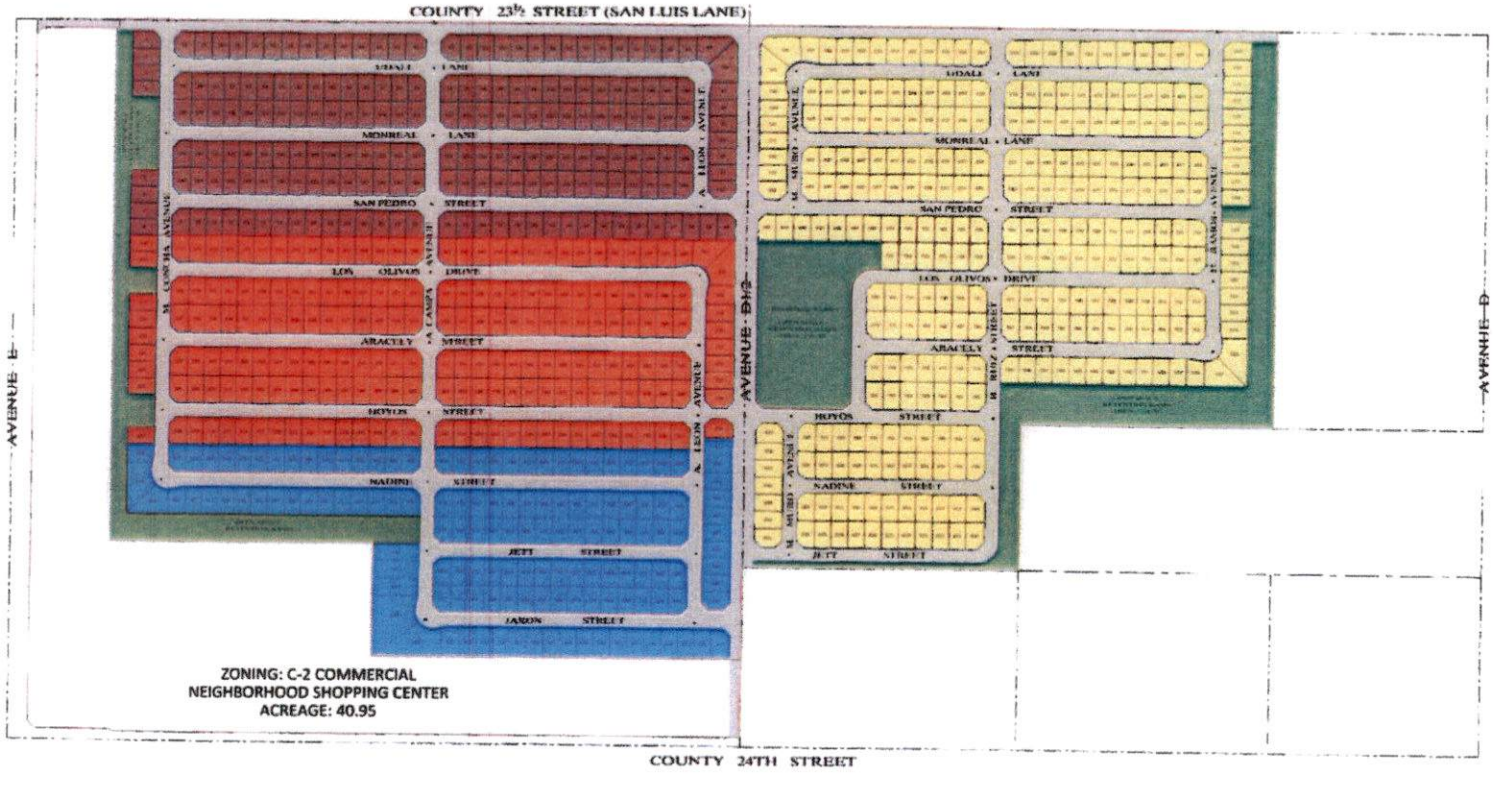
LOS MEZQUITES SUBDIVISION

DATE OF PREPARATION: NOVEMBER 2021 NUMBER OF LOTS: 897
MASTER PLAN LAYOUT

Parcel 227-11-005: A portion of the SW¼ of Section 14, Township 11 South Range 24 West. Except road right of way. **(108.91 acres)**

Parcel 227-11-004: South East ¼ of Section: 11 Township: 11S Range: 24W SE4 EXC THE E 751.25 FT OF N 1449.58 FT & EXC S 660 FT +/- & EXC THE E 1652.78 FT OF THE N 576.11 FT +/- OF S 1185.05 FT +/- **(74.64 acres)**

N
W E
S
SCALE: 1"=200'



PRELIMINARY
NOT FOR
CONSTRUCTION

Edais Engineering, Inc.
3075 S. Avenue 4 E
Yuma, Arizona 83365
(928)344-3566
najeh@edaisgroup.com

LOS MEZQUITES UNIT 2

ENGINEERS COST ESTIMATE

June 8, 2022

ITEM	ITEM DESCRIPTION	QUANTITY	UNIT	UNIT PRICE	AMOUNT
A.)	**Subdivision Grading and Road Improvement**				
1	Earthwork/Mass Grading (Complete)	1	LS	0.00	0.00
2	Stormwater Pollution Prevention	1	LS	15,000.00	15,000.00
3	Grading Under ABC	34,297	SY	1.17	40,127.49
4	Grading Under Sidewalk	66,213	SF	0.25	16,553.25
5	6" ABC	32,244	SY	9.90	319,215.60
6	10" ABC	2,053	SY	13.77	28,269.81
7	3" AC w/Flush Coat	34,297	SY	22.18	760,707.46
8	6" Vertical Curb	13,755	LF	16.25	223,518.75
9	Concrete Sidewalk	63,213	SF	5.20	328,707.60
10	Concrete Cross Gutter	9,262	SF	7.47	69,187.14
11	Driveway	198	EA	850.00	168,300.00
12	Depressed Sidewalk	1	EA	750.00	750.00
13	Wheel Chair Ramps	28	EA	1,200.00	33,600.00
14	Sawcut Existing Pavement	25	LF	2.50	61.25
15	Survey Monuments	14	EA	780.00	10,920.00
16	Stop Signage and Barricades	1	LS	15,500.00	15,500.00
17	Spillways, Rip Rap and Bollards	1	LS	7,500.00	7,500.00
18	6' High Walls	2,256	LF	42.00	94,752.00
Subtotal					**$ 2,132,670.35**
B.)	**Water System**				
1	8" C900Water Main Labor	6,417	LF	8.50	54,544.50
2	8" Water Valve Labor	18	EA	425.00	7,650.00
2	Fire Hydrant Labor	18	EA	2,250.00	40,500.00
3	Misc. Fittings Labor	1	LS	7,500.00	7,500.00
4	1" Water Service Labor	198	EA	275.00	54,450.00
5	Meter Boxes Labor	198	EA	110.00	21,780.00
6	2" Water Service Labor	1	EA	1,125.00	1,125.00
7	Blowoff Valve Labor	2	EA	1,000.00	2,000.00
8	2" Backflow Preventor Labor	1	EA	1,375.00	1,375.00
Subtotal					**$ 190,924.50**

C.)	Sewer System				
1	8" Sewer Line Labor	7,118	LF	8.50	60,503.00
2	4" Polymer Manhole Labor	17	EA	2,500.00	42,500.00
3	4" Sewer Service Labor	198	EA	250.00	49,500.00
4	Lift Station and Force Main	1	EA	275,000.00	275,000.00
Subtotal					**$ 427,503.00**

D.)	Storm Drain System				
1	30"HDPE Pipe Labor	948	LF	24.00	22,752.00
2	24" HDPE Pipe Labor	666	LF	16.00	10,656.00
3	Concrete Catch Basins & Headwall	6	EA	4,500.00	27,000.00
4	Concrete Manholes	4	EA	3,000.00	12,000.00
5	Landscaping & Irrigation	1	LS	45,000.00	45,000.00
Subtotal					**$ 117,408.00**

E.)	Utilities				
1	Street Lights	30	EA	1,500.00	45,000.00
2	Utilities Conduit and Trenching	18,000	LF	7.50	135,000.00
3	APS Fees	200	EA	1,500.00	300,000.00
Subtotal					**$ 480,000.00**

F.)	Construction Staking, Inspection and Testing				
1	Engineering	1	LS	0.00	0.00
2	Construction Staking	1	LS	80000.00	80000.00
3	Inspection, Testing & Certification	1	LS	45000.00	45000.00
Subtotal					**$ 125,000.00**
TOTAL					**$ 3,473,505.85**



AGENDA ITEM REVIEW FORM

Regular City Council Meeting **5. G.**

Meeting Date: 06/22/2022

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

Submitted By: Fernando Villegas, Principal Planner, Planning & Zoning Department, Development Services

Action Requested: Motion

ITEM:

Discussion and possible action on any and all matters regarding Subdivision Case No. 2022-0043F. A request by Edais Engineering Inc., on behalf of Riedel Holdings LLC, for the approval of Los Mezquites Unit 2 final plat; the property is located on the southeast corner of Avenue E and County 23-1/2 Street (San Luis Lane) in San Luis Arizona. **(Jose A. Guzman, Director of Planning and Zoning)**

A. Staff Presentation
B. Action on Subdivision Case No. 2022-0043F

SUMMARY:

This subdivision will contain approximately 77.68 acres and will consist of 197 residential lots. The lots range in size from approximately 6,000 square feet to 6,400 square feet. Assessor's Parcel Number 227-11-011. The City of San Luis City Council approved on January 12, 2022, Rezoning Case No. 2021-0693 rezoning 186 acres to Medium Density Residential (R1-6).

GENERAL PLAN:

City Council approved Major Amendment Case No. 2021-0340 changing the land use designation to Medium Density Residential (MDR). The Major Amendment allowed the applicant to rezone the property to R1-6. (Rezoning Case No. 2021-0693).

DEVELOPMENT AGREEMENT:

A development agreement was approved by Resolution No. 2204, the term of the development agreement is for five (5) years. The development agreement approved includes the following conditions:

- Dedication of Right of Way. At present time owners shall dedicate appropriate right-of-way to the City along County 23 ½ Street and Avenue D ½ alignments in accordance with the updated standards for right-of-way as provided by Public Works Department. Dedication of right of way on County 24th shall be 62 feet from center of alignment and 130 feet within 300 feet of the intersection. Dedication of said right-of-way shall occur at such time and in such manner as required by the City in its sole discretion.
- Development of Improvements. At such time that any lot created by City Lot Split Case Number 2021-0387 or any lot within the Rezoning Case No. 2021-0693 is developed, public improvements, including but not limited to streets, roads, retention basins, utility extensions, utility mains, including pumping stations, lift stations, force mains, traffic signalization, and other off-site public improvements will be made pursuant to City standards as may be required by the Public Works Director of City in his sole discretion. The location of such improvements and/or its development is not confined to the lot being developed, but rather may be located on any portion

of the entire Property that is the subject of this agreement.

- Owner agrees to make such dedications of property as may be needed or necessary for such development in the discretion of the Public Works Director. Such dedications and the development of such improvements as described above shall be a condition of the issuance of any building permit(s) or other use permit(s) for the development of any such lot or portion of such lot.
- Street Lights. At such time that any lot created by City Lot Split Case Number 2021-0387 or any lot within Rezoning Case No. 2021-0693 is developed, the Public Works Director may require, in his sole discretion, that the development of street lights in the public right-of-way is needed or desired, the development of such street lighting in the manner and at the locations as may be determined by the Public Works Director, in his sole discretion, shall be a condition of the issuance of building permit(s) or other use permit(s) for the development of any such lot.
- Residential Development. Developer is requesting Rezoning Case No. 2021-0693 to change Assessor Parcel Number 227-11-004 and portion of parcel 227-11-005 to Medium Density Residential (R1-6) to allow for single-family development. At such time as any portion of the property is developed with single-family homes, the development will be of lots no less in size of 6,000 square feet, amending the lot size requirement and removing the minimum home size on Resolution No. 933.
- Traffic Light Contribution. 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.
- Waste Water Treatment Plant. Developer agrees to execute, record, and deliver such agreements, easements, and/or covenants conditions and restrictions that run with the land which is the subject of this development agreement for the benefit of the City of San Luis that will allow the real property of Developer that is the subject of this agreement to be used for fumes or odors from its wastewater treatment operations located at 358 N. Avenue D, and to waive any claims for any damages that might arise from wastewater treatment operations, whatsoever, and agree to indemnify and hold the City of San Luis and its officers, agents, and employees harmless from any and all claims, whatsoever, known or unknown, emanating from wastewater treatment operations including, but not limited to, claims arising from fumes or odors.
- Land Dedication for Park. Owner wishes to donate to the City, and City agrees to accept from Owner, certain land within the Property, containing 5 gross acres of buildable land in addition to the open space requirement. Owner agrees to convey to the City by executing a Deed, free and clear of all liens and encumbrances.
- Covenants Conditions and Restrictions. For any lot developed or to be developed as other than residential development, Owner shall record a covenant, condition, and restriction to run with the land prohibiting the development and use of the property as a school, public or private, of any kind nature, or description.
- Special Taxing Districts. Owner agrees to agree to the formation of a street lighting improvement district, a community facilities district and any enhanced municipal district needed.
- Regulations. The terms of this Agreement are in addition to City codes, rules, fees, and regulations that are applicable to this action.
- Buffer.Developer agrees to build an 8-foot cmu wall along the entire property line along the Detention Center and the East Waste Water Treatment Plant. Including as a buffer, a 30 feet wide green area, and the residential street, totaling 82 feet.

REZONING:

The City of San Luis City Council approved on January 12, 2022, Rezoning Case No. 2021-0639 rezoning 186 acres to Medium Density Residential (R1-6). The Rezoning was approved with the following conditions:

1. Developer must comply with all provisions and conditions of the development agreement approved by Resolution No. 2204.
2. That any development of the property, or a 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.
3. Development must comply with Public Works Standards as approved by City Council during the Final Plat. Updated Public Works Standards to include right-of-way requirements, pavement thickness, and other applicable standards.
4. Developer, on behalf of itself, its heirs, successors, and assigns agree to transfer a strip of land 30 feet wide all along the Detention Center property. Title to said property shall vest to the San Luis Facility Development Corporation in fee simple free and clear of all liens and encumbrances.

STAFF RECOMMENDATION:
The applicant has provided the information and materials necessary for the review of the Final Plat for Los Mezquites Unit 2 Subdivision.

Staff recommends approval of this Final Plat with the following conditions:

1. Developer must comply with all provisions and conditions of the development agreement approved by Resolution No. 2204.
2. A road connection from the southeast corner of the subdivision to County 24th Street should be provided as requested by the Fire Department.
3. No Building Permits shall be issued until the construction of the lift station is finalized.
4. All Arizona Department of Transportation (ADOT) comments for the traffic study must be addressed to the satisfaction of ADOT.
5. Developer agrees to sign the petitions for the creation of a street lighting improvement district, a community facilities district, and any enhanced municipal district needed, prior to the recordation of the plat.
6. Developer shall develop and construct any and all improvements needed and necessary for the signalization of the intersections at 24th Street and Ave. E and 23 ½ and Ave. E in accordance with the Public Works Standards of the City and the standards of the Arizona Department of Transportation, subject to the payback provisions of Section 15.10.130 (C) of the City Code.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE SUBDIVISION CASE NO. 2022-0043F WITH CONDITIONS AS PRESENTED BY STAFF.

Fiscal Impact

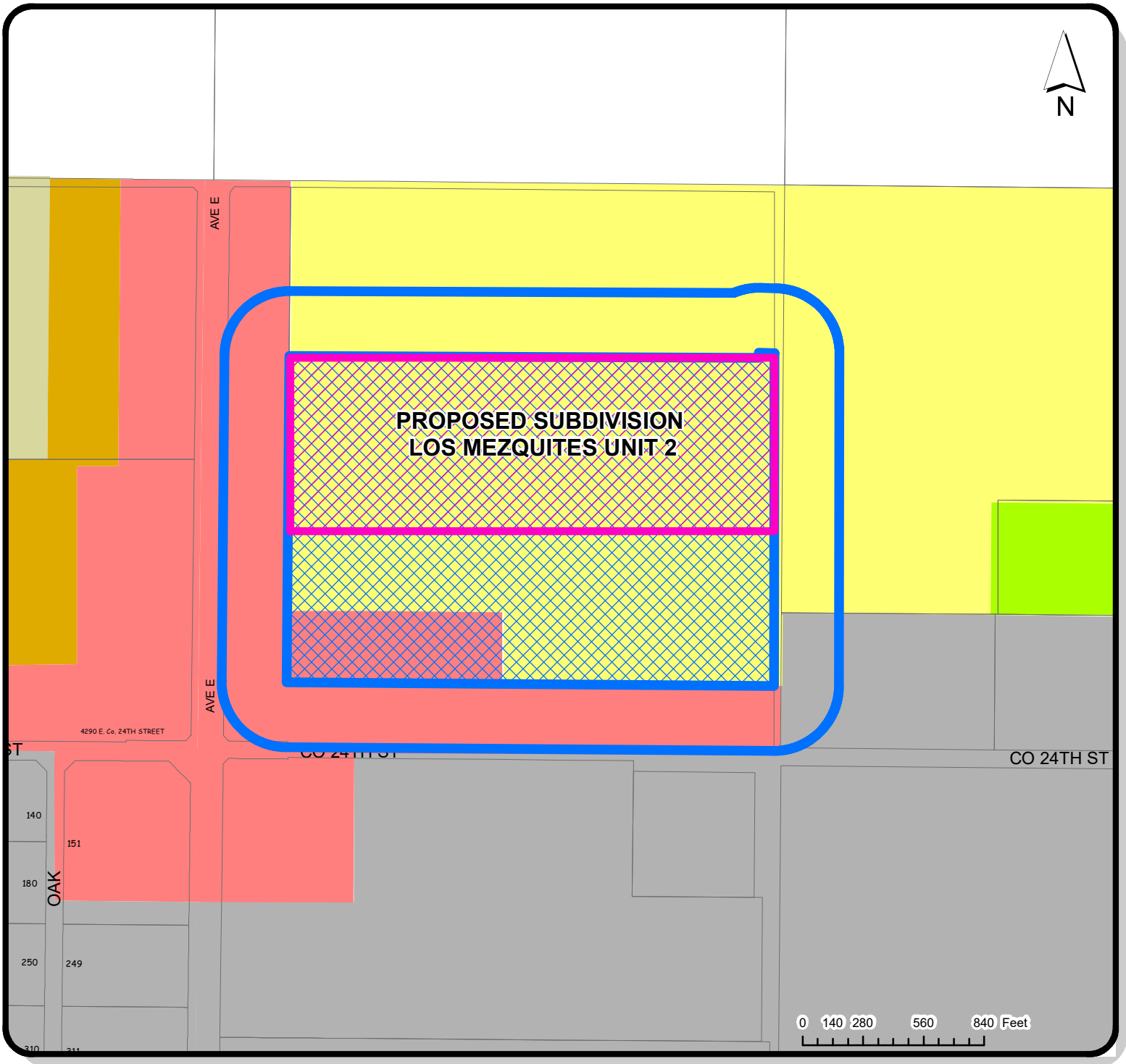
IS THERE FISCAL IMPACT ASSOCIATED WITH THIS ITEM:	N/A
CITY/STATE/FEDERAL FUNDS:	N/A
TOTAL:	N/A
BUDGETED AMOUNT:	N/A
AVAILABLE AMOUNT TO TRANSFER:	N/A
ACCT NAME & GL#/REMAINING BALANCE BEFORE PURCHASE:	N/A

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

N/A

Attachments

Location Map
Final Plat Unit 2
Development Agreement
Fire Dept Comment Letter



LOCATION MAP

LOCATION OF SUBJECT PROPERTY

PARCEL 227-11-011

300ft Notification Area

Proposed Subdivision Location

SUBDIVISION

CASE #
2022-0043-F

DATE:
1/19/2022

PLANNING & ZONING

GIS

CREATED BY:
ISAAC GUTIERREZ

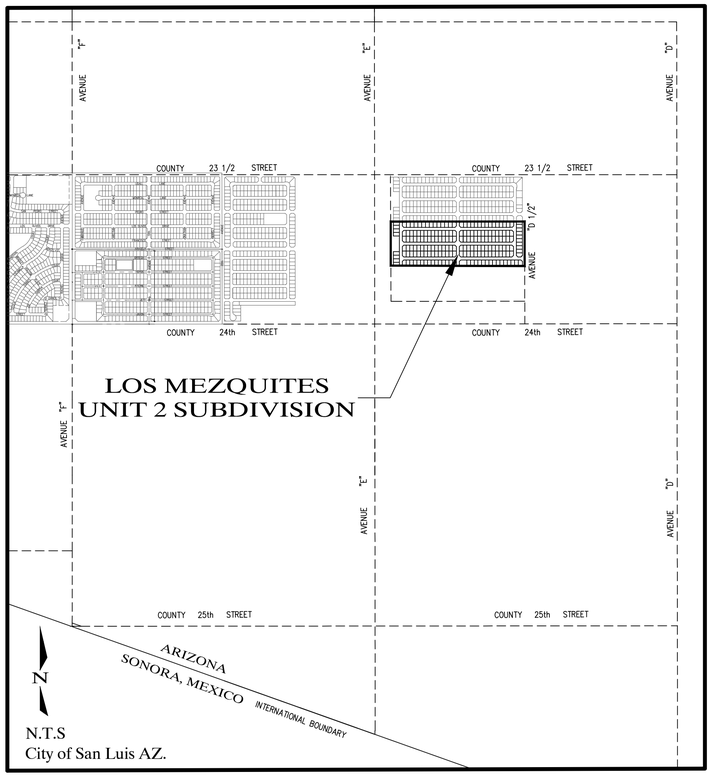
CHECKED BY:
FERNANDO VILLEGAS

APPROVED BY:
JOSE A. GUZMAN

LOS MEZQUITES SUBDIVISION UNIT 2

A SUBDIVISION OF PARCEL B OF THE AMENDED SAN LUIS PORT LOT SPLIT AS RECORDED IN BOOK 33 OF PLATS, PAGE 64, YUMA COUNTY RECORDERS OFFICE, YUMA COUNTY, ARIZONA
BEING A PORTION OF THE N 1/2 OF THE SW 1/4 OF SECTION 11, T11S, R24W, G.&S.R.B.&M., YUMA COUNTY , ARIZONA
DATE OF PREPARATION: NOV 2021 NUMBER LOTS: 197 ACREAGE: 77.6820 ACRES

FINAL PLAT



VICINITY MAP

DEDICATION

KNOW ALL MEN BY THESE PRESENTS: THAT RIEDEL HOLDINGS, L.L.C., AN ARIZONA LIMITED LIABILITY COMPANY, AS OWNER HAS THIS THE _____ DAY OF_____ 2022, CAUSED A PORTION OF THE NW1/4 OF THE SW1/4 OF SECTION 11, T11S, R24W, G. & S. R. B. & M. YUMA COUNTY, ARIZONA, AS PLATTED HEREON, TO BE SUBDIVIDED INTO LOTS, TRACT & STREETS UNDER THE NAME OF "LOS MEZQUITES SUBDIVISION UNIT 2" AND HEREBY DECLARES THAT THE ACCOMPANYING PLAT SETS FORTH THE LOCATION AND GIVES THE DIMENSIONS OF THE LOTS AND STREETS, CONSTITUTING SAID "LOS MEZQUITES SUBDIVISION UNIT 2" AND THAT EACH LOT SHALL BE KNOWN BY THE NUMBER, THE TRACT BY THE LETTER AND THE STREETS BY THE NAME GIVEN EACH RESPECTIVELY ON SAID PLAT;

AND THAT RIEDEL HOLDINGS, L.L.C., AS OWNER, HEREBY DEDICATES THE STREETS SHOWN HEREON TO THE CITY OF SAN LUIS FOR ITS USE AND BENEFIT, AND THAT THE EASEMENTS ARE DEDICATED FOR THE USES SHOWN AND DEFINED ON SAID PLAT AND AS SET FORTH IN THE DECLARATION OF RESERVATIONS, COVENANTS, CONDITIONS AND RESTRICTIONS RECORDED CONCURRENTLY HEREWITH. TRACT "A" IS DEDICATED TO THE CITY OF SAN LUIS FOR USE AS STORM WATER RETENTION BASIN AND COMPATIBLE RECREATIONAL USES. THE EASEMENTS ARE DEDICATED FOR THE PURPOSE SHOWN HEREON. A THREE FOOT NON-CONSTRUCTION AND NO OBSTRUCTION EASEMENT FROM THE FURTHER PROJECTION ON ANY SIDE OF ALL FIRE HYDRANTS; A TWELVE INCH NON-CONSTRUCTION AND NO OBSTRUCTION EASEMENT AROUND WATER METERS; AND 24 INCH NON-CONSTRUCTION AND NO OBSTRUCTION EASEMENT FOR STREET LIGHTS IS HEREBY GRANTED.

IN WITNESS WHEREOF: RIEDEL HOLDINGS, L.L.C., HAS CAUSED ITS CORPORATE NAME TO BE SIGNED AND ITS CORPORATE SEAL TO BE AFFIXED BY THE SIGNATURE OF NIEVES GARCIA RIEDEL, AS MEMBER, THEREUNTO DULY AUTHORIZED ON THIS THE _____ DAY OF_____ 2022.

_____

BY:
NIEVES GARCIA RIEDEL, MEMBER
RIEDEL HOLDINGS, L.L.C.

ACKNOWLEDGMENT

STATE OF ARIZONA)
> SS
COUNTY OF YUMA)

ON THIS THE _____DAY OF _____2022 BEFORE ME, THE UNDERSIGNED OFFICER PERSONALLY APPEARED, NIEVES GARCIA RIEDEL, WHO ACKNOWLEDGED HERSELF TO BE MEMBER OF RIEDEL HOLDINGS, L.L.C., AN ARIZONA LIMITED LIABILITY COMPANY, AND SHE AS SUCH OFFICER BEING AUTHORIZED TO DO SO, EXECUTED THE FOREGOING INSTRUMENT FOR THE PURPOSES THEREIN CONTAINED, BY SIGNING THE NAME OF THE LIMITED LIABILITY COMPANY BY HERSELF, AS SUCH OFFICER.

IN WITNESS WHEREOF, I HAVE SET MY HAND AND OFFICIAL SEAL.

BY: _____
NOTARY PUBLIC

MY COMMISSION EXPIRES: _____

LOT AREAS

LOT	AREA	LOT	AREA	LOT	AREA	LOT	AREA	LOT	AREA	LOT	AREA	LOT	AREA	LOT	AREA
196	6000.00 SF	221	6000.00 SF	246	6000.00 SF	271	6000.00 SF	296	6000.00 SF	321	6000.00 SF	346	6000.00 SF	371	6000.00 SF
197	6000.00 SF	222	6000.00 SF	247	6000.00 SF	272	6187.50 SF	297	6000.00 SF	322	6000.00 SF	347	6187.50 SF	372	6000.00 SF
198	6000.00 SF	223	6000.00 SF	248	6000.00 SF	273	6187.50 SF	298	6000.00 SF	323	6000.00 SF	348	6187.50 SF	373	6000.00 SF
199	6000.00 SF	224	6000.00 SF	249	6000.00 SF	274	6000.00 SF	299	6000.00 SF	324	6000.00 SF	349	6000.00 SF	374	6000.00 SF
200	6000.00 SF	225	6000.00 SF	250	6000.00 SF	275	6000.00 SF	300	6000.00 SF	325	6000.00 SF	350	6000.00 SF	375	6000.00 SF
201	6000.00 SF	226	6000.00 SF	251	6000.00 SF	276	6000.00 SF	301	6000.00 SF	326	6000.00 SF	351	6000.00 SF	376	6000.00 SF
202	6187.50 SF	227	6000.00 SF	252	6000.00 SF	277	6000.00 SF	302	6187.50 SF	327	6000.00 SF	352	6000.00 SF	377	6187.50 SF
203	6000.00 SF	228	6000.00 SF	253	6000.00 SF	278	6000.00 SF	303	6187.50 SF	328	6000.00 SF	353	6000.00 SF	378	6187.50 SF
204	6000.00 SF	229	6000.00 SF	254	6000.00 SF	279	6000.00 SF	304	6000.00 SF	329	6000.00 SF	354	6000.00 SF	379	6000.00 SF
205	6000.00 SF	230	6000.00 SF	255	6000.00 SF	280	6000.00 SF	305	6000.00 SF	330	6000.00 SF	355	6000.00 SF	380	6000.00 SF
206	6000.00 SF	231	6187.50 SF	256	6000.00 SF	281	6000.00 SF	306	6000.00 SF	331	6000.00 SF	356	6000.00 SF	381	6000.00 SF
207	6000.00 SF	232	6375.00 SF	257	6187.50 SF	282	6000.00 SF	307	6000.00 SF	332	6187.50 SF	357	6000.00 SF	382	6000.00 SF
208	6000.00 SF	233	6375.00 SF	258	6187.50 SF	283	6000.00 SF	308	6000.00 SF	333	6187.50 SF	358	6000.00 SF	383	6000.00 SF
209	6000.00 SF	234	6266.60 SF	259	6000.00 SF	284	6000.00 SF	309	6000.00 SF	334	6000.00 SF	359	6000.00 SF	384	6000.00 SF
210	6000.00 SF	235	6266.60 SF	260	6000.00 SF	285	6000.00 SF	310	6000.00 SF	335	6000.00 SF	360	6000.00 SF	385	6000.00 SF
211	6000.00 SF	236	6266.60 SF	261	6000.00 SF	286	6000.00 SF	311	6000.00 SF	336	6000.00 SF	361	6000.00 SF	386	6000.00 SF
212	6000.00 SF	237	6266.60 SF	262	6000.00 SF	287	6187.50 SF	312	6000.00 SF	337	6000.00 SF	362	6187.50 SF	387	6000.00 SF
213	6000.00 SF	238	6266.60 SF	263	6000.00 SF	288	6187.50 SF	313	6000.00 SF	338	6000.00 SF	363	6187.50 SF	388	6000.00 SF
214	6000.00 SF	239	6266.60 SF	264	6000.00 SF	289	6000.00 SF	314	6000.00 SF	339	6000.00 SF	364	6000.00 SF	389	6000.00 SF
215	6000.00 SF	240	6266.60 SF	265	6000.00 SF	290	6000.00 SF	315	6000.00 SF	340	6000.00 SF	365	6000.00 SF	390	6000.00 SF
216	6187.50 SF	241	6266.60 SF	266	6000.00 SF	291	6000.00 SF	316	6000.00 SF	341	6000.00 SF	366	6000.00 SF	391	6000.00 SF
217	6187.50 SF	242	6267.20 SF	267	6000.00 SF	292	6000.00 SF	317	6187.50 SF	342	6000.00 SF	367	6000.00 SF	392	6187.50 SF
218	6000.00 SF	243	6187.50 SF	268	6000.00 SF	293	6000.00 SF	318	6187.50 SF	343	6000.00 SF	368	6000.00 SF	393	1,693,416 SF
219	6000.00 SF	244	6000.00 SF	269	6000.00 SF	294	6000.00 SF	319	6000.00 SF	344	6000.00 SF	369	6000.00 SF		
220	6000.00 SF	245	6000.00 SF	270	6000.00 SF	295	6000.00 SF	320	6000.00 SF	345	6000.00 SF	370	6000.00 SF		

APPROVED

STATE OF ARIZONA)
> SS
CITY OF SAN LUIS)

THIS SUBDIVISION AS PLATTED HEREON HAS BEEN APPROVED BY THE MAYOR AND THE CITY COUNCIL OF THE CITY OF SAN LUIS, ARIZONA.

_____
MAYOR DATE

_____
CITY MANAGER DATE

_____
DIRECTOR OF PLANNING AND ZONING DEPARTMENT DATE

_____
CITY ENGINEER DATE

_____
CITY PUBLIC WORKS DIRECTOR DATE

BASIS OF BEARING

THE MID-SECTION LINE OF SECTION 11, T11S, R24W, G.&S.R.B.&M., YUMA COUNTY, ARIZONA, AS SHOWN ON DKT. 1848, PAGE 711, YUMA COUNTY RECORDERS OFFICE, YUMA COUNTY, ARIZONA.
BEARING N 00°26'29" E

RESTRICTIVE COVENANTS

HAVE BEEN RECORDED CONCURRENTLY AND ARE A PART OF THIS PLAT

SUBDIVIDER/OWNER

RIEDEL HOLDINGS, LLC
1910 JUAN SANCHEZ BLVD
P.O. BOX 1649
SAN LUIS, AZ. 85349
(928) 627-8593

SURVEYOR'S CERTIFICATE

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

NOT FOR RECORDATION
FOR REVIEW ONLY

_____
JUAN N. LOMELI R.L.S. No. 22767

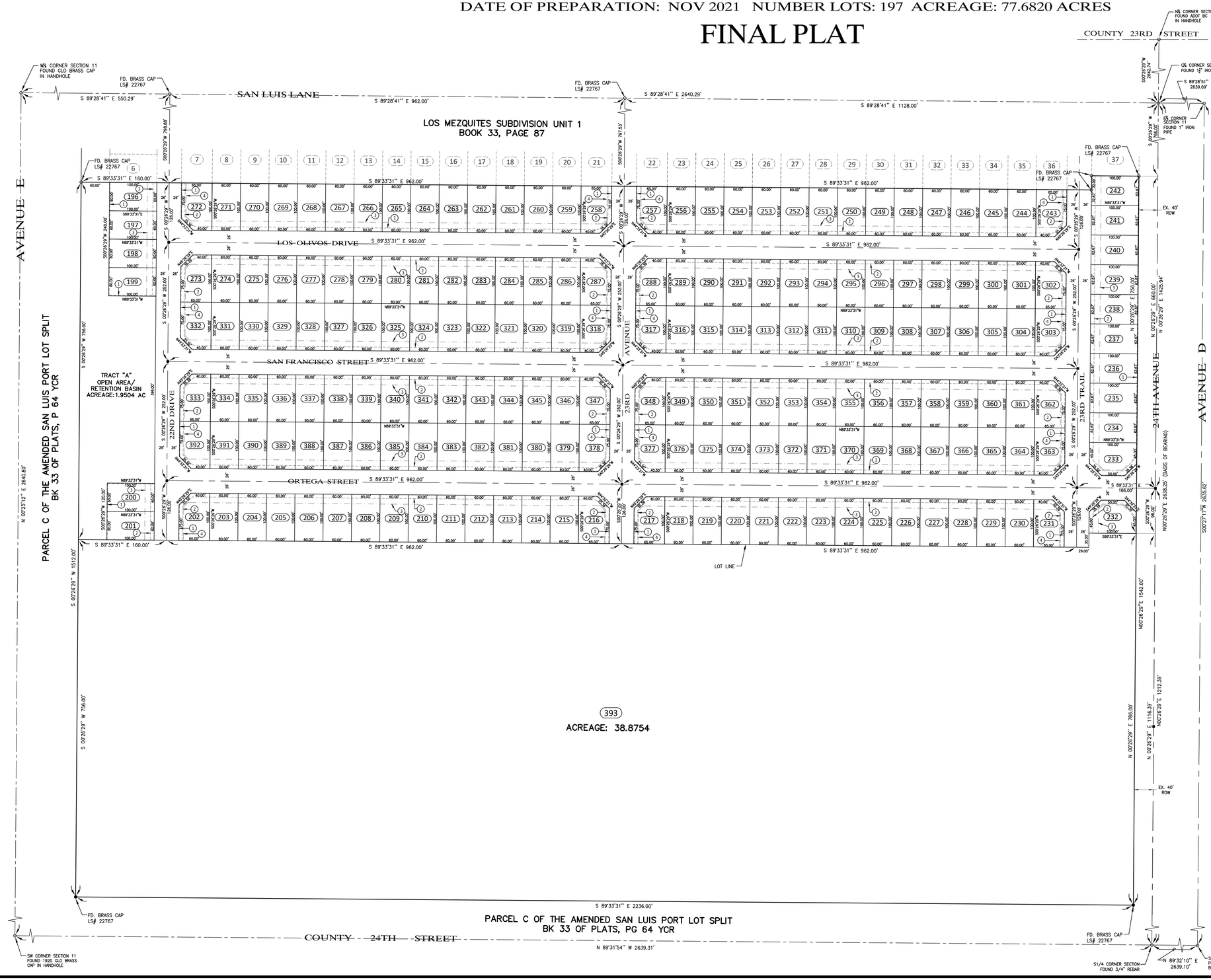
PREPARED BY:

Edais
Engineering, Inc.
3075 S. AVENUE 4 E
YUMA, ARIZONA 85365
(928) 344-3566

LOS MEZQUITES SUBDIVISION UNIT 2

A SUBDIVISION OF PARCEL B OF THE AMENDED SAN LUIS PORT LOT SPLIT AS RECORDED IN BOOK 33 OF PLATS, PAGE 64, YUMA COUNTY RECORDERS OFFICE, YUMA COUNTY, ARIZONA
BEING A PORTION OF THE N 1/2 OF THE SW 1/4 OF SECTION 11, T11S, R24W, G.&S.R.B.&M., YUMA COUNTY , ARIZONA
DATE OF PREPARATION: NOV 2021 NUMBER LOTS: 197 ACREAGE: 77.6820 ACRES

FINAL PLAT



N
W E
S
SCALE: 1"=100'

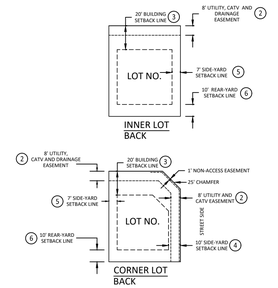
LEGEND

	SUBDIVISION BOUNDARY LINE
	LOT LINE
	CENTERLINE / SECTION LINE
	RIGHT OF WAY LINE
	SETBACK LINE
	EASEMENT LINE (TYPE AS SHOWN)
(197)	NEW LOT NUMBER
(10)	EXISTING LOT NUMBER
■	NEW STREET MONUMENT CITY OF YUMA STD DETAIL No. 4-030
○	EXISTING MONUMENT (TYPE AS NOTED)
ROW	RIGHT OF WAY
NAE	NON ACCESS EASEMENT
PUE	PUBLIC UTILITY EASEMENT
APN	ASSESSOR'S PARCEL NUMBER
BK	BK
PG	PG
YCR	YUMA COUNTY RECORDS

KEYNOTES

1. NEW 1' NON-ACCESS EASEMENT
2. NEW 8' PUE (PUBLIC UTILITY EASEMENT)
3. NEW 20' FRONT YARD SETBACK LINE
4. NEW 10' STREET SIDE YARD SETBACK LINE
5. NEW 7' SIDE YARD SETBACK LINE
6. NEW 10' REAR YARD SETBACK LINE

TYP. LOT LAYOUT



OPEN SPACE

MIN. OPEN SPACE REQUIRED = (38.8066 AC) X 5% = 1.94 AC
OPEN SPACE PROVIDED = 1.9504 AC

SURVEYOR'S CERTIFICATE

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NOT FOR RECORDATION
FOR REVIEW ONLY

JUAN N. LOMELI R.L.S. No. 22767

PREPARED BY:

Edais
Engineering, Inc.
3075 S. AVENUE 4 E
YUMA, ARIZONA 85365
(928) 344-3566

CONFORMED COPY
2021-47097 RESOLUTION
12/22/2021 09:51:20 AM Pages: 13 Fees: $15.00
Requested By:CITY OF SAN LUIS
Recorded By: arios
Robyn Stallworth Pouquette County Recorder, YUMA County AZ

WHEN RECORDED MAIL TO:

CITY OF SAN LUIS
ATTN: CITY CLERK
P.O. BOX 1170
SAN LUIS, ARIZONA 85349

The above area is to be reserved for recording information

****

CAPTION HEADING:

Resolution
Resolution No. 2204
Riedel Holdings, L.L.C.
Los Mezquites Development Agreement

OFFICE OF THE
MAYOR
CITY OF SAN LUIS

Resolution

NO. 2204

A RESOLUTION OF THE MAYOR AND CITY COUNCIL OF THE CITY OF SAN LUIS, ARIZONA AUTHORIZING AND DIRECTING THE ENTERING INTO A DEVELOPMENT AGREEMENT DEVELOPMENT BETWEEN THE CITY OF SAN LUIS, ARIZONA AND RIEDEL HOLDINGS, AZ LLC.

WHEREAS, Nieves Riedel, Riedel Holdings, L.L.C.; Owner, desires to enter into a development agreement for Los Mezquites project to be located in San Luis, Arizona; and

WHEREAS, A.R.S. § 9-500.05 grants power to a municipality to enter into development agreements; and

WHEREAS, the parties desire to enter into such agreement; and

WHEREAS, the applicant and the city staff agreed to all matters in the City's proposed development agreement; and

NOW, THEREFORE, BE IT RESOLVED by the Mayor and Council of the City of San Luis, State of Arizona, as follows:

SECTION 1. That the development agreement proposed by the staff of the City of San Luis, Arizona attached hereto as Exhibit "A", is hereby approved;

PASSED AND ADOPTED by the Mayor and City Council of the City of San Luis, Arizona, this 21st day of December 2021.

APPROVED:

A Carrasco

Africa Luna-Carrasco, Vice-Mayor

ATTEST:

Deputy City Clerk

for Sonia Cornelio, City Clerk

APPROVED AS TO FORM:

Kay Marion Macuil

Kay Marion Macuil, City Attorney

LOS MEZQUITES DEVELOPMENT AGREEMENT

THIS DEVELOPMENT AGREEMENT (the "**Agreement**") is entered into as of 21st day of December, 2021 ("**Effective Date**") by and between the City of San Luis an Arizona municipal corporation (the "**City**") and Riedel Holdings, AZ LLC, (the "**Owner**"). This Agreement is entered into pursuant to City Resolution Number 2204.

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, Owner, owns real property located in the municipal limits of the City which is legally described on Exhibit 1 (the **"Property")** and is currently being developed for a commercial shopping center ("**Shopping Center**") and residential housing ("**Housing**"), and

C. WHEREAS, Owner has applied for a rezoning and lot split in order to develop the aforementioned Shopping Center and Housing Projects;

D. WHEREAS, A.R.S. § 9-500.05 provides, in part, that a development agreement can provide for the permitted uses of land; the density and intensity of uses; reservation or dedication of land for public purposes; conditions, terms, restrictions and requirements for public infrastructure; conditions, terms, restrictions and requirements relating to the governing body's intent to form a special taxing district pursuant to title 48; and any other matters relating to the development of the property; and

E. WHEREAS, the City and Owner desire to enter into an agreement to provide for the rezoning and the splitting of land and provide for the lands future development; and

F. WHEREAS, the City's governing body has authorized execution of this Agreement by Resolution No. 2204;

NOW, THEREFORE, the parties agree as follows:

AGREEMENT

DEFINITIONS

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

Agreement shall mean this development agreement.

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

Owner shall mean and refer to Riedel Holdings LLC, and any successor in ownership.

Property as used in this Agreement shall mean and refer to all of the real Property, which is legally described in Exhibit 1.

ARTICLE 1. DEVELOPMENT PLAN

1.1. Duration of Development Agreement. The term of this Agreement shall be for a period of five (5) years from date of execution.

1.2 Failure of Timely Performance. In the event that either party hereto fails to perform any of its obligations which are set forth in or contemplated by this Agreement in a timely manner, and should such failure not otherwise be excused by agreement of the parties or by the terms of this Agreement, such failure shall be considered to be a breach of this Agreement and the nonbreaching party shall have their respective remedies set forth in Section 5.3 of this Agreement.

1.3.Review Process. The City acknowledges the necessity for expeditious review by the City of all plans and other materials ("**Submitted Materials**") submitted by the Owner to the City hereunder or under any zoning procedure, permit procedure, or other governmental procedure pertaining to the development of the Property and agrees to use its reasonable efforts accomplish such an expeditious review of the Submitted Materials whenever possible.

ARTICLE 2. SPECIAL PROVISIONS FOR DEVELOPMENT

2.1 Dedication of Right of Way. At present time Owners shall dedicate appropriate right-of-way to the City along County 23 ½ Street and Avenue D ½ alignments in accordance with the updated standards for right-of-way as provided by Public Works Department. Dedication of right of way on County 24th shall be 62 feet from center of alignment and 130 feet within 300 feet of the intersection. Dedication of said right-of-way shall occur at such time and in such manner as required by the City in its sole discretion.

2.2 Development of Improvements. At such time that any lot created by City Lot Split Case Number 2021-0387 or any lot within the Rezoning Case No. 2021-0693 is developed, public improvements, including but not limited to streets, roads, retention basins, utility extensions, utility mains, including pumping stations, lift stations, force mains, traffic signalization, and other off-site public improvements will be made pursuant to City standards as may be required by the Public Works Director of City in his sole discretion. The location of such improvements and/or its development is not confined to the lot being developed, but rather may be located on any portion of the entire Property (Exhibit 1) that is the subject of this agreement. Owner agrees to make such

dedications of property as may be needed or necessary for such development in the discretion of the Public Works Director. Such dedications and the development of such improvements as described above shall be a condition of the issuance of any building permit(s) or other use permit(s) for the development of any such lot or portion of such lot.

2.3 Street Lights. At such time that any lot created by City Lot Split Case Number 2021-0387 or any lot within Rezoning Case No. 2021-0693 is developed, the Public Works Director may require, in his sole discretion, that the development of street lights in the public right-of-way is needed or desired, the development of such street lighting in the manner and at the locations as may be determined by the Public Works Director, in his sole discretion, shall be a condition of the issuance of building permit(s) or other use permit(s) for the development of any such lot.

2.4 Residential Development. Developer is requesting Rezoning Case No. 2021-0693 to change Assessor Parcel Number 227-11-004 and portion of parcel 227-11-005 to Medium Density Residential (R1-6) to allow for single-family development. At such time as any portion of the property is developed with single family homes, the development will be of lots no less in size of 6,000 square feet, amending the lot size requirement and removing the minimum home size on Resolution No. 933.

2.5 Traffic Light Contribution. 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.

2.6 Waste Water Treatment Plant. Developer agrees to execute, record, and deliver such agreements, easements, and/or covenants conditions and restrictions that run with the land which is the subject of this development agreement for the benefit of the City of San Luis that will allow the real property of Developer that is the subject of this agreement to be used for fumes or odors from its wastewater treatment operations located at 358 N. Avenue D, and to waive any claims for any damages that might arise from wastewater treatment operations, whatsoever, and agree to indemnify and hold the City of San Luis and its officers, agents, and employees harmless from any and all claims, whatsoever, known or unknown, emanating from wastewater treatment operations including, but not limited to, claims arising from fumes or odors.

2.7 Land Dedication for Park. Owner wishes to donate to the City, and City agrees to accept from Owner, certain land within the Property, containing 5 gross acres of buildable land in addition to the open space requirement. Owner agrees to convey to the City by executing a Deed, free and clear of all liens and encumbrances.

2.8 Covenants Conditions and Restrictions. For any lot developed or to be developed as other than residential development, Owner shall record a covenant, condition and restriction to run with the land prohibiting the development and use of the property as a school, public or private, of any kind nature, or description.

2.9 Special Taxing Districts. Owner agrees to agree to the formation of a street lighting improvement district, a community facilities district and any enhanced municipal district needed.

2.10 Regulations. The terms of this Agreement are in addition to City codes, rules, fees, and regulations that are applicable to this action.

2.11 Buffer. Developer agrees to build an 8 foot cmu wall along the entire property line along the Detention Center and the East Waste Water Treatment Plant. Including as a buffer, a 30 feet wide green area and the residential street, totaling 82 feet.

ARTICLE 3. INDEMNIFICATION

3.1. Owner agrees to defend, indemnity and hold harmless City, its officers, officials and employees ("**Indemnified Group**") for liability from and against claims, damages, losses and expenses of any nature whatsoever (including but not limited to reasonable attorney fees, court costs, the costs of appellate proceedings, and all claim adjusting and handling expense), relating to, arising out of, resulting from or alleged to have resulted from the Owner's acts, errors, mistakes or omissions relating to any action or inaction of the Owner under this Agreement, including but not limited to work or services in the performance of this Agreement by any subcontractor or anyone directly or indirectly employed by or contracting with the Owner or a subcontractor or anyone for whose acts any of them may be liable.

3.2. If any claim, action or proceeding is brought against the Indemnified Group, by reason of any event that is the subject of this agreement, Owner (at its sole cost and expense) shall pay, resist or defend such claim or action on behalf of the Indemnified Group by the attorney of the Owner, or if covered by insurance, Owner's insurer, all of which must be approved by City, which approval shall not be unreasonably withheld or delayed. The City shall cooperate with all reasonable efforts in the handling and defense of such claim. Notwithstanding the foregoing, the City may engage its own attorney to defend or assist in its defense, and the Owner shall pay the reasonable costs and expenses thereof.

3.3. Any settlement of claims must fully release and discharge the Indemnified Group from any liability for such claims. The release and discharge shall be in writing and shall be subject to approval by the City, which approval shall not be unreasonably withheld or delayed. If Owner neglects or refuses to defend any of the Indemnified Group as required by this Agreement, any recovery or judgment against the Indemnified Group for a claim covered by this Agreement shall conclusively establish Owner's liability to the Indemnified Group in connection with such recovery or judgment. If the City desires to settle such dispute, the City shall be entitled to settle such dispute in good faith and Owner shall be liable for the amount of such settlement, and all expenses in connection with such settlement.

3.4. The indemnity provisions of this Agreement shall survive the termination of this Agreement.

ARTICLE 4. MEDIATION AND DEFAULT

4.1. Representatives. To further the cooperation of the parties in implementing this Agreement, the City and Owner each shall designate and appoint a representative to act as a liaison between the City and its various departments and the Owner. The initial representative for the City (the "**City Representative**") shall be the City Manager, and the initial representative for the Owner shall be its project manager, as identified by the Owner from time to time (the "**Developer Representative**"). The representatives shall be available at all reasonable times to discuss and review the performance of the parties to this Agreement and the development of the Property.

4.2. Mediation. In the event that there is a dispute hereunder which the parties cannot resolve between themselves, the parties agree that there shall be a forty-five (45) day moratorium on litigation during which time the parties agree to attempt to settle the dispute by nonbinding mediation before commencement of litigation. In the event that the parties cannot agree upon the selection of a mediator within seven (7) days, either party may request the presiding judge of the Superior Court of Yuma County to assign a mediator from a list of mediators maintained by the Arizona Municipal Risk Retention Pool.

4.3. Default. Failure or unreasonable delay be any party to perform any term or provision of this Agreement for a period of ten (10) days after written notice thereof from another party shall constitute a default under this Agreement. If the default is of a nature which is not capable of being cured within ten (10) days, the cure shall be commenced within such period, and diligently pursued to completion. The notice shall specify the nature of the alleged default and the manner in which the default may be satisfactorily cured. In the event of a default hereunder by any party, the non-defaulting party shall be entitled to all remedies at both law and in equity, including, without limitation, specific performance and the right to perform the obligation(s) of which the defaulting party is in default and to immediately seek reimbursement from the defaulting party of all sums expended in order to cure such default, together with interest on all such sums from the date said sums are expended by the non-defaulting party for the purpose of curing the default to the date such sums are paid in full.

ARTICLE 5. CONFLICT OF INTEREST; REPRESENTATIVES NOT INDIVIDUALLY LIABLE

5.1. Conflict of Interest. Pursuant to Arizona law, rules and regulations, no member, official or employee of the City shall have any personal interest, direct or indirect, in this Agreement, nor shall any such member, official or employee participate in any decision relating to this Agreement which affects his or her personal interest or

the interest of any corporation, partnership or association in which he or she is, directly or indirectly, interested. This agreement is subject to the provisions of A.R.S. §38-511.

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

ARTICLE 6. MISCELLANOUS PROVISIONS

6.1. Notices. All notices and communications provided for herein, or given in connection herewith, 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: City Manager
City of San Luis
P.O. Box 1170
1090 E. Union Street
San Luis, Arizona 85349

If to the Owner: Nieves Riedel, Riedel Holdings, L.L.C.
1964 E. Cesar Chavez Blvd., Suite 1
P O Box 1649
San Luis, Arizona 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 given by mail shall be deemed delivered 72 hours following deposit in the United States Postal Service in the manner set forth above.

6.2. Waiver. No delay in exercising any right or remedy shall constitute a waiver thereof, and no waiver by the parties of the breach of any provision of this Agreement shall be construed as a waiver of any preceding or succeeding breach of the same or of any other provision of this Agreement.

6.3. 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.

6.4. 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 Owner represents and warrants that it is duly formed and validly existing under the laws of the State of Arizona and that it is duly qualified to do business in the State of Arizona and is in good standing

under applicable state laws. The Owner and the City warrant to each other that the individuals executing this Agreement on behalf of their respective parties are authorized and empowered to bind the party on whose behalf each individual is signing. The Owner represents to the City that by entering into this Agreement, the Owner has bound the Property and all persons and entities having any legal or equitable interest therein to the terms of the Agreement.

6.5. 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.

6.6. 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.

6.7. Governing Law. The laws of the State of Arizona shall govern the interpretation and enforcement of this Agreement. The parties agree that venue for any action commenced in connection with this Agreement shall be proper only in a court of competent jurisdiction located in Yuma County, Arizona, and the parties hereby waive any right to object to such venue.

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

6.9. 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.

6.10. Notice of Conveyance or Assignment. The Owner 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.

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

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

6.13. 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 Owner, or any successor in interest, in the event of any default or breach by the

City or for any amount that may become due to the Owner or successor, or under any obligation under the terms of this Agreement.

6.14. Employment Eligibility, E-Verify

1. The Owner warrants his compliance with all federal immigration laws and regulations that relate to its employees and its compliance with A.R.S. § 23214, subsection A.
2. A breach of a warranty under paragraph 1 shall be deemed a material breach of the Agreement that is subject to penalties up to and including termination of the contract.
3. That the City retains the legal right to inspect the papers of any contractor or subcontractor employee who work on the Agreement to ensure that the contractor or subcontractor is complying with the warranty under paragraph 1.

6.15. Time is of the Essence. Time is of the essence of this agreement.

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

THE CITY OF SAN LUIS,
an Arizona municipal corporation

By: ACarrasco
Vice Mayor KMM

THE OWNER, Riedel Holding, L.L.C.

By: President
Its:

ATTEST:

By: Deputy City Clerk
City Clerk

APPROVED AS TO FORM:

Kay Marian Macuil
City Attorney

STATE OF ARIZONA)
) ss.
County of Yuma)

The foregoing instrument was acknowledged before me this 21st day of December 2021, by Africa Luna-Carrasco, Vice-Mayor of the City of San Luis, Arizona, a municipal corporation.

Angelica Cifuentes
Notary Public

My Commission Expires: 05-11-2023

Angelica Cifuentes
Notary Public - Arizona
Yuma County
Commission Number 562004
My Comm. Exp. 5/11/2023

STATE OF ARIZONA)
) ss.
County of Yuma)

The foregoing instrument was acknowledged before me this 22ND day of DECEMBER 2021, by NIEVES RIEDEL, on behalf of Riedel Holdings L.L.C., an Arizona Limited Liability Corporation.

Janet Taylor
Notary Public

My Commission Expires: 09/28/2025

Janet Taylor
Notary Public - Arizona
Yuma County
Commission Number 613060
My Comm. Exp. 9/28/2025

Exhibit 1

Los Mezquites Development Agreement

LOS MEZQUITES SUBDIVISION

DATE OF PREPARATION: NOVEMBER 2021 NUMBER OF LOTS: 897

MASTER PLAN LAYOUT

Parcel 227-11-005: A portion of the SW¼ of Section 14, Township 11 South Range 24 West. Except road right of way. **(108.91 acres)**

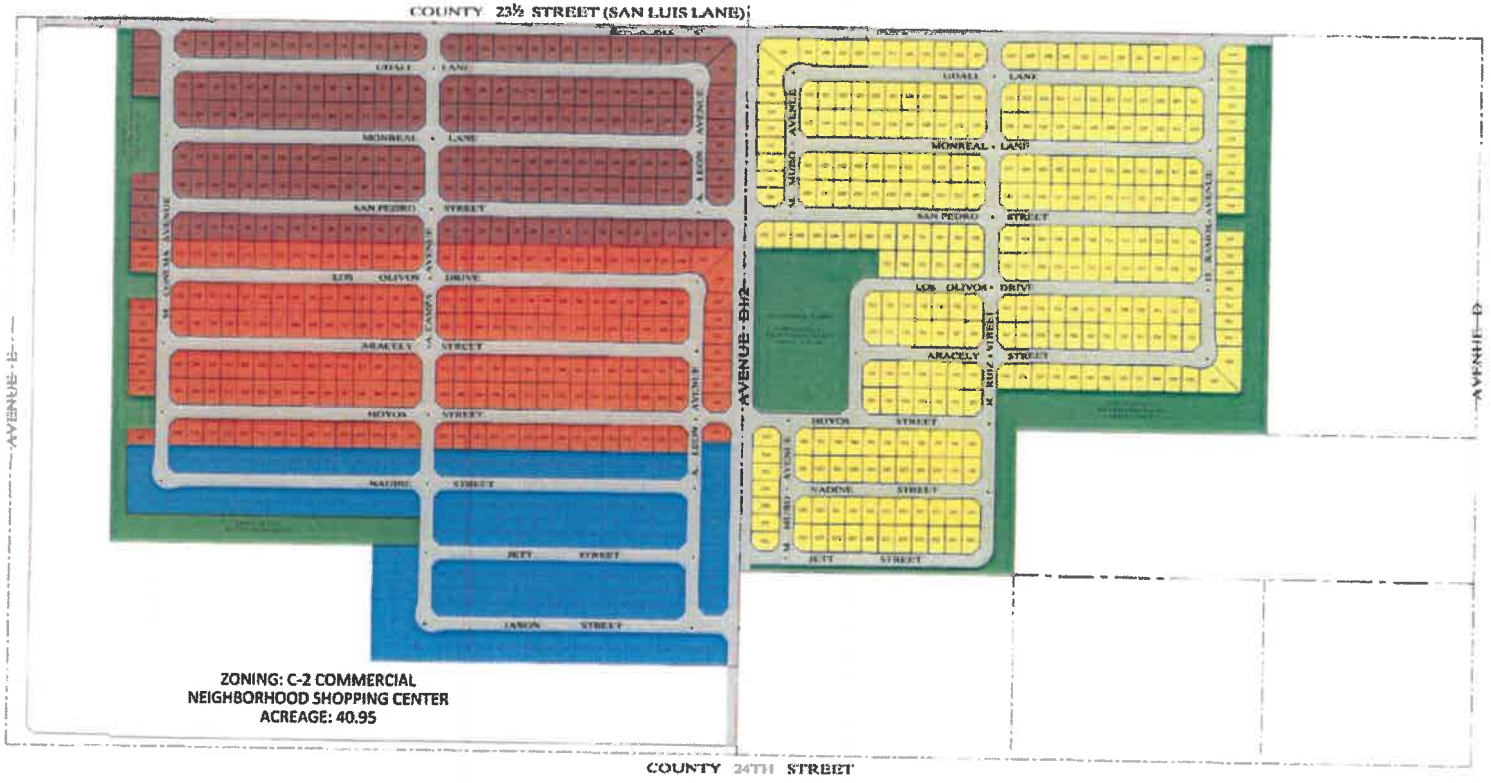
Parcel 227-11-004: South East ¼ of Section: 11 Township: 11S Range: 24W SE4 EXC THE E 751.25 FT OF N 1449.58 FT & EXC S 660 FT +/- & EXC THE E 1652.78 FT OF THE N 576.11 FT +/- OF S 1185.05 FT +/- **(74.64 acres)**

N

W E

S

SCALE: 1"=200'



PRELIMINARY
NOT FOR
CONSTRUCTION

January 20, 2022

SUBDIVISION CASE NUMBER: 2022-0040P

CASE SUMMARY: A request by Edais Engineering Inc., on behalf of Riedel Holdings LLC for the preliminary plat approval for Los Mezquites Unit 2. This subdivision will contain 198 lots, in approximately 38.80 acres. The minimum lot size is 6,000 square feet. The property is located west of Avenue D ½ and north of County 24th Street. PID # 227-11-011 (the north half), San Luis, Arizona.

PUBLIC MEETING: March 8, 2022

COMMENTS DUE: February 1, 2022

Your comments on this case will help us prepare an accurate and timely staff report. Your comments on this case will be inserted "as is" into the staff report with your name, department, and telephone number, should the applicant have any questions. Your comments are a public record and will be available to the public, media, and the applicant, in addition to the Commission hearing this case. Please complete the section below and return via e-mail. For additional information, please contact the Planning and Zoning Department at (928) 341-8563 or at Fervillegas@sanluisaz.gov

Thank you,

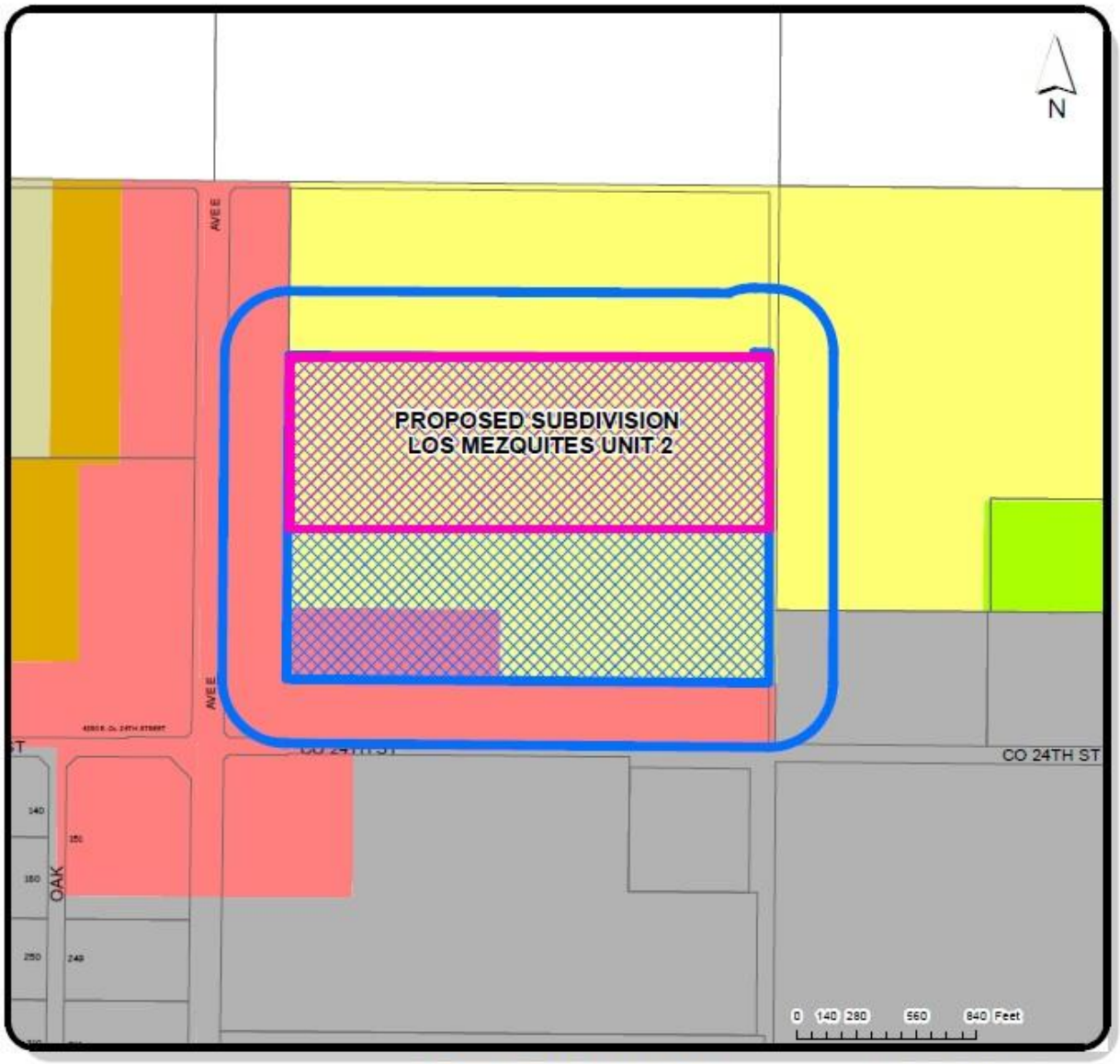
Fernando Villegas
Principal Planner
Attachment: Location Map, Preliminary Plat and Master Plan

☑ COMMENTS ☐ NO COMMENTS

Enter Comments below:

The City of San Luis Fire Department has concerns regarding access to the subdivision, during development, and at full build out. This parcel is land locked without access from Avenue D ½ and Co.24th Street, and San Luis Lane is currently a single lane road, which will not provide adequate emergency access to the subdivision, if blocked by traffic. A second means of ingress/egress, to the entire project, will need to be provided for Fire Fighting tactics prior to construction. The City of San Luis Fire Department reserves the right to comment upon subsequent submittals.

Date:
01/20/22
Agency:
The City of San Luis Fire Department
Phone:
928/341-8550
Return to: Fervillegas@sanluisaz.gov



LOCATION MAP

LOCATION OF SUBJECT PROPERTY

PARCEL 227-11-011

300ft Notification Area

Proposed Subdivision Location

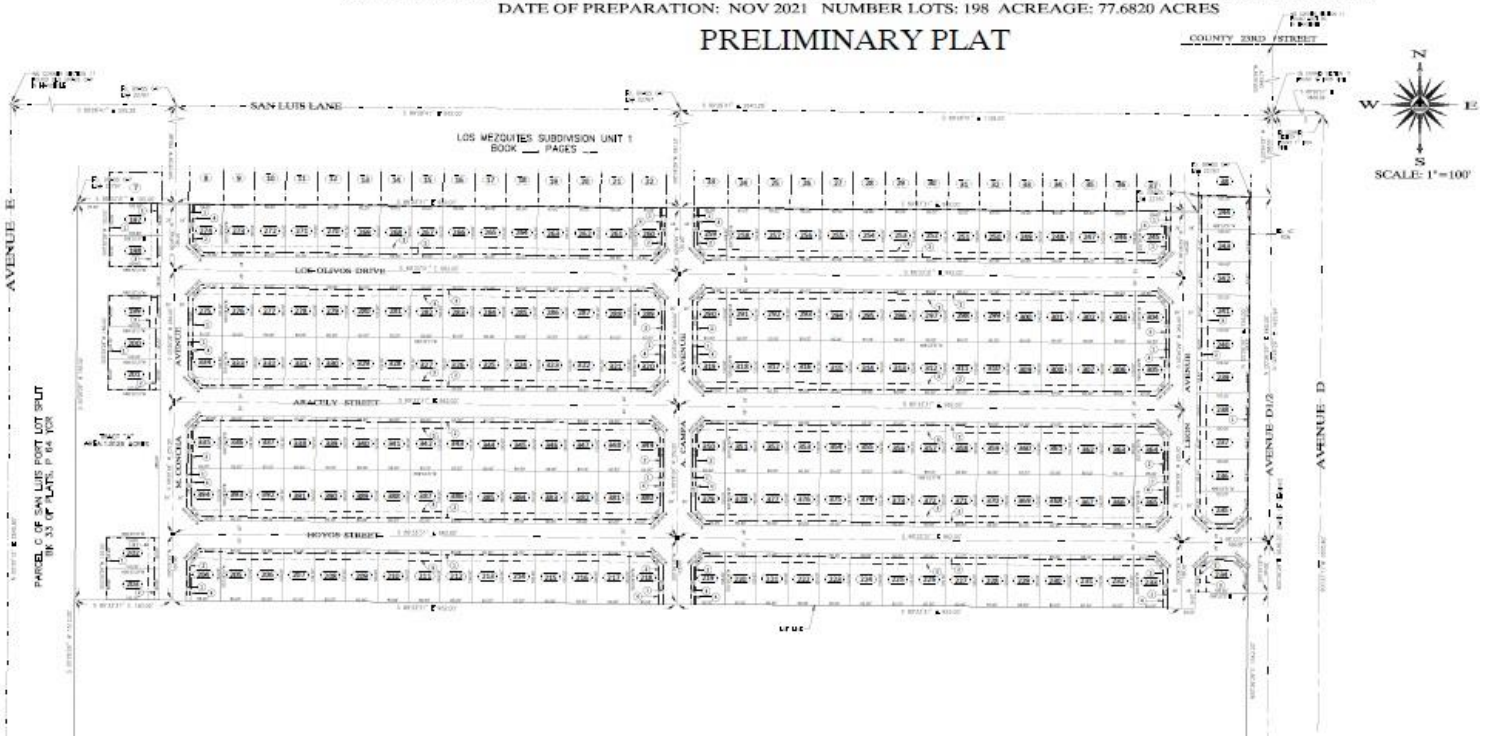
SUBDIVISION

CASE #
2022-0040-P

LOS MEZQUITES SUBDIVISION UNIT 2

A SUBDIVISION OF PARCEL B OF THE SAN LUIS PORT LOT SPLIT AS RECORDED IN BOOK 33 OF PLATS,
PAGE 64, YUMA COUNTY RECORDERS OFFICE, YUMA COUNTY, ARIZONA
BEING A PORTION OF THE N 1/2 OF THE SW 1/4 OF SECTION 11, T11S, R24W, G.&S.R.B.&M., YUMA COUNTY , ARIZONA
DATE OF PREPARATION: NOV 2021 NUMBER LOTS: 198 ACREAGE: 77.6820 ACRES

PRELIMINARY PLAT



LOS MEZQUITES SUBDIVISION

DATE OF PREPARATION: NOVEMBER 2021 NUMBER OF LOTS: 854

MASTER PLAN LAYOUT

UNIT #
UNIT 1
UNIT 2
UNIT 3
UNIT 4

ACREAGE
RESIDENTIAL: 186.84 AC
COMMERCIAL: 40.95 AC
TOTAL : 227.79 AC

OPEN SPACE/RETENTION BASIN: 13.82 AC

N
W E
S
SCALE: 1"=200'



ZONING: C-2 COMMERCIAL
NEIGHBORHOOD SHOPPING CENTER
ACREAGE: 40.95

REVISIONS

PRELIMINARY LAYOUT

LOS MEZQUITES SUBDIVISION

EDAIS Engineering, Inc.

PRELIMINARY NOT FOR CONSTRUCTION

DATE:
DRAWN:
CHECKED:
PROJECT:
SHEET NUMBER
1

Re: Los Mezquites Final Plat-ADOT Southwest District Comments

Good morning, below are comments regarding the Los Mezquites Subdivision and Von Verde Development. Please contact me if you have any questions. Thank you.

1. The intersection of Ave E/ Cesar Chavez Blvd is recommended to have dual left turn lanes in the WB direction. However, the Synchro calculation still shows LOS F in the year 2031.
2. Intersection Ave E/ Cesar Chavez Blvd: The existing storage for the WBL is about 560' and EBR is about 580' as shown in the sketch attached. Please verify the storage length that is used in the Synchro model. It seems 250' is used for both turn lanes.
3. The turn lane design should follow ADOT TGP 430 to determine the storage/ gap and taper for the intersection of Ave E/ Cesar Chavez. Please verify table 20.
4. Please provide the recommendations that have the LOS D or better for the intersection of Ave E/ Cesar Chavez in the year 2031 and 2036.

Isabell Garcia
Development TES
Southwest District
P- (928) 317-2159
E-mail- IGarcia@azdot.gov

LOS MEZQUITES SUBDIVISION

DATE OF PREPARATION: NOVEMBER 2021 NUMBER OF LOTS: 854

MASTER PLAN LAYOUT

UNIT #
UNIT 1
UNIT 2
UNIT 3
UNIT 4

ACREAGE
RESIDENTIAL: 186.84 AC
COMMERCIAL: 40.95 AC
TOTAL : 227.79 AC

OPEN SPACE/RETENTION BASIN: 13.82 AC

N
W E
S
SCALE: 1"=200'



REVISIONS

PRELIMINARY LAYOUT

LOS MEZQUITES SUBDIVISION

EDAIS Engineering, Inc.

PRELIMINARY NOT FOR CONSTRUCTION

DATE:
DRAWN:
CHECKED:
PROJECT:
SHEET NUMBER
1