DEL NORTE SOLID WASTE MANAGEMENT AUTHORITY
CITY OF CRESCENT CITY
COUNTY OF DEL NORTE
STATE OF CALIFORNIA

Board of Supervisors Chambers
Flynn Center 981 H Street
Crescent City, CA

Special Session **Tuesday July 5, 2016** **3:30 PM**

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The Solid Waste Management Authority of the City of Crescent City and the County of Del Norte, State of California, is now meeting in Special Session. Only those items that indicate a specific time will be heard at the assigned time. All items may be taken out of sequence to accommodate public and staff availability.

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All documents referred to in this agenda are available at the Office of the Del Norte Solid Waste Management Authority at 1700 State Street in Crescent City, between the hours of 8 A.M. and 5 P.M. Monday through Friday OR online at www.recycledelnorte.ca.gov
For more information call 465-1100 or email dnswma@recycledelnorte.ca.gov

3:30 PM **CALL MEETING TO ORDER / ROLL CALL**
PLEDGE OF ALLEGIANCE

PUBLIC COMMENTS:

3:30 PM ANY MEMBER OF THE PUBLIC MAY ADDRESS THE SOLID WASTE MANAGEMENT AUTHORITY ON ANY MATTER ON OR OFF THE AGENDA. After receiving recognition from the Chair, please give your name and address for the record. Comments will be limited to three minutes.

1. CLOSED SESSION ITEMS:

1.1 CONFERENCE WITH LABOR NEGOTIATORS (Gov. Code Section 54957.6) Agency designated representatives: Tedd Ward, DNSWMA Director and Jeannine Galatioto. Employee Organization: Del Norte Solid Waste Management Authority Employees / SEIU Local 1021

OPEN SESSION ITEMS:

2. CONSENT AGENDA

2.1 Approve minutes, Regular Session, Tuesday June 21, 2016. **

2.2 Approve payment to CalPERS Fiscal Services Division in the amount of $11,125 towards the Authority's FY 15/16 OPEB obligations. **

2.3 Approve a budget transfer in the amount of $1,305.00 **

END CONSENT AGENDA

3. **DIRECTOR'S & TREASURER'S REPORTS**
Agenda items 2.1 through 2.5 are provided for information only
   3.1 Director's Report **
   3.2 Treasurer/Controller Report for May 2016 **
   3.3 Claims approved by Director for June 2016 **

DISCUSSION/ACTION ITEMS

4. **LANDFILL POSTCLOSURE**

   4.1 Discussion and possible action regarding Notice of Collection from PennCredit Corporation in the amount of $26,566.00 and Regional Water Quality Control Board staff review of 'First-half 2016 Water-Quality Monitoring Report and Evaluation of Threat and Complexity Rating for Crescent City Landfill. **

5. **COLLECTIONS FRANCHISE – No Items**

6. **TRANSFER STATION**

   6.1 Discussion regarding textile recycling service to begin at the Del Norte County Transfer Station starting on 01 August 2016. **

7. **OTHER GENERAL SOLID WASTE AUTHORITY MATTERS**

   7.1 Discussion and possible action regarding Authority Resolution 2016-01, APPROVING A MEMORANDUM OF UNDERSTANDING BETWEEN THE DEL NORTE SOLID WASTE MANAGEMENT AUTHORITY AND THE SERVICE EMPLOYEES INTERNATIONAL UNION (SEIU) LOCAL 1021 ON BEHALF OF THE DEL NORTE SOLID WASTE MANAGEMENT AUTHORITY EMPLOYEES, and Resolution 2016-02, ESTABLISHING BENEFITS FOR UNREPRESENTED POSITIONS OF ADMINISTRATIVE ASSISTANT AND FACILITIES AND PROGRAMS COORDINATOR.**

   7.2 Discussion and possible action regarding possible changes to the date for the August 2016 meeting and all regular meetings of the Authority Board. **

ABANDONED VEHICLE ABATEMENT SERVICE AUTHORITY

8. Discussion and possible action regarding release of a Request for Proposals for Removal and Towing of Abandoned Vehicles. **

9. **ADJOURNMENT**

Adjourn to the next Regular Meeting of the Del Norte Solid Waste Management Authority scheduled for 3:30 P.M., August 16, 2016 at the Del Norte County Board of Supervisors' Chambers, 981 H Street, Suite 100 in Crescent City.

**** Asterisks next to Agenda Item indicates an associated attachment**

DEL NORTE SOLID WASTE MANAGEMENT AUTHORITY
CITY OF CRESCENT CITY
COUNTY OF DEL NORTE
STATE OF CALIFORNIA
Regular Session, Tuesday June 21, 2016, 3:30 PM

PRESENT: Commissioner Ron Gastineau, Secretary
Commissioner Gerry Hemmingsen, County Alternate
Commissioner Blake Inscore, Vice Chair
Commissioner Eli Naffah
Director Tedd Ward
Legal Counsel Martha Rice
Authority Clerk Katherine Brewer
Authority Treasurer/Controller Rich Taylor

ABSENT: Commissioner Chris Howard
Commissioner Martha McClure, Chair

ALSO PRESENT: Dave Mason, Del Norte County Code Enforcement Officer
Brent VanWormer, Hambro Waste Solutions Group
Joel Wallen, Hambro Waste Solutions Group
Wes White, Hambro Waste Solutions Group
Julie Badorek, Julindra Recycling
Jeaninne Galatioto, Labor Negotiations Contractor

3:30 PM CALL MEETING TO ORDER

Vice Chair Inscore called the meeting to order in regular session at 3:30 p.m. Roll was taken with Commissioners Gastineau, Hemmingsen, Inscore, and Naffah present.

PLEDGE OF ALLEGIANCE

The pledge was led by Vice Chair Inscore.

3:30 PM PUBLIC COMMENTS:

There were no public comments.

2.1

OPEN SESSION ITEMS:

Being as Commissioner Hemmingsen needed to leave early, the agenda items were taken out of order.

2. CONSENT AGENDA

2.1 Approve minutes, Regular Session, Tuesday, May 17, 2016.

2.2 Approve Memorandum of Understanding between the Del Norte Solid Waste Management Authority and the Crescent City-Del Norte County Chamber of Commerce for the purpose of providing recycling units and support for Chamber and Visitor Bureau activities. **091503**

2.3 Status Report regarding CalRecycle grants supporting used oil recycling. **150901**

2.4 Receive, file, and submit completed 2016 survey of the Crescent City Landfill by Richard B. Davis, Inc. **040101**

2.5 Receive, file, and submit July 1, 2015 Actuarial Report on GASB 45 Retiree Benefit Valuation. **180520**

2.6 Approve a budget transfer in the amount of $83,255.00. **022101**

END CONSENT AGENDA

Item 2.6 was removed from the Consent Agenda for discussion. On a motion by Commissioner Gastineau, seconded by Commissioner Naffah, and unanimously carried on a polled vote, the Del Norte Solid Waste Management Authority approved and adopted the consent agenda, consisting of items 2.1 to 2.5.

After a brief discussion, on a motion by Commissioner Hemmingsen, seconded by Commissioner Naffah and unanimously carried on a polled vote, the Del Norte Solid Waste Management Authority approved and adopted item 2.6, a budget transfer in the amount of $83,255.00.

DISCUSSION/ACTION ITEMS

7. OTHER GENERAL SOLID WASTE AUTHORITY MATTERS

7.1 Public hearing and possible adoption of Del Norte Solid Waste Management Authority Ordinance 2016-01, INCREASING DISPOSAL RATE COMPONENTS AT THE DEL NORTE COUNTY TRANSFER STATION AND ESTABLISHING A RATE FOR IMPROPER DISPOSAL FOR THE GASQUET AND KLAMATH TRANSFER STATIONS.

Vice Chair Inscore opened the public hearing at 3:40 P.M.. There were no public comments. Vice Chair Inscore then closed the hearing. On a motion by Commissioner Gastineau, seconded by Commissioner Hemmingsen, and unanimously carried on a polled vote, the Del Norte Solid Waste Management Authority adopted Ordinance 2016-

01, INCREASING DISPOSAL RATE COMPONENTS AT THE DEL NORTE COUNTY TRANSFER STATION AND ESTABLISHING A RATE FOR IMPROPER DISPOSAL FOR THE GASQUET AND KLAMATH TRANSFER STATIONS.

7.2 Public hearing, discussion, and possible adoption of the proposed Authority budget for FY 16/17. **022102**

Vice Chair Inscore opened the public hearing at 3:45 p.m. There were no public comments. Vice Chair Inscore then closed the hearing. On a motion by Commissioner Gastineau, seconded by Commissioner Naffah and carried unanimously on a polled vote, the Del Norte Solid Waste Management Authority approved and adopted the Authority budget for FY 16/17.

7.3 Discussion and possible action regarding the Second Amended Joint Powers Agreement between the City of Crescent City and the County of Del Norte Creating the Del Norte Solid Waste Management Authority. **101503**

Director Ward informed Authority Board Members that both the County of Del Norte and the City of Crescent City had adopted the Second Amended Joint Powers Agreement as included in the agenda. No further action was necessary.

7.4 Discussion and possible action regarding Authority Resolution 2016-01, APPROVING A MEMORANDUM OF UNDERSTANDING BETWEEN THE DEL NORTE SOLID WASTE MANAGEMENT AUTHORITY AND THE SERVICE EMPLOYEES INTERNATIONAL UNION (SEIU) LOCAL 1021 ON BEHALF OF THE DEL NORTE SOLID WASTE MANAGEMENT AUTHORITY EMPLOYEES, and Resolution 2016-02, ESTABLISHING BENEFITS FOR UNREPRESENTED POSITIONS OF ADMINISTRATIVE ASSISTANT AND FACILITIES AND PROGRAMS COORDINATOR. **211401, 160504**

This item was tabled until the next meeting.

7.5 Discussion and possible action regarding a revised Title II Project Submission Form to the USDA Forest Service in the amount of $32,295.00 for the Forest and River Cleanup Partnership. **061501 G2**

After a brief discussion, on a motion by Commissioner Hemmingsen, seconded by Commissioner Naffah and unanimously carried on a polled vote, the Del Norte Solid Waste Management Authority acknowledged and approved a revised Title II Project Submission Form to the USDA Forest Service in the amount of $32,295.00 for the Forest and River Cleanup Partnership, with the Director approved to adjust budget allocations prior to final submittal.

3. DIRECTOR'S & TREASURER'S REPORTS
Agenda items 3.1 through 3.5 are provided for information only

3.1 Director's Report. **231501**
3.2 Treasurer/Controller Report for April 2016.
3.3 Claims approved by Director for May 2016.
3.4 Monthly Cash and Charge Reports for May 2016.
3.5 Earned Revenue Comparisons between FY14/15 and FY15/16.

The above-listed reports were presented and accepted.

4. LANDFILL POSTCLOSURE

4.1 Discussion and possible action regarding Regional Water Quality Control Board staff review of "First-half 2016 Water-Quality Monitoring Report and Evaluation of Threat and Complexity Rating for Crescent City Landfill".

Director Ward reported that there was no new information on this issue.

5. COLLECTIONS FRANCHISE

5.1. Discussion and possible action regarding the Recycling Ad Hoc Committee and meetings related to the 04 May 2016 letter from Julie Badorek, General Manager of Julindra Recycling. **102101**

Director Ward updated Authority Board Members that meetings were continuing with the Recycling Ad Hoc Committee, Recology Del Norte and Julindra.

Commissioner Hemmingsen left the meeting at 4:00 P.M.

6. TRANSFER STATION

6.1 Discussion and possible action regarding a letter from Hambro/WSG dated 08 June, 2016. **080104**

This item was tabled until a later meeting.

6.2 Discussion regarding the first Mattress Recycling Collection Event held at the Del Norte County Transfer Station on June 4th. **130120**

Joel Wallen, Operations Manager Hambro/WSG, updated Board Members that the event had been well attended and that traffic flow had been smooth. 275 mattresses or box springs were received, and only 47 of these were landfilled.

7. OTHER GENERAL SOLID WASTE AUTHORITY MATTERS

7.6 Discussion and possible action regarding the process for and status of redesignation of the North Coast Recycling Market Development Zone. **180505**

Director Ward briefly updated Board Members on the status of redesignation of the North Coast Recycling Market Development Zone.

ABANDONED VEHICLE ABATEMENT SERVICE AUTHORITY

8. Discussion and possible action regarding the 10 March, 2016 letter to Dave Mason, County Code Enforcement Officer and review of the draft First Revised Joint Powers Agreement for the Del Norte County Abandened Vehicle Abatement Service Authority and draft Resolutions for possible adoption by the Del Norte County Board of Supervisors and the City Council of the City of Crescent City. **010203**

The Vice Chair recessed the meeting of the Del Norte Solid Waste Management Authority at 4:15 p.m., and immediately convened as the Abandoned Vehicle Abatement Service Authority (AVA) with Commissioners Inscore, Gastineau, and Naffah present. There was a brief discussion, but no action was taken.

The Vice Chair adjourned the meeting of the Abandoned Vehicle Abatement Service Authority at 4:20 p.m. and immediately reconvened as the Del Norte Solid Waste Management Authority.

1. CLOSED SESSION ITEMS:

1.1 CONFERENCE WITH LABOR NEGOTIATORS (Gov. Code Section 54957.6) Agency designated representatives: Tedd Ward, DNSWMA Director and Jeannine Galatioto. Employee Organization: Del Norte Solid Waste Management Authority Employees/SEIU Local 1021

The Vice Chair recessed the open meeting of the Del Norte Solid Waste Management Authority and convened in closed session at 4:23 p.m. The closed session was adjourned at 4:54 p.m. and the meeting reconvened immediately in open session. Counsel reported that no action was taken.

9. ADJOURNMENT

Adjourn to the Special Meeting of the Del Norte Solid Waste Management Authority scheduled for 3:30 p.m., July 5, 2016 at the Del Norte County Board of Supervisors' Chambers, 981 H Street, Suite 100 in Crescent City.

There being no further business to come before the Authority, the Vice Chair adjourned the meeting at 4:55 p.m., until the Regular Meeting on July 5, 2016.

_____ Date / /

Blake Inscore, Vice Chair
Del Norte Solid Waste Management Authority

ATTEST:

_____ Date / /

Ron Gastineau, Secretary
Del Norte Solid Waste Management Authority

Submitted:

_____ Date / /

Katherine Brewer, Clerk
Del Norte Solid Waste Management Authority

Vendor Cal PERS
Fiscal Services Division
PO Box 942703
Sacramento CA 94229-2703

Claim ID: 7623

AUDITOR COPY

Vendor ID: 18592

☐ PBSP Expense
☐ Change of Address

Special Warrant Routing

15/16

Fund	Dept	Line	Proj	Amount	Description
422	421	70800		$11,125.00	2015/2016 post-employment benefits (agreement)
		Total Claim:		$11,125.00	

I HEREBY CERTIFY THE ARTICLES OR SERVICES DESCRIBED ON THE ATTACHED INVOICES WERE NECESSARY FOR USE BY THE DEPARTMENT AND HAVE BEEN RECEIVED, AND THAT NO PRIOR CLAIM FOR SAME HAS BEEN

X Jedd Ward
Signature of Department Head/Authorized Deputy

5/31/2016
Claim Date

2.2

CalPERS

Employer Contribution By Check Under Agreement and Election to Prefund Other Post Employment Benefits

C1000139725 CERBT Acct. No.	Del Norte Solid Waste Management Authority Employer Name

1700 State Street, Crescent City, CA 95531
Employer Address

Tedd Ward	Director		707-465-1100
Authorized Employer Representative Name	Title	Signature	Telephone Number

Effective date of Agreement and Election to Prefund Other Postemployment Benefits: _____ / _____ / _____
Month (mm) Day (dd) Year (yyyy)

$11,125.00 Amount of Contribution	_____ _____ Check Number

Notes:

Contributions to the Prefunding Plan are governed by the terms of the *Agreement and Election to Prefund Other Postemployment Benefits (Agreement)*.

To ask questions concerning Contributions to the Pre-funding Plan, call 1-888-225-7377, or email questions to CERBT4U@calpers.ca.gov

For proper crediting to your prefunding account, please complete this form and mail with your check payable to CalPERS at the following address:

CalPERS
Fiscal Services Division
PO Box 942703
Sacramento, CA. 94229-2703

In addition, please email an electronic copy of this form to FCSD-CERBT@calpers.ca.gov to ensure timely processing of your contribution.

For CalPERS use only

Bank Deposit Code: PEB

Deposit Date ____/____/_____
(mm/dd/yyyy)

PERS01F0030 DMC (02-2007)

Del Norte County Budget Transfer Request

FY 16 /17	Fund	Dept.	Line Item	Description	Budget Transfer Amount(s) Reduce Expenditures or Increase Revenue	Budget Transfer Amount(s) Increase Expenditures or Reduce Revenue
Solid Waste	422	421	10012	Overtime		$ 45
Solid Waste	422	421	10015	Part-time / Temp		$ 418
Solid Waste	422	421	10040	Worker's Comp		$ 2
Solid Waste	422	421	20221-75	Printing - Oil Grant 14/15	$ 85	
Solid Waste	422	421	20231	Professional Services		$ 85
Solid Waste	422	421	20240	Advertising / Publications		$ 90
Solid Waste	422	421	20240-079	Advertising - DOC Grant 15/16	$ 400	
Solid Waste	422	421	20285-079	Spec. Dept. Expense - DOC 15/16		$ 400
Solid Waste	422	421	20288	City Collections		$ 265
Solid Waste	422	421	90300	Interest	$ 820	
				Total Amounts	$ 1,305	$ 1,305

Department complete and send to Auditor's Office for transfer number before sending to CAO. Round amounts up to whole dollars.

Department Justification - Include cover letter that addresses the following: 1) Reason for request; 2) Why sufficient balances exist to

Department Head Signature _____ Date _____

Auditor's Office: Sufficient balances exist per above
(Under $100 Auditor's Office approves)

Deputy Auditor-Controller _____ Date _____

TR No. _____ Budget Revision No. _____

_____Includes Revenue Appropriation _____Requires 4/5ths Vote

County AdministrativeOfficer:
(Under $1000 - CAO approves)
Recommendation: Approve _____
Deny _____
Submit for Board approval _____

County Administrative Officer _____ Date _____

Passed by Board of Commissioners of the Del Norte Solid Waste Management Authority on 05 July 2016.

Ayes:
Noes:
Absent:

Attest: Clerk of the Board

By: _____
Katherine Brewer

_____
Martha McClure, Chair
Del Norte Solid Waste Management Authority

2.3

Del Norte Solid Waste Management Authority

1700 State Street, Crescent City, CA 95531
Phone (707) 465-1100 Fax (707) 465-1300
www.recycledelnorte.ca.gov

The Authority's mission is the management of Del Norte County solid waste and recyclable material in an environmentally sound, cost effective, efficient and safe manner while ensuring 100% regulatory compliance with law.

Director's Report

Date: 29 June 2016
To: Commissioners of the Del Norte Solid Waste Management Authority
From: Tedd Ward, M.S. – Director

File Number: **231501 – Authority Work Plans**

Summary: The Del Norte Solid Waste Management Authority continues to operate the Klamath, Gasquet and Del Norte County Transfer Stations and to provide required monitoring, accounting and reports to overseeing agencies. Authority staff provide these services without any financial support from the City of Crescent City or the County of Del Norte, and without receiving a penny of taxes. The rates charged at Authority-managed facilities continue to be lower than any comparable facilities in Humboldt or Curry Counties.

Consent Agenda Items: Item 2.2 - This is a partial payment for the Authority's outstanding 'Other Post-Employment Benefits' (OPEB) obligations. While this is an underpayment towards this outstanding liability, most municipal government agencies are underpaying these obligations and staff are not yet aware of any agency which has addressed these obligations in a substantially different way that the Authority might emulate. Though included in the adopted Authority budget, this item is agendized as all payments above $5,000 (with the exception of payments to Hambro/WSG for transfer station operation services) must be separately approved by the Authority Board.

Item 2.3 This is a budget transfer in the amount of $1,305. The largest increase in spending is $418 for part-time / temporary employees, as we have had to rely on such employees as two of our permanent staff are on FMLA leave. Two adjustments were made as some grant expenses had been charged to the incorrect budget line. There is a slight increase to City collections associated with the Authority's efforts to increase recycling and reduce the volume and frequency of trash collections. This resulted in a slight increase during the summer months due to the addition of the recycling bin, while

3.1

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the reduction in trash collection frequency will be implemented this coming fall. The revenue to cover these changes comes primarily from the increase in interest received this fiscal year above initial budget projections.

Finances and Audits: On 28 June 2016, staff from the Del Norte County Auditor's office and Authority Treasurer Rich Taylor conducted another surprise cash count. These surprise cash counts continue to confirm that the Authority's records and accounts continue to accurately reflect Authority's assets *to the penny.*

Authority Administrative Assistant Lisa Babcock and Account Clerk Katherine Brewer worked especially hard during these past few weeks as part of the additional efforts associated with fiscal year end.

Authority staff have received notice from CalRecycle that they will be reviewing our financial reports related to the beverage container recycling grant for FY 13/14 on behalf of the City of Crescent City. Authority staff will submit these reports electronically before the July 28 deadline. This is one of 60 such requests they have sent to jurisdictions across the State. All jurisdictions will be required to submit similar financial reports for similar grants for FY 14/15.

Facilities: **Agenda Item 6.1** describes the new textile recycling service that will start in August at the Del Norte County Transfer Station.

On June 16, in coordination with the County Department of Weights and Measures, the scales at the Del Norte County Transfer Station were checked. The outbound scale was not in calibration. Administrative Assistant Lisa Babcock did an outstanding job of coordinating with Scales Northwest, who had replaced a load cell and recalibrated the scales just one month earlier. The scales were adjusted by Shasta Scale from Humboldt County for just $600, and are now re-certified.

Staff are working with Creative Information Systems and Shawn Slater to update our Scale Management Software to version 10. Staff are having the new system installed on a separate computer so gate attendants will have opportunity to train on the new system before transitioning to this new version of our main software tool.

Staff had been working with the County Building and Maintenance to construct a desk for use at the Klamath Transfer Station. Eventually it became clear that there was not adequate County staff capacity in that department to complete this task. Subsequently, Rick Lauchstedt donated a desk for use by the Authority and staff have delivered and installed it.

Facilities and Programs Coordinator Kayleen Warner oversaw the mowing of the top deck at the Crescent City Landfill as part of the annual vegetative maintenance activities. This mowing is done to control gophers and voles, which can burrow through drainage berms and cause erosion issues. With the grass mowed, hawks and other raptors can more readily hunt such burrowing creatures, keeping their numbers in check.

Public Outreach and Education: Staff are working with representatives from the US Forest Service to modify the grant budget and related agreements to conduct cleanups on USFS Six Rivers Forest properties in Del Norte County.

Staff are preparing for the Del Norte County Fair, August 4th -7th. Once again, the Authority is a major sponsor of this vital community event (we are sponsoring 'Family Day,' Sunday August 7th) and we will have a booth to promote and discuss Authority recycling and waste reduction programs. The Authority's continuing Fair sponsorship is paid using beverage container and oil recycling grants.

Vendor Contract Management and Oversight: Agenda Item 6.1 - Staff have been working with Hambro/WSG developing an outreach strategy in preparation for the start of textile recycling at the Del Norte County Transfer Station starting August 1st. Staff are planning on a press release and possible press event later this month to make sure the newspaper, radio stations, and general public are aware of this new service when it begins in August.

Agenda Item 8 – The primary function of the Abandoned Vehicle Abatement Service Authority (AVA) – which has the identical Board to the DNSWMA – is to facilitate the towing and removal of abandoned vehicles. To do this, the AVA contracts with a local towing company. As the current AVA towing agreement expires this month, it is appropriate timing for the release of a Request for Proposals soliciting competitive proposals from interested towing companies. The AVA Board will have the opportunity to award this agreement to a qualified proposing towing company at the August AVA meeting. This RFP and the attached towing agreement have been reviewed by Dave Mason, County Code Enforcement Officer as well as legal counsel Rice.

Compliance: Agenda Item 4.1 includes both the Collection Notice from PennCredit and the e-mail correspondence with Gina Morrison of the North Coast Regional Water Quality Control Board (RWQCB) related to the outstanding $26,566 balance of the Waste Discharge Fees imposed by the State Water Resources Control Board (SWRCB) based on the Threat/Complexity rating issued by the RWQCB staff regarding the Crescent City Landfill. Ms. Morrison's e-mail indicates support for reducing the Threat/Complexity rating as of May 2016, though it is not clear what SWRCB's attitude will be towards this outstanding balance. Based on consultation with Vice Chair Inscore, staff are planning on submitting a letter to PennCredit later this month regarding the process and status of the Authority's ongoing appeal of this WDR fee.

Administration: Agenda Item 7.2 is an opportunity for the Board to set the August meeting date and time or to modify meeting times to accommodate Commissioner's availability.

Personnel / Staffing: All Authority-managed facilities were open during posted

hours and all shifts were covered. Starting in July and extending through September, both the Gasquet and Klamath Transfer Stations are open one extra day each week for customer convenience. As two of the Authority's permanent refuse site attendants are currently on FMLA leave, staff have initiated a hiring process for an additional temporary / part time refuse site attendant. Also during this past month Refuse Site Attendant Joseph Hernandez completed his probationary period, and he is now a permanent member of the Authority staff.

In addition for the summer, staff have increased the hours for the person covering breaks and lunch at the Del Norte County Transfer Station on weekends. This had been a 3 hour shift, but there was not enough time for mid-day review of tickets and payments. By adding two hours to these relief shifts, staff are hoping to reduce ticketing errors over these busy summer weekends and reduce the level of effort required from the Account Clerk to reconcile weekend totals.

Item 7.1 is the MOU negotiated with SEIU Local 1021 representing the Del Norte Solid Waste Management Authority Employees. The adopted Authority budget for FY 16/17 incorporates projected expenses associated with the current status of those negotiations.

Solid Waste
Balance Sheet
May 31, 2016

Unaudited

ASSETS

422 010 00000	Cash Solid Waste	888,931.97
422 010 00300	Imprest Cash	3,500.00
422 010 00500	I Bank Loan Deposit Held by County	198,177.17
422 010 01100	Accounts Receivable	2,829.64
422 010 03200	Land	493,000.00
422 010 03300	Transfer Station	3,266,990.64
422 010 03400	Equipment	158,443.55
422 010 03410	Buildings & Improvements	141,638.89
422 010 03440	Accum Depr Equipment	(157,499.00)
422 010 03450	Accum Depr Bldg & Improv	(100,380.00)
422 010 03460	Accum Depr Transfer Station	(837,202.00)
	Total Assets	4,058,430.86

LIABILITIES AND FUND EQUITY

422 010 05105	Sales Tax Payable	66.11
422 010 05210	Sublease Payable	2,727,290.50
422 010 05300	Compensated Absences Payable	45,281.00
422 010 05400	Deferred Revenue	2,331.64
422 010 05500	Post Closure Liability	2,180,935.25
422 010 05600	Net OPEB Obligation	273,578.00
422 010 07100	Fund Balance	(2,059,192.90)
422 010 09600	Investment in Capital Assets net of related debt	578,198.00
	Revenue	2,677,888.56
	Expenditure	(2,367,945.30)
	Total Liabilities and Fund Equity	4,058,430.86

3.2

1:39 PM

06/30/16

Del Norte Solid Waste Management Authority
A/R Aging Summary
As of June 30, 2016

	Current	1 - 30	31 - 60	61 - 90	> 90	TOTAL
Borges Dairy	272.75	0.00	237.39	0.00	0.00	510.14
California Dept. Parks & Rec.	691.83	0.00	0.00	0.00	0.00	691.83
Certified Construction	0.00	0.00	0.00	0.00	6.90	6.90
Certified Plumbing Co.	0.00	0.00	0.00	0.00	12.76	12.76
Cetnar Construction Inc.	41.23	0.00	82.44	0.00	0.00	123.67
Chimney Kraft	12.79	0.00	0.00	0.00	0.00	12.79
Del Norte Roofing	0.00	0.00	12.79	0.00	0.00	12.79
Elk Valley Storage	14.22	0.00	0.00	0.00	0.00	14.22
HASP / Jordan Recovery Centers	579.98	0.00	0.00	0.00	0.00	579.98
Hintz Construction*CLOSED*	0.00	0.00	0.00	0.00	127.60	127.60
Hiouchi Community Fellowship	49.75	0.00	0.00	0.00	0.00	49.75
Larson Services	25.59	0.00	0.00	0.00	0.00	25.59
Lucky 7 Casino	-29.61	0.00	0.00	0.00	0.00	-29.61
McCullough Construction, Inc.	7,739.52	0.00	0.00	0.00	0.00	7,739.52
Northcoast Marine Mammal Ctr.	0.00	-7.11	0.00	0.00	0.00	-7.11
Pacific Northwest Physical Therapy	42.64	0.00	0.00	0.00	0.00	42.64
Porter's Trucking *CLOSED*	0.00	0.00	0.00	0.00	2,033.84	2,033.84
Ray's Mobile Home Service	232.02	0.00	0.00	0.00	0.00	232.02
Recology Del Norte (Franchise)	0.00	-0.11	0.00	0.00	0.00	-0.11
Red Sky Roofing	15,108.19	0.00	0.00	0.00	0.00	15,108.19
Ritchie Homes	42.65	0.00	0.00	0.00	0.00	42.65
Rogers, Luu T.	101.56	0.00	0.00	0.00	0.00	101.56
Seawood Village	2,577.32	0.00	0.00	0.00	0.00	2,577.32
Smith River Rancheria	2,290.85	0.00	0.00	0.00	0.00	2,290.85
Steel	79.60	0.00	95.91	0.00	0.00	175.51
TOTAL	29,872.88	-7.22	428.53	0.00	2,181.10	32,475.29

Statement of Revenues and Expenditures

Printed on: 6/27/2016 10:19:07 AM

Statement of Month Ended: 5/31/2016

Fund: 422 Solid Waste
Dept: 421 Solid Waste

Line	Proj	Description	Month Actual	YTD Actual	YTD Budget	YTD Variance	% Exp
Revenues							
90153		Franchise Fees	21,799.00	218,566.00	258,075.00	-39,509.00	84.7
90300		Interest - Solid Waste	0.00	2,801.95	1,800.00	1,001.95	155.7
90301		Late Payment Fee	0.00	74.28	0.00	74.28	0
90650	062	Oil Grant 15/16	0.00	15,000.00	15,000.00	0.00	100
90650	075	Oil Grant - 14/15	0.00	0.00	7,910.00	-7,910.00	0
90650	079	DOC Grant 15/16	0.00	0.00	15,000.00	-15,000.00	0
91003		Gate Tipping Fees	161,854.04	1,576,875.35	1,872,000.00	-295,124.65	84.2
91003	099	Gate Tipping Fees - Prior Yr	0.00	234.50	0.00	234.50	0
91004		Authority Service Fees	86,736.68	848,504.46	999,000.00	-150,495.54	84.9
91004	099	DNSWMA Tipping Fees - Prior Yr	0.00	117.97	0.00	117.97	0
91121		Misc Reimbursements	0.00	539.05	1,000.00	-460.95	53.9
91121	123	Bad Check Fee Reimb	25.00	175.00	100.00	75.00	175.0
91129	065	DOC Grant 14/15	0.00	15,000.00	15,000.00	0.00	100
Total Revenues			**270,414.72**	**2,677,088.56**	**3,184,885.00**	**-506,996.44**	**84.08**
10010		Payroll	-18,406.01	-211,668.66	-241,365.00	29,696.34	87.7
10012		Overtime	0.00	-688.22	-750.00	61.78	91.8
10015		Part-time/Temp	-3,239.58	-25,177.63	-28,000.00	2,822.37	89.9
10020		Retirement	-5,258.14	-62,621.98	-72,525.00	9,903.02	86.3
10030		Employee Benefits	-9,203.29	-101,238.59	-110,605.00	9,366.41	91.5
10033		Employee Life Insurance	-18.00	-216.90	-352.00	135.10	61.6
10035		Management Life Insurance	-36.98	-371.72	-501.00	129.28	74.2
10040		Worker's Compensation	-3,112.67	-34,239.37	-37,352.00	3,112.63	91.7
Total Salaries & Benefits			**39,274.67**	**436,223.07**	**491,450.00**	**55,226.93**	**88.76**
20110		Clothing	0.00	0.00	-110.00	110.00	0
20121		Communications	-370.03	-3,162.84	-3,450.00	287.16	91.7
20140		Household Expense	-386.01	-4,682.41	-5,595.00	912.59	83.7
20150		Insurance-Office	0.00	0.00	-10,420.00	10,420.00	0
20152		Vehicle Insurance	0.00	-2,675.76	-3,525.00	849.24	75.9
20155		Liability Insurance	0.00	-1,758.75	-2,345.00	586.25	75.0
20170		Maintenance-Equipment	0.00	-102.45	-350.00	247.55	29.3
20171		Maintenance-Vehicles	-422.30	-845.18	-3,400.00	2,554.82	24.9
20175		Maintenance-Computers	0.00	-51.71	-554.00	502.29	9.3
20180		Maint-Structures/Improvements & TS Maint	-150.25	-18,222.56	-21,700.00	3,477.44	84.0
20200		Memberships	0.00	-6,000.00	-7,600.00	1,600.00	78.9
20221		Printing	-155.76	-370.76	-488.00	117.24	76.0
20221	062	Printing-Oil Grant 15/16	0.00	0.00	-500.00	500.00	0
20221	065	Printing - DOC 14/15	0.00	0.00	-4,500.00	4,500.00	0
20221	075	Printing - Oil Grant 14/15	-1.29	-94.57	-1,085.00	990.43	8.7
20221	079	Printing - DOC Grant 15/16	0.00	0.00	-3,000.00	3,000.00	0
20223		Postage	-52.66	-922.01	-1,400.00	477.99	65.9
20224		Office Supplies	-108.45	-4,907.52	-5,000.00	92.48	98.2
20227		Books/Subscriptions	0.00	0.00	-109.00	109.00	0

Printed on: 6/27/2016 10:19:07 AM

Statement of Revenues and Expenditures

Statement of Month Ended: 5/31/2016

Fund: 422 Solid Waste
Dept: 421 Solid Waste

Line	Proj	Description	Month Actual	YTD Actual	YTD Budget	YTD Variance	% Exp
20230		Prof Serv-Co/City	-50.16	-1,631.82	-10,000.00	8,368.18	16.3
20231		Prof Serv	-6,167.50	-25,828.91	-31,815.00	5,986.09	81.2
20232		Prof Serv-Well Monitoring	-3,978.00	-30,253.70	-33,500.00	3,246.30	90.3
20232	002	Data Processing - Software	0.00	-592.33	-5,140.00	4,547.67	11.5
20233		Audit	0.00	-7,350.00	-7,800.00	450.00	94.2
20234		Legal Counsel	-3,621.80	-11,697.88	-14,000.00	2,302.12	83.6
20235		Treasurer	-920.00	-6,360.00	-7,600.00	1,240.00	83.7
20236		Security	0.00	-620.84	-1,687.00	1,066.16	36.8
20237		Credit Card Service Fees	-1,223.51	-12,247.95	-13,500.00	1,252.05	90.7
20238		TS Collection	-2,217.60	-17,370.36	-28,000.00	10,629.64	62.0
20239		Transfer Station Operations	-156,515.56	-1,415,854.24	-1,914,000.00	498,145.76	74.0
20239	001	Post Closure Maintenance	-41.46	-1,798.60	-8,000.00	6,201.40	22.5
20240		Advertising/Publications	0.00	-719.85	-1,370.00	650.15	52.5
20240	062	Advertising-Oil Grant 15/16	0.00	-814.90	-2,000.00	1,185.10	40.7
20240	065	Advertising - DOC 14/15	0.00	-1,635.00	-3,034.80	1,399.80	53.9
20240	075	Advertising - Oil Grant 14/15	0.00	-2,476.00	-2,476.00	0.00	100
20240	079	Advertising - DOC Grant 15/16	0.00	-34.80	-2,965.20	2,930.40	1.2
20250		Lease of Equipment	-262.06	-2,861.94	-3,112.00	250.06	92.0
20251		Lease - Gasquet Transfer Station	0.00	-661.39	-662.00	0.61	99.9
20270		Minor Equipment	0.00	0.00	-1,000.00	1,000.00	0
20275		Small Tools	0.00	-362.47	-750.00	387.53	48.3
20280		Delivery Service	0.00	-270.00	-600.00	330.00	45.0
20281		Household Hazardous Waste Event	0.00	-30,008.00	-30,898.00	890.00	97.1
20283		Community Clean-up	-451.95	-4,519.50	-5,500.00	980.50	82.2
20285		Special Dept Expense	-32.30	-2,146.45	-2,285.00	138.55	93.9
20285	062	Spec Dept Exp-Oil Grant 15/16	-125.00	-2,023.48	-4,601.52	2,578.04	44.0
20285	065	Spec Dept Exp - DOC 14/15	-985.00	-2,040.00	-2,040.00	0.00	100
20285	068	Spec Dept Exp - DOC 13/14	0.00	-2,460.00	-2,460.00	0.00	100
20285	075	Spec Dept Exp - Oil Grant 14/15	-1,020.82	-1,020.82	-6,332.48	5,311.66	16.1
20285	079	Special Dept Exp - DOC Grant 15/16	0.00	0.00	-4,500.00	4,500.00	0
20286		Cash Over/Under	75.84	233.06	-175.00	408.06	-133.2
20288		City Collections	-1,558.46	-15,584.60	-18,120.00	2,535.40	86.0
20290		Travel	-39.96	-1,494.64	-3,000.00	1,505.36	49.8
20290	062	Travel-Oil Grant - 15/16	0.00	0.00	-2,500.00	2,500.00	0
20290	065	Travel - DOC 14/15	0.00	-99.00	-4,441.50	4,342.50	2.2
20290	079	Travel - DOC Grant 15/16	0.00	-1,441.50	-3,058.50	1,617.00	47.1
20297		Vehicle Fuel	-118.64	-1,129.67	-1,600.00	470.33	70.6
20301		State Fees	-200.00	-30,825.00	-68,931.00	38,106.00	44.7
Total Services & Supplies			**181,100.69**	**1,679,799.10**	**2,328,586.00**	**648,786.90**	**72.14**
30490		Depreciation Expense	0.00	0.00	-98,000.00	98,000.00	0
Total Other Charges			**0.00**	**0.00**	**98,000.00**	**98,000.00**	**0.00**
70530	025	Interfund-Repayment to County	0.00	-202,271.13	-202,275.00	3.87	100.0
70530	199	Interfund-Cost Plan	-4,507.00	-49,577.00	-53,449.00	3,872.00	92.8

CLAIMS APPROVED BY THE DIRECTOR

Del Norte Solid Waste Management Authority
Claims for June 2016

Date Paid	Paid to:	Budget	Amt. Paid	Description
6/1/2016	Cal PERS	70800	$ 11,125.00	2015/2016 Post-Employment Benefits
6/2/2016	Richard D. Taylor	20235	$ 500.00	Statement Treasurer/Controller May 2016
6/2/2016	enABL, Inc.	20232	$ 2,075.00	Inv en2016-040 EDF reports & prof. serv 05/2016
6/2/2016	U.S. Bank	20110	$ 53.23	Global Ind., safety clothing
	U.S. Bank	20110	$ 54.28	eSafety Supplies, safety clothing
	U.S. Bank	20170	$ 119.88	Amazon signature pads, equipment
	U.S. Bank	20285 075	$ 146.17	New Pig inv. 4716279-00, oil grant
6/2/2016	Crescent Hay & Feed	20140	$ 9.70	Receipt #185098 Straw, Household
6/2/2016	Mission Linen Supply	20140	$ 33.74	Inv. 502549093 household linen
	Mission Linen Supply	20140	$ 30.86	Inv. 502456762 household linen
6/2/2016	Hi-Tech Security	20236	$ 990.00	Inv 16-04013 upgrades, Security
6/2/2016	Recology Del Norte	20238	$ 554.40	INV 1056 Old Gasquet Toll Rd May 2016
	Recology Del Norte	20238	$ 1,848.00	INV 1057 Klamath Beach Rd May 2016
6/16/2016	Ricoh USA, Inc	20250	$ 249.98	INV 96958416 5/30-6/29 Copier Rental
6/16/2016	Bi Coastal Media	20240-075	$ 425.00	INV 2598-1 Motor oil Recycling Ads KPOD-FM
	Bi Coastal Media	20240-075	$ 425.00	INV 2598-2 Motor oil Recycling Ads KCRE-FM
6/16/2016	Creative Information Systems	20232-002	$ 4,530.00	Cust ID# 9627 SMSTurbo Software Upgrade
6/16/2016	Curry Transfer-Roto-Rooter	20140	$ 153.80	Klamath TS Porta Potty May 2016
	Curry Transfer-Roto-Rooter	20140	$ 225.05	Gasquet TS Porta Potty May 2016
6/16/2016	US Cellular	20121	$ 140.03	Cell phone service 06/04-07/03/2016
6/16/2016	G H Outreach	20285-062	$ 100.00	INV 299573 May 2016 Recycling service
6/16/2016	Lawrence & Associates	20231	$ 2,265.00	INV 23551 Project #015063.00 April 2016
6/16/2016	Hambro WSG	20239	$ 170,223.64	INV 2016-05 Materials Management May 2016
6/16/2016	Black & Rice, LLP	20234	$ 1,601.60	Legal Services for May 2016
6/16/2016	The Triplicate	20240	$ 150.00	Board meeting announcement
	The Triplicate	20240	$ 179.70	Public Rate Announcement
6/16/2016	Crescent Ace Hardware	20140	$ 6.72	INV 611228 Household Supplies
6/16/2016	Charter Spectrum Comm.	20121	$ 89.97	Services for 6/19-7/18/2016 Office phones
6/16/2016	Redwood Leavitt Insurance	20150	$ 10,419.02	Office Insurance Policy 5/16/16-5/16/17
6/16/2016	Hi-Tech Security	20236	$ 72.00	INV 16-06355 Prepay Commercial Monitoring
6/16/2016	Mark Wooding	20285	$ 120.00	Reimbursement of overpayment on A/R account
6/16/2016	Ming Tree Real Estate	20285	$ 16.10	Reimbursement of overpayment on A/R account
6/16/2016	The Triplicate	20240-075	$ 1,241.50	INV 2342487 Advertising KIWI Dog May 2016
	The Triplicate	20240	$ 319.38	INV 2342487 Advertising Clean Sweep May 2016
6/21/2016	Mission Linen Supply	20140	$ 57.67	Linen Services for June 2016
6/21/2016	Crescent Ace Hardware	20275	$ 10.75	INV 612860 Socket Adapters
6/21/2016	Recology Del Norte	20288	$ 1,287.97	INV 04845871-1001 Front ST-Cultural Center
	Recology Del Norte	20283	$ 451.95	INV 04845897-500 Cooper Ave-County Yard
	Recology Del Norte	20288	$ 249.38	INV 04845905-900 Tenth ST-City Yard
6/21/2016	Del Norte County Road Div	20239-001	$ 475.32	INV 14007 Landfill Maintenance January 2016
	Del Norte County Road Div	20239-001	$ 965.35	INV 14008 Landfill Maintenance February 2016
6/27/2016	Floyd L. Clemann	20239-001	$ 570.00	INV 301851 Landfill Maintenance June 2016
6/27/2016	Crescent Ace Hardware	20239-001	$ 4.58	INV 613655 Landfill markers
	Crescent Ace Hardware	20170	$ 19.79	INV 613655 Misc Nuts and bolts
	Crescent Ace Hardware	20140	$ 6.49	INV 613655 drain opener
	Crescent Ace Hardware	20170	$ 8.18	INV 613785 1/4" drive guide
6/27/2016	C. Renner Petroleum	20285-075	$ 42.93	INV 239133 76 Firebird 5/30 oil
6/28/2016	Shasta Scale	20180	$ 600.00	INV I . 2140 Service order # 517 Scale Maint.
6/29/2016	Darren Davis	20290	$ 289.98	Mileage Reimbursement 05/21-06/29/16
6/29/2016	Bonnie Smith	20290	$ 219.78	Mileage Reimbursement 01/02-05/14/2016
6/29/2016	Richard D. Taylor	20235	$ 740.00	Treasurer/Controller Services June 2016
6/29/2016	Katherine Brewer	20290	$ 30.89	Mileage Reimbursement 04/28-06/27/2016
6/29/2016	The Triplicate	20240	$ 90.60	Ad # 71132861 D Rates/Textiles/IMP disposal fees
03/30/216	IT ESP, Inc.	20231	$ 2,400.00	INV 962 Computer set up & Maintenance
	TOTAL		$ 219,015.36	

3.3

PennCredit Corporation

Hours: Mon-Thur 8am-10pm EST
Fri 8am-8pm, Sat 8am-12pm EST

Phone: 800-900-1380

NOTICE OF COLLECTION

06/21/16

CLIENT: Water Resources Control Board
ID NUMBER: C9829541
TOTAL BALANCE DUE: $26,566.00

ACA INTERNATIONAL The Association of Credit and Collection Professionals Member

Our client has referred your delinquent account(s) referenced below for collection. Our client is serious about collecting all monies owed them and I am sure your intentions are to honor your debt. Send payment using the enclosed envelope or you may go online to http://account.penncredit.com to make payment or contact our office to pay over the phone. Contact our office if you are unable to pay the amount due.

Unless you notify this office within 30 days after receiving this notice that you dispute the validity of this debt or any portion thereof, this office will assume this debt is valid. If you notify this office in writing within 30 days from receiving this notice that you dispute the validity of this debt or any portion thereof, this office will obtain verification of the debt or obtain a copy of a judgment and mail you a copy of such judgment or verification. If you request this office in writing within 30 days after receiving this notice this office will provide you with the name and address of the original creditor, if different from the current creditor.

This is an attempt to collect a debt by a debt collector and any information obtained will be used for that purpose. The important rights included above apply to each account individually and you have the right to dispute any or all of the accounts included in this notice. In the event you choose to exercise your important rights included above please indicate which account(s) you are disputing.

SERVICE RENDERED	SERVICE DATE	ACCOUNT NUMBER	BALANCE
WATER QUALITY PERMIT 1A77002ODN	2015/11/02	WD0108614	$26,566.00

RECEIVED
JUN 27 2016
DNSWMA

California:
The state Rosenthal Fair Debt Collection Practices Act and the federal Fair Debt Collection Practices Act require that, except under unusual circumstances, collectors may not contact you before 8 am or after 9 pm. They may not harass you by using threats of violence or arrest or by using obscene language. Collectors may not use false or misleading statements or call you at work if they know or have reason to know that you may not receive personal calls at work. For the most part, collectors may not tell another person, other than your attorney or spouse, about your debt. Collectors may contact another person to confirm your location or enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission at 1-877-FTC-HELP or www.ftc.gov.

P.A.-9333-0-0

1 of 1

DETACH AND RETURN WITH PAYMENT TO EXPEDITE CREDIT TO YOUR ACCOUNT

P.O Box 1259, Department 91047
Oaks, PA 19456
CHANGE SERVICE REQUESTED

IF PAYING BY VISA, MASTERCARD OR DISCOVER, FILL OUT BELOW

☐ VISA ☐ MASTERCARD ☐ DISCOVER

CARD NUMBER	EXP. DATE
SIGNATURE	AMOUNT

Visit http://account.penncredit.com to pay your bill online.

Payments received by check will be electronically deposited, unless you pay by non-consumer type check. You may opt out of this program by paying with a money order or a travelers check. In the unlikely event your check (payment) is returned unpaid, we may elect to electronically (or by paper draft) re-present your check (payment) up to two more times. You also understand and agree that we may collect a return processing charge by the same means, in an amount not to exceed that as permitted by state law.

ID NUMBER: C9829541 06/21/16

91203 - 1641

DEL NORTE SOLID WASTE MANAGEME
TEDD WARD
1700 STATE ST
CRESCENT CITY CA 95531-9282

PENN CREDIT
916 S 14th ST
PO BOX 988
HARRISBURG PA 17108-0988

001704

4.1

91203-NEW-1641

Tedd Ward

From: Morrison, Gina@Waterboards <Gina.Morrison@waterboards.ca.gov>
Sent: Wednesday, June 29, 2016 5:24 PM
To: Tedd Ward
Cc: Reed, Charles@Waterboards
Subject: RE: WDR Fee Collection Notice to DNSWMA

Tedd,

Paperwork with the results of the well sampling only arrived at our office in May (2 months before the end of the fiscal year), prior to that you did not have the data to assert that you were not impacting domestic water wells near your facility.

I have met with my supervisors this afternoon and they have agreed to lower your rating to a 2A for the next fiscal year. I also got them to agree to ask the State Board to retroactively apply that rating to this fiscal year. The retroactive part is ultimately up to the State Board – so we will have to wait and see.

We will be requiring that the domestic wells be sampled as part of the routine well monitoring. We will be sending you a letter in regards to all this (it probably won't go out until at least next week since my senior is out of the office this week).

I'll be in touch about the report changes and work on your new MRP.

Gina

From: Tedd Ward [mailto:tedd@recycledelnorte.ca.gov]
Sent: Monday, June 27, 2016 2:57 PM
To: Morrison, Gina@Waterboards
Cc: 'Bonnie Lampley'; kayleen@recycledelnorte.ca.gov
Subject: WDR Fee Collection Notice to DNSWMA

Gina:

Please see the attached collection notice. We would very much appreciate your cooperation and support as we continue to assert that we do not owe this unpaid balance.

Tedd Ward, M.S. – Director
Del Norte Solid Waste Management Authority
1700 State Street
Crescent City, CA 95531

707-465-1100 office
707-465-1300 fax
707-954-0953 mobile

From: Morrison, Gina@Waterboards [mailto:Gina.Morrison@waterboards.ca.gov]
Sent: Thursday, June 16, 2016 4:04 PM
To: Tedd Ward <tedd@recycledelnorte.ca.gov>
Subject: RE: 1st half monitoring & T/C report - final

Not yet. Should get to it next week.

From: Tedd Ward [mailto:tedd@recycledelnorte.ca.gov]
Sent: Wednesday, June 15, 2016 4:38 PM
To: Morrison, Gina@Waterboards
Subject: RE: 1st half monitoring & T/C report - final

Hi Gina.

We are publishing our monthly agenda tomorrow. Anything to report re. the review of this report?

Thanks,

Tedd Ward, M.S. – Director
Del Norte Solid Waste Management Authority
1700 State Street
Crescent City, CA 95531

707-465-1100 office
707-465-1300 fax
707-954-0953 mobile

From: Morrison, Gina@Waterboards [mailto:Gina.Morrison@waterboards.ca.gov]
Sent: Thursday, June 02, 2016 11:12 AM
To: Tedd Ward <tedd@recycledelnorte.ca.gov>
Subject: RE: 1st half monitoring & T/C report - final

Sorry Tedd I have been overwhelmed with end of year and summer construction stuff. I am still onboard to get it done before start of our fiscal year. Hopefully I'll get to the review next week.

Gina

From: Tedd Ward [mailto:tedd@recycledelnorte.ca.gov]
Sent: Wednesday, June 01, 2016 9:16 AM
To: Morrison, Gina@Waterboards
Cc: 'Bonnie Lampley'; kayleen@recycledelnorte.ca.gov
Subject: RE: 1st half monitoring & T/C report - final

Good Morning Gina.

I just thought I would check in to see how your review of this report was proceeding. Do you need any additional information at this time?

Thanks,

Tedd Ward, M.S. – Director
Del Norte Solid Waste Management Authority
1700 State Street
Crescent City, CA 95531

707-465-1100 office

707-465-1300 fax
707-954-0953 mobile

From: Tedd Ward [mailto:tedd@recycledelnorte.ca.gov]
Sent: Thursday, May 12, 2016 8:08 AM
To: 'Morrison, Gina@Waterboards' <Gina.Morrison@waterboards.ca.gov>
Cc: 'Bonnie Lampley' <blampley@lwrnc.com>; 'kayleen@recycledelnorte.ca.gov' <kayleen@recycledelnorte.ca.gov>
Subject: FW: 1st half monitoring & T/C report - final

Gina:

Attached is the final report plus attachments. Should we also mail a printed copy to your office?

Tedd Ward, M.S. – Director
Del Norte Solid Waste Management Authority
1700 State Street
Crescent City, CA 95531

707-465-1100 office
707-465-1300 fax
707-954-0953 mobile

From: Bonnie Lampley [mailto:blampley@lwrnc.com]
Sent: Wednesday, May 11, 2016 4:04 PM
To: Tedd Ward (tedd@recycledelnorte.ca.gov) <tedd@recycledelnorte.ca.gov>; kayleen@recycledelnorte.ca.gov
Subject: 1st half monitoring & T/C report - final

Tedd and Kayleen,

Here is the final version of the report. The three excel files go with it; they are Attachment B.

Let me know if you have any questions.

Regards,
Bonnie

Bonnie E. Lampley
Principal Hydrogeologist
blampley@lwrnc.com
www.lwrnc.com

3590 Iron Court • Shasta Lake, CA 96019 • 530.275.4800 (phone) • 530.275.7970 (fax)

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Del Norte Solid Waste Management Authority

1700 State Street, Crescent City, CA 95531
Phone (707) 465-1100 Fax (707) 465-1300
www.recycledelnorte.ca.gov

The Authority's mission is the management of Del Norte County solid waste and recyclable material in an environmentally sound, cost effective, efficient and safe manner while ensuring 100% regulatory compliance with law.

Staff Report

Date:	30 June 2016
To:	Commissioners of the Del Norte Solid Waste Management Authority
From:	Tedd Ward, M.S. – Director
File Number:	080104 – Transfer Station Operations
Topic:	Textile Recycling to start on August 1st at the Del Norte County Transfer Station

Summary / Recommendation: No action required. This is a status report.

Background: Following the negotiations with Hambro/WSG to extend the transfer station operations agreement, the approval of Transfer Station Operations Change Order 23, and adoption of Rate Ordinance 2016-01, starting on August 1, 2016, textile recycling services will be offered at the Del Norte County Transfer Station.

Analysis: Textiles and clothing comprise approximately 2.8% of the materials disposed at the Del Norte County Transfer station. In other words, approximately 1.1 million pounds of these materials were disposed in 2015. Over 90% of those materials can now be recycled under this new program. Customers who properly separate clothing and textiles for recycling will also save money, as the cost to recycle textiles will be just $75.15 per ton, compared to the $144.04 per ton rate for trash.

Starting in August, the following textiles can be recycled at the Del Norte County Transfer Station:

- Clothing (must be clean and dry)
- Linens (no mattress cover or bed pillows)
- Towels
- Curtains
- Linens
- Shoes (bagged separately from other items)

Items are accepted in any condition EXCEPT if they are wet, dirty, mildewed or contaminated with hazardous materials. Bags of textiles containing shoes will also be rejected. Under garments, medical boots or braces or shoes with major holes are not included in this textile recycling program.

6.1

Del Norte Solid Waste Management Authority

1700 State Street, Crescent City, CA 95531
Phone (707) 465-1100 Fax (707) 465-1300
www.recycledelnorte.ca.gov

The Authority's mission is the management of Del Norte County solid waste and recyclable material in an environmentally sound, cost effective, efficient and safe manner while ensuring 100% regulatory compliance with law.

Staff Report

Date:	30 June 2016
To:	Commissioners of the Del Norte Solid Waste Management Authority
From:	Jeannine Galatioto Tedd Ward, M.S. – Director
File Numbers:	211401 – Employee's Union, 16504 - Personnel
Topic:	Resolutions 2016-01, 2016-02, and the Memorandum of Understanding between the Del Norte Solid Waste Management Authority and Service Employees International Union (SEIU) Local 1021 on Behalf of the Del Norte Solid Waste Management Authority Employees

Summary / Recommendation: That the Board take each of the following actions:

1) Adopt Resolution 2016-01 approving the Memorandum of Understanding (MOU) between the Del Norte Solid Waste Management Authority and Service Employees International Union (SEIU) Local 1021.
2) Adopt Resolution 2016-02 Establishing Benefits for Unrepresented Positions of Administrative Assistant and Facilities and Programs Coordinator providing salary, benefits and working conditions to mid-management positions not included within any bargaining unit and classified as exempt from the overtime provisions of the State and Federal Fair Labor Standards Acts (FLSA). The Resolution provides the same salary and benefit changes as those provided to positions represented by SEIU Local 1021.

Background:

The current operating MOU was ratified in March 2011 and expired March 2016. This MOU was not reopened as provided by Article XVI for purposes of meeting and conferring on items of economic significance or mutual consent. During the term of this agreement there were significant changes in the California Public Employees Reform Act (PEPRA) that could have precipitated cause to re-open the agreement.

7.1

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Salary/Benefits
In January 2013 PEPRA changed the way CalPERS retirement and benefits are applied and places compensation limits on members. All permanent employees of DNSWMA are CalPERS members. Employees hired on or after January 1, 2013 are required to contribute 6.25% of their gross pay to CalPERS. Previously, the CalPERS employee contribution for these employees was paid by the Authority.

Employees hired prior to January 1, 2013 are required to pay 7% of their gross pay to CalPERS which was previously paid by the Authority. Consequently, this significantly reduced the take home pay of every employee. During this period of time the County negotiated a salary increase to compensate Del Norte County employees for the loss of pay. The Authority was in transition during this time and did not follow suit.

The salary increases provided in this agreement compensate employees for PEPRA changes, address the new minimum wage law, and caps the employer contribution to CalPERS for the employer share of retirement to 20%. It provides that employees will pay 50% of the **employers** share in excess of 20%, not to exceed a total member contribution of 8%. In the event that CalPERS raises the employer contribution this provision provides for a cost saving/sharing for the Authority.

Working Conditions
In addition to salary and benefit changes the agreement addresses appropriate work attire, inclement weather clothing and safety equipment that clarifies expectations, improves working conditions and reduces risk.

Modifications to the Grievance Procedure provide procedural clean-up language and binding arbitration by an arbitrator selected by mutual agreement from local attorneys. Arbitration of a grievance by a local attorney confines costs and assures neutrality for both the Authority and the employee.

Article X: Union Security provides for Agency Shop. As a condition of employment all workers covered by this agreement shall elect to either be members or an agency fee payer of the Union and have Union dues deducted from their pay checks. Management tentatively agreed to this provision contingent upon a favorable majority vote of all represented members. The Myers-Milias Brown Act (MMBA) provides for Agency Shop upon the approval of a majority of the employees who cast ballots and vote in a secret ballot election in favor of Agency Shop. The members of this bargaining unit agreed to Agency Shop designation by majority vote.

Analysis: Changes to wages and salaries are proposed primarily for two reasons: equity and to reduce staff turnover. Staff turnover is a significant cost and challenge to the Authority. Typically, it takes approximately five months from the date the Authority

requests that Human Resources begin a hiring process for a vacant position to the time a person is fully trained as a Refuse Site Attendant (two months for recruitment and interviews, three months for training). With fewer than 10 employees, office staff necessarily cover gate shifts during the training process or when our agency is short staffed just to keep our facilities open during our set hours. During the summer months (July--September) the facilities in Gasquet and Klamath are each open an extra day each week, increasing the demands on staff. For all these reasons, whenever even a single staffperson leaves the Authority, it reduces capacity of the agency as a whole for several months.

Proposed Salary Increases
8% effective first full pay period in July 2016.
3.4% effective first full pay period in July 2017
$0.50 per hour increase effective July 2018 for all hourly employees and $40 per bi-weekly increase for all full-time salaried employees.

The first increase effective July 2016 compensates employees for the increased PERS costs to employees for PEPRA changes and provides for a slight percentage increase to offset the increase in the CPI, the change in the minimum wage law and the lack of a cost of living increase since 2007/2008.
The increase effective July 2017 continues to address the increase in the CPI over the last eight years and continues to address the increase in the California minimum wage.
The salary increase effective July 2018 continues to address the increase in the minimum wage as it escalates over the next five years.

These salary increases are proposed to occur over a three year span allowing the Authority to plan and budget accordingly. As the Board was not able to address this issue during the regular June Authority meeting, there was an additional side letter making these changes retroactive to the first of July, which was incorporated into the revised version of Resolution 2016-01.

Alternatives: Not approve the MOU and direct staff to continue the employer/employee negotiation process.

Resolution No. 2016-01

A RESOLUTION OF THE GOVERNING BOARD OF THE DEL NORTE SOLID WASTE MANAGEMENT AUTHORITY APPROVING A MEMORANDUM OF UNDERSTANDING BETWEEN THE DEL NORTE SOLID WASTE MANAGEMENT AUTHORITY AND EMPLOYEES / SEIU LOCAL 1021

WHEREAS, the California Government Code requires that the Governing Board shall fix, by resolution or ordinance, the compensation of all appointive officers and employees; and

WHEREAS, pursuant to the Governing Board's direction, the Authority's bargaining team has negotiated in compliance with the Meyers-Milias-Brown Act and all other applicable requirements to reach agreement with the Employees Union, SEIU Local 1021, upon a new Memorandum of Understanding ("MOU") that meets the needs of both parties and covers the period July 1, 2016 through June 30, 2019, included as Exhibit A to this resolution; and

WHEREAS, the Sideletter Agreement between DNSWMA and SEIU 1021 dated June 29, 2016 agrees that Authority employees shall receive retroactive pay on the first full pay period after ratification of the MOU for any wages lost since July 1, 2016, included as Exhibit B to this resolution.

NOW, THEREFORE, BE IT RESOLVED by the Governing Board of the Del Norte Solid Waste Management Authority that the attached Memorandum of Understanding Between the Del Norte Solid Waste Management Authority and SEIU Local 1021 for July 1, 2016 through June 30, 2019 attached hereto is approved.

BE IT FURTHER RESOLVED that the Side Letter Agreement dated June 29, 2016 attached hereto is also approved.

APPROVED AND ADOPTED by the governing Board of the Del Norte Solid Waste Management Authority at a regular meeting thereof on the ____ day of _____, 2016, by the following polled vote:

AYES:
NOES:
ABSENT:
ABSTAN:

_____
Martha McClure, Chair of the Board

ATTEST:

_____
Kathleen Brewer, Clerk of the Board

Sideletter Agreement between

DNSWMA and SEIU 1021

June 29, 2016

Retroactive Pay

Although the MOU between the Authority and SEIU 1021, representing Authority employees, was finalized between the Authority's representative and the bargaining unit prior to July 1, 2016, the MOU is not able to be put to a vote until after July 1, 2016 due to Authority Board scheduling issues. Therefore, the parties agree that Authority employees shall receive retroactive pay on the first full pay period after ratification of the MOU for any wages lost since July 1, 2016, the effective date of the MOU.

For the Union

6-29-2016

For the DNSWMA

EXHIBIT A

MEMORANDUM OF UNDERSTANDING

Del Norte Solid Waste Management Authority

And

SEIU Local 1021

July 1, 2016 – June 30, 2019

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Attachment A – Positions Covered & Salary Schedule A-1

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ARTICLE I

TERM

This Memorandum of Understanding shall be entered and in effect from July1, 2016- June 30, 2019 by the Del Norte Solid Waste Management Authority (hereafter DNSWMA) and Service Employees International Union Local 1021 (hereafter Union). This agreement is entered into under the authority of the Meyers-Milias-Brown Act (MMBA) Gov't Code section 3500 et seq. and ordinances of the DNSWMA. Nothing in this article is intended to derogate from legal protections enjoyed by employees under Federal or State law, except to the extent that variance, exception or exclusion is permitted through collective bargaining. If any term of this Agreement is found to be illegal, the offending term is severed and the remainder of the Agreement shall continue to have effect, and the parties agree to meet and confer on the subject matter of the severed term. At least sixty (60) days prior to the expiration either party shall file a written notice with the other of its desire to amend, modify or terminate this Memorandum of Understanding.

RECOGNITION

The DNSWMA recognizes the Union as the exclusive collective bargaining agent for all regular permanent full-time and permanent part-time employees in the miscellaneous unit, excluding all Executive Management, Management, Confidential and Extra-Help employees. See Attachment A for a list of classifications covered by this Agreement.

ASSIGNABILITY TO SUCCESSORS IN INTEREST

This contract will be fully assignable and binding upon any successor in interest of the Joint Powers Authority, and jointly and severally to any member thereof that shall succeed to operations or which shall assume operational control of the assets of the Joint Powers Authority and/or which shall assume the benefit and burdens of the third party contracts of the Joint Powers Authority for hauling and collection of waste.

MANAGEMENT RIGHTS AND RESPONSIBILITY

The DNSWMA retains, solely and exclusively, all the rights, powers and authority exercised or held prior to the execution of this Agreement, except as expressly limited by a specific provision of this Agreement. Without limiting the generality of the foregoing, the right, powers and authority retained solely and exclusively by DNSWMA and not abridged herein, include, but are not limited to, the following: To manage and directs its business and personnel; to manage, control and determine the mission of its departments, building facilities and operations; to create, change, combine or abolish jobs, departments and facilities in whole or in part; to direct the work force; to increase or decrease the work force and determine the number of employees needed; to hire, transfer, promote, layoff and maintain the discipline and efficiency of its employees; to establish work standards, schedules of operation and reasonable work load; to specify or assign work requirements and require overtime; to schedule work, working hours and shifts; to adopt rules of conduct; to determine the type and scope of work to be performed by DNSWMA employees and the services to be provided; classify positions and determine the content and title of such classifications; to determine the methods, processes, means and places of providing services and to take whatever action necessary to prepare for and operate in an emergency. The exercise of these rights shall not preclude employees or their representatives from meeting and conferring with the DNSWMA on the impact of DNSWMA actions on matters within the scope of representation pursuant to Government Code § 3500 et seq.

Management is expected to conform to the standard of conduct expected of public employees and is expected to refrain from activity which is in violation of federal, state or local law, or the DNSWMA Employer-Employee Relations Policy.

ARTICLE II
DEFINITIONS

2.1. These definitions shall be applied throughout this MOU. Terms not defined shall have their ordinary dictionary and shall have the respective meanings given unless it is clearly apparent from the context that they are used in a different sense. The definition of a word shall apply to any of its variants.

2.2. **Anniversary Date:** The anniversary of the date that a given employee began performing the duties of a given permanent position. This date may change if an employee is promoted, demoted, or changes positions, classifications or is granted an unpaid leave of absence. Probationary periods do not affect anniversary dates.

2.3. **Appointing Authority:** The Director of the DNSWMA or his or her designee, who has the authority to fill a vacant position and to remove employees from employment.

2.4. **Assignment:** A particular project, program and/or activity related to the function and needs of the department.

2.5 **Class Series:** A series of positions in a particular class consisting of entry, journey and/or lead person levels (i.e. I, II, III, etc).

A. Entry level is typically a trainee level. The entry levels are assigned duties that will increase experience. Employees perform the more routine, less complex job assignments, while learning the more complex operation, policies, assignments and programs related to their department or division function.

B. Journey level is the experienced working level. It is the second level in a class series and may be assigned paraprofessional, complex job assignments under minimal supervision. Employees advanced to this level in the series have demonstrated the ability to adequately fulfill the assigned responsibilities.

C. Lead worker or skilled level is the most experienced characterized by a combination of high level job assignments. Employees perform the full range of journey or specialist job assignments while also providing work direction, training and coordination for other workers. The emphasis of this series is on performing the more paraprofessional, complex work assignments. Employees advanced to this level are provided general direction in the performance of their responsibilities.

2.6. **Catastrophic Illness or Injury:** A severe illness or injury which is expected to incapacitate the employee for an extended period of time and which creates a financial hardship because the employee has exhausted all of his/her accumulated paid leave time. Catastrophic illness or injury is further defined as a debilitating illness or injury of an employee that results in the employee being required to take time off from work for an extended period. An employee's job related illness or injury subject to worker's compensation coverage may be eligible for the catastrophic leave provision.

2.7. **Class:** A group of positions with the same title and alike in duties, responsibilities and authorities requiring the same qualifications and level of compensation (salary). Positions in this group are assigned to various program and/or activities at the department head's discretion.

2.8. **Classification:** The process of job analysis and documentation by which newly created positions are defined and delineated in a formal class description, and assigned a specified rate of pay.

2.9. **Job Description:** The document, which defines the general essential duties, responsibilities and required skills, training and education applicable to incumbents in that class or position.

2.10. **Compensatory Time (CTO) (comp time):** Time off with pay to compensate an employee for overtime worked in lieu of overtime pay.

2.11. **Continuous Service:** Uninterrupted employment with the DNSWMA from the effective date of employment. For purposes of establishing seniority, eligibility for benefits, or vesting of permanent benefits, the following shall not constitute interruptions of service: paid or unpaid Family Leave under FMLA or CFRA; authorized leaves of absence with pay up to 1 calendar year in length. Unpaid periods of absence shall cause an adjustment, to total time served, anniversary dates and relative seniority.

2.12. **Demotion:** Movement of an employee from one position to another position with a lower maximum salary range.

2.13. **Disciplinary Action:** A negative action taken against an employee by the appointing authority in response to an employee's action or actions that constitutes grounds for discipline.

2.14. **Discrimination:** As generally used in personnel law, discrimination refers to the unlawful adverse treatment of an employee or groups of employees, whether intentional or unintentional, based on characteristics including, but not limited to, race, color, national origin, religion, sex, handicap or age.

2.15. **Dismissal:** Termination of employment with DNSWMA for reasons attributable to the employee for violation(s) of standards of conduct or safety regulations; unsatisfactory performance or any combination thereof that constitute cause and grounds for dismissal.

2.16. **Employee:** Any person who has been hired and occupying an authorized position in DNSWMA service:

A. **Confidential Employee:** "Confidential employee" means any employee who is required to develop or present management positions with respect to employer-employee relations or whose duties normally requires access to confidential information that is used to contribute significantly to the development of management positions.

B. **Temporary/Extra Help Employee:**

- An extra-help position is a generic term for a non-allocated position used to fill unanticipated, temporary needs of the Authority. An extra help employee is limited to working less than 1,000 hours per fiscal year.

- Extra help employees do not receive vacation, sick leave, holiday pay, health benefits, PERS benefits unless statutorily required by CalPERS, longevity pay or other benefits, incentives or conditions of employment specifically provided to permanent full-time or permanent part-time except those mandated by law. Extra help employees do not have a probationary period or achieve permanent status and shall not be eligible for benefits defined in this MOU.

- Acknowledging that DNSWMA has relatively few employees and that there are more work hours during the summer months (June thru October) than during the winter, extra-help employees may be needed from time to time. Extra-help shall not be normally used when the staffing could be appropriately assigned to a fully trained permanent employee. In no way shall the use of an extra-help employee be used in lieu of hiring a permanent full or part time position.

C. **Limited-Term Employee:** An employee who works in a program of a limited duration, to be specified at the commencement of employment. Limited-term employees are paid per unit of work or on an hourly basis. Limited-term employees will not accrue holidays, vacation, sick leave or be entitled to group insurance or other benefits provided to permanent employees, nor are they covered by the provisions of this MOU.

D. **Executive Management Employee:** An employee classification status that requires the incumbent employee to exercise significant responsibility for formulating Departmental policy or administering DNSWMA programs. Executive Management positions will be designated by the Governing Board.

E. **Management Employee:** An employee classification status that requires the incumbent employee to exercise significant responsibility for formulating Departmental policy or administering DNSWMA programs in the absence of the appointing authority. Management positions shall be designated by the Governing Board.

F. **Mid-Management Employee:** An employee classification designated by the Board of Supervisors engaging in specialized and responsible work requiring knowledge acquired by prolonged course(s) or specialized instruction or study and whose work may include management duties of a department, division or unit.

G. **Professional Employee:** An employee classification status that requires specialized knowledge and skills attained through completion of a recognized course of instruction, including but not limited to: attorneys, physicians, registered nurses, engineers, architects, teachers and the various types of physical, chemical and biological scientists.

H. **Supervisory Employee:** An employee classification in which an employee has the authority, in the interest of the employer to recommend disciplinary action, assign tasks to, other employees, or the responsibility to assign work to and direct them, or to adjust their grievances, or effectively recommend that action, if in connection with the foregoing functions, the exercise of that authority is not of a merely routine or clerical nature, but requires the use of independent judgment.

I **Permanent Employee:** An employee who is hired to perform the duties of a full-time or part-time position allocated to a departmental staffing chart, and who has completed the initial six-month or one-year probationary period required in Article VI.

J. **Probationary Employee:** An employee serving in a permanent full-time or part-time position, who has not yet completed the six-month or one-year probationary period as required in Article VI, herein.

K. **Provisional Employee:** An employee filling a permanent full-time or part-time position while awaiting certification from an eligibility list or completion of hiring procedures. Provisional employment must be approved by the Personnel Officer. Under no circumstances will an employee be in a provisional status for more than ninety (90) days unless approved by the Governing Board.

2.17. **Fair Labor Standards Act:** A federal law that governs minimum wage, overtime pay, equal pay, child labor standards and record keeping requirements. Not all employees of local government are affected by the FLSA. Certain positions are covered by the FLSA but exempted from specific provisions. Positions affected by the FLSA are designated as exempt, non-exempt or not covered. An employee's status as exempt or non-exempt establishes whether that

employee is subject to overtime under the Act. For purposes of this MOU the designations apply only to the overtime provisions:

A. **Exempt Employee:** An employee classification status that establishes that the employee is not subject to FLSA overtime provisions. Overtime and compensatory time off will be provided pursuant to Article 4.9 and 4.10 hereinafter.

B. **Non-Exempt Employee:** An employee classification status that establishes that the employee is subject to the FLSA overtime provisions.

C. **Non-Covered Official/Employee:** A management classification status that designates that the official is not covered under the overtime provisions of the FLSA.

2.18. **Flextime:** A variation, but not a reduction, in working hours intended to provide better "time-planning" for employees' or DNSWMA needs. All flextime earned or used must be in the same workweek.

2.19. **Governing Board:** The Board of Commissioners of the Del Norte Solid Waste Management Authority.

2.20. **Grievance:** A grievance is a written complaint of an employee or group of employees alleging a violation or misapplication of a provision of this MOU, or adopted DNSWMA policies, state or federal law or regulation.

2.21. **Grievant:** A grievant is an employee or groups of employees within the bargaining unit alleging a grievance.

2.22. **Immediate Family:** The lawful spouse or registered domestic partner, parent, or parent in-law, sibling, child, grandparent or grandchild of the employee, step-children, step-siblings, step-parents, step-grandparents or step-grandchildren residing in the same household.

2.23. **Layoff:** Termination of employment due to a reduction in force, by policy decision of the Governing Board.

2.24. **Leave of Absence:** Absence from duty, whether paid or not, under the provisions of Article V herein.

2.25. **Longevity:** Ten or more years of permanent, uninterrupted service for DNSWMA or with the City of Crescent City, the County of Del Norte, or for any future or former member of the Joint Powers Authority. Employees are entitled to tack continuous periods of service at DNSWMA with continuous periods before service at any member or former member of the JPA. For purposes of this article, changing employer employment from any member of the JPA to DNSWMA is not a break in service.

2.26. **PERB:** Public Employee Relations Board.

2.27. **Performance Improvement Plan:** A written plan devised by the Appointing Authority to assist an employee to improve deficient performance to an acceptable level.

2.28. **Personnel Officer:** The Director of the DNSWMA or his or her designee.

2.29. **Position:** A collection of tasks, duties and responsibilities assigned to and performed by one employee, as authorized by the Governing Board.

A. **Emergency Position:** A position authorized by the Governing Board during an emergency situation in order to prevent endangerment of public health and safety. Entitlement to benefits will be on a case-by-case basis as authorized by the Governing Board.

B. **Grant Position:** A position typically of limited duration created as a result of a public or private grant. Employment is contingent on grant funding and if the grant funding should cease, the position will be terminated. An employee who is laid off from a grant position shall have the same retreat rights as any employee as provided in Article X of this MOU.

C. **Permanent Full-Time Position:** Any position approved and allocated on the DNSWMA staffing chart by the Governing Board, in which the employee works a continuing year-round shift of thirty-five (35) hours or more per week.

D. **Permanent Part-Time Position:** A position, designated by the Governing Board to be permanent, in which the employee works a continuing, year-round shift averaging twenty (20) hours or more per week, but less than thirty-five (35) hours per week. All these employees are entitled to benefits provided permanent full-time employees under this MOU, such benefits are pro-rated in proportion as the part-time employees regular weekly hours bear to full-time hours for that position.

E. **Work Experience Position:** A temporary position which is designated to provide job training to persons who might not otherwise be able to compete in the labor market for regular positions, or a position established to give temporary on the job training for full-time students.

2.30. **Probationary Period:** A period regarded as part of the examination process, which provides the Appointing Authority with an opportunity to observe and evaluate an employee's competence and ability to perform the assigned duties satisfactorily.

2.31. **Progressive Discipline:** An approach to imposing disciplinary action in which a lesser penalty may be appropriate for minor offenses the first time and more severe penalties are imposed for repeating the same or other offense(s). Progressive discipline will be used when the Appointing Authority believes that progressive discipline will serve the dual purpose of providing both corrective warning and a penalty to an employee whom the Appointing Authority intends to retain as an employee after discipline. Discipline may be imposed at any level depending upon the severity of the action of the employee. Progressive discipline will not be required when the Appointing Authority believes dismissal to be the appropriate discipline because of the severity of the employee's conduct.

2.32. **Promotion:** The movement of an employee from one position in one class to a position in a class with a higher maximum salary rate, or an increase in pay for an employee's current position as a result of a reclassification.

2.33. **Reclassification:** The process of job analysis and documentation by which positions are re-defined in response to changes in the duties, responsibilities and skills required of the incumbents. Reclassified positions may be assigned to different pay rates when justified by the degree of change. Reclassification does not affect an employee's anniversary date, unless reclassification results in a promotion.

2.34 **Regular Working Day/Business Day and Overtime:** The Appointing Authority will schedule employees work hours, consistent with the operational needs of the DNSWMA. Not all employees need work the same days or hours. The regular working/business week, consists of

forty (40) hours during seven (7) consecutive days including Friday through the following Thursday, excluding holidays, with the following exceptions:

A. Those positions designated by the Governing Board as thirty-five (35) hours per week, shall consist of thirty-five (35) hours during seven consecutive days including Friday through the following Thursday, excluding holidays.

C. The Appointing Authority may authorize an employee or group of employees to work an altered work schedule/flextime where the needs of the employee(s) make an altered work schedule/flextime either necessary or convenient and neither the DNSWMA nor the employees are unduly affected thereby. In no case may such altered work schedule/flextime be approved if to do so would result in a violation of the FLSA or require the payment of overtime compensation.

D. The Appointing Authority may offer flextime in lieu of compensatory time off or overtime if the operational needs of the department require an employee to work more than their assigned hours in a day. The employee may decline flextime, in which case the employee will receive either compensatory time off or overtime consistent with the provisions of this MOU.

E. DNSWMA gate attendants and staff on assigned standby may be regularly scheduled for shifts longer than eight (8) hours per day under the following conditions:

1. Weekday shifts for gate attendants at the Transfer Station will be from 7:45 AM until 5:30 PM, including an unpaid one-hour break for lunch and two (2) paid fifteen-minute breaks. Regular shifts at the Transfer Station can extend beyond these hours if necessary to print the required reports and properly compile that day's transactions.

2. Administrative staff will not schedule any gate attendant to work more than four (4) full consecutive weekday shifts at the Transfer Station except under extraordinary circumstances.

3. Gate attendants at the Gasquet or Klamath small-volume transfer stations are open and staffed during the posted hours. Gate attendants at these small-volume transfer stations are allowed to take a lunch and two (2) fifteen-minute breaks at their own schedule as customer traffic allows, and will be compensated for travel between the DNSWMA office and each small-volume transfer station or will be given access to a DNSWMA vehicle for this purpose.

4. Administrative staff will not schedule any person to be on assigned standby for the purpose of providing support and back-up to the Transfer Station for more than three (3) consecutive weekends except under extraordinary circumstances.

5. Persons scheduled to work on the weekends for the purpose of providing breaks and lunch relief for the gate attendant at the Transfer Station may be required to work more than three (3) weekend days per pay period.

6. Administrative staff will distribute a schedule for gate attendants, as well as those on assigned standby or scheduled to provide breaks and lunch relief for gate attendants, one (1) week prior to the start of each calendar month unless extraordinary circumstances require otherwise. Persons with these duties are

advised to submit vacation requests at least two (2) weeks in advance of the upcoming calendar month.

2.35. **Suspension:** Temporary separation of an employee from DNSWMA service without pay for disciplinary reasons. Suspensions may only occur as a result of a disciplinary action conducted in accordance with Article XII, or LAPS.

2.36. **Transfer:** Movement of an employee from one position to another.

A. **Demotional Transfer:** Movement of an employee from one position in a class to a different position in the same class at a lower rate of pay, or to a position in a different class with a lower rate of pay.

B. **Lateral Transfer:** Movement of an employee from one position in a class to a different position in the same class and at the same rate of pay.

C. **Promotional Transfer:** Movement of an employee from one position to a different position in at a higher rate of pay.

2.37. **Y-Rate:** A personnel action in which an employee is placed in a class with a lower maximum rate of pay but continues to receive the specific bi-weekly pay rate the employee received in the higher class until such time as the rate of pay of the lower class exceeds that specific rate.

ARTICLE III
GENERAL INFORMATION

3.1 **Union:** All employees are eligible to join the union with the exception of Confidential, Management, and Executive Management employees as defined in Sections 2.21.A, 2.21.E, and 2.21.D respectively. Confidential, Executive Management, and Management employees may not represent an employee or the Union in any disciplinary action or grievance, or in a meet/confer. Once an employee applies for membership in the Union, they agree to maintain their membership and cannot revoke it except during the month of October of each year.

A. **Release Time:** The Union Chapter President or designee will be granted up to four (4) hours paid release time per month to conduct union business. At least seventy-two (72) hours notice will be provided of any intent to use release time under this provision. Additionally, DNSWMA will grant up to two (2) hours of paid release time for the President or designee to attend meetings of the Governing Board whenever an agenda item affects the Union or its members or represented employees. This release time will be without loss of compensation and may not be accumulated.

B. **Union Paid Release Time:** Upon written request of the Union, with not less than ten (10) days advanced notice, DNSWMA will release any employee without loss of pay to attend union functions or activities for a period not to exceed three (3) business days, consistent with the operational needs of the DNSWMA. The DNSWMA will invoice the Union for the cost of payroll and benefits for that employee within thirty (30) days of the lost time, and the Union will reimburse the DNSWMA in full within thirty (30) days of receiving a timely invoice. The total number of days that may be released under this paragraph shall not exceed three (3) days (24 hours) per calendar year, inclusive of all employees.

C. **Use of DNSWMA Facilities:** The Union is entitled to use DNSWMA facilities, including computers, networks, email and phones and interoffice mail for official union communications. Such use must be limited in scope and time to actual release or break time and may not include any long distance phone charges or printing of more than 150 pages per fiscal year.

D. **Release Time for Negotiations:** Union members who serve as the Union's team for bargaining are entitled to paid release time for any scheduled bargaining session, independently of any release time discussed above, and additional time as needed for meetings of the bargaining team when bargaining is open, not to exceed two (2) hours per scheduled bargaining session.

E. **Payroll Deduction:** The County and DNSWMA agree to the automatic deduction of Union dues, agency shop fees if applicable, and voluntary Union sponsored vision insurance plans, and voluntary COPE contributions.

F. **Union Designated Area Representatives on the Union Executive Board** shall be Shop Stewards for the purpose of representing bargaining unit members. The Union may designate one (1) Area Representative per year, who will serve as Union Shop Steward, including the Union's Chief Steward.

G. **No bargaining unit members may be denied representation** due to release time limits in this MOU. In providing representation, Union Officers or Area Representatives will inform the Appointing Authority of their need for representation time. The supervisor may deny such time solely based upon operational need. If it is not possible to grant time as originally requested, the supervisor must arrange for release at the earliest possible time.

H. **New Employee Information and Orientation:** Each new employee in a represented classification shall be given a written statement approved by the Union notifying him or

her that the Union is the recognized employee organization for their classification. This statement shall include a space for the new employee's name, signature and contact information. The Union shall have the opportunity to make a 15 minute presentation with new DNSWMA employee(s) as practical during the first month of their employment. The Union President shall not lose any compensation to meet with any new represented employee(s).

I. **Bulletin Boards:** The DNSWMA will furnish adequate bulletin board space measuring approximately 24x36 inches for the exclusive use of the Union at each worksite. The Bulletin board shall be located in mutually acceptable areas. Prior to posting, any material shall be plainly and legibly initialed by an authorized representative of the Union.

J. **Right of Reasonable Notice:** The Union has the right to be given reasonable written notice of any new or proposed amendments to any ordinance, rule, resolution, or regulation that is directly related to matters within the scope of representation.

K. **No Discrimination:** Provisions of this Memorandum shall be applied to all employees without unlawful discrimination as to age, sex (including gender, gender identity, gender expression, transgender, pregnancy and breastfeeding) race, color, creed, national origin, physical or mental disability, medical condition, sexual orientation, political affiliation, military and veteran status or any other consideration made unlawful by federal, state or local law. The parties agree that prohibition against sexual discrimination includes sexual harassment.

3.2 **Production and Distribution of the MOU:** DNSWMA will provide a copy of this MOU and any later amendments to each current employee in the bargaining unit. DNSWMA will also provide a copy of the MOU to any new employee upon hire during orientation.

3.3 **Conflicts of Interest:** Employees may be required to declare their private financial interests, including any outside employment. Employees must comply with the DNSWMA's Conflict of Interest Code.

ARTICLE 4
COMPENSATION AND HOURS OF EMPLOYMENT

4.1 **Salary Schedule:** The salary schedules for all positions in the bargaining unit are attached hereto as Attachment A. Hourly wages will be indicated for Refuse Site Attendant and bi-weekly wages for all other classifications.

- Effective in the first full pay period in July 2016, all bargaining unit members will receive a 8.0% salary increase.
- Effective in the first full pay period in July 2017, all bargaining unit members will receive a 3.4% salary increase.
- Effective in the first full pay period in July 2018, all bargaining unit members will receive a base wage increase of $0.50 per hour for all hourly pay rates, and an increase of $40 per bi-weekly pay period for all full-time salaried employees.

4.2 **Altered Work Hours:**

A. The Appointing Authority may establish an alternative work schedule for employees. Eligibility, participation in, and implementation of any such work schedules will be at the sole discretion of the Appointing Authority.

B. The Appointing Authority may authorize an employee to work an altered work schedule where the needs of the employee make an altered work schedule either necessary or convenient and neither the DNSWMA nor the employees are unduly affected thereby. In no case will such altered work schedule be approved if to do so would result in a violation of the FLSA or require the payment of overtime compensation.

C. Any employee or group of employees desiring an alternative schedule may request, in writing, that the Appointing Authority establish such a schedule. Such a request will be considered by the Appointing Authority, but will not require the establishment of or assignment to such a shift. The Appointing Authority will have fourteen (14) calendar days to notify the employee or group of employees of his/her decision in writing with the reasons for the decision explained.

D. Long Term Altered Work Schedules: The Appointing Authority, at the request of the employee(s), may establish long term alternate work schedules for individual employees or groups of employees. Alternate work schedules include, but are not limited to, for purposes of this paragraph: four (4) ten (10) hour days (also known as 4 tens), 9 80's, which consists of eight 9-hour workdays, one 8-hour workday and one additional day off every other work week, and a weekly work schedule consisting of forty (40) work hours during five (5) work days at other than traditionally scheduled hours for the assigned shift. Establishment of an alternative work schedule may be approved if it is consistent with operational requirements. The request, and the approval or denial, must be in writing. Permanent changes or cancellations of the alternate work schedule for cause may not be made without fourteen (14) days notice to the affected parties. Any proposed termination of such schedule will be appealable to the Appointing Authority within five (5) working days of notification of its termination. The Appointing Authority's decision will be final and not subject to grievance under Article XI of this MOU. In no case will alternate work schedules be approved if to do so would result in a violation of the Federal Labor Standards Act or require payment of overtime compensation.

4.3 **Beginning Salary:** Newly hired employees will be compensated at Step A of the appropriate salary schedule and range. Where it is difficult to hire qualified personnel or where a person of unusually high qualifications is hired, the Appointing Authority may request the Governing

Board to appoint at a higher step, but in no event higher than Step C. The Governing Board must approve appointment at a step higher then Step A.

4.3a **Bilingual Pay:** An employee in a position that has been approved as requiring the use of bilingual skills on a continuing basis averaging ten (10) percent of work time may qualify for bilingual pay. Use of bilingual skills includes any combination of conversational, interpretational, or translation work. The ten (10) percent standard is verified on a quarterly basis and is based upon the time spent conversing, interpreting or transcribing in a second language.

A. The position must be in a work setting where the bilingual skills are required to meet the needs of the public in either a direct public contact position or an institutional setting, or the position is utilized to perform interpretation, translation or specialized bilingual activities.

B. Upon qualification, employees in the designated positions will be compensated at a rate of one hundred ($100.00) per pay period. Continuing payment will be based upon the quarterly verification and approval by the Appointing Authority. In the event of two or more employees in the department with bilingual skills, the Appointing Authority may request certification of those skills and appoint from the list of certified. If the employees are equally qualified, the more senior employee shall be selected.

4.4 **Probationary and Annual Salary Increases:** Employees who are subject to a six-month probationary period, and who attain permanent status will progress from their current step to the next step within a range on the salary schedule effective on their probationary evaluation date. Employees will progress from one step to the next within a range on the salary schedule each year on the employee's anniversary date until Step E is attained, provided that the employee's work performance is at a satisfactory level or above. In the event of a below satisfactory rating, the step increase will be effective upon attaining a satisfactory rating following completion of a Corrective Action Plan. The Appointing Authority will make recommendation to the Personnel Officer for approval. Any employee whose performance is determined below satisfactory will be given fifteen (15) working days notice prior to the step increase due date that a step increase will not be provided.

4.5 **Longevity Step Increases:** After completion of ten (10) years of uninterrupted, continuous service, an employee will advance to step F of the appropriate range. After completion of fifteen (15) years of uninterrupted, continuous service, an employee will advance to step G of the appropriate range. After completion of twenty (20) years of uninterrupted, continuous service, an employee will advance to step H of the appropriate range. After completion of twenty-five (25) years of uninterrupted, continuous service, an employee will advance to step I of the appropriate range. An employee on step F, G, H or I, if promoted, will remain at their longevity step in the new salary range.

4.6 **Step Placement After Promotion or Open Hiring:** If an employee is promoted or applies and is selected through open hiring for a position in a higher class, the employee will be placed at the lowest step of the new salary range that insures a minimum of 5 percent (5%) increase in salary; provided, however, that this position does not conflict with Section 4.4. In the event the promotion or open hiring places the employee in a class paid less than 5 percent (5%) more than the old class, the employee will be placed at the same step in the new range that he or she held in the old range.

4.7 **Y-Rating:** An employee who is Y-rated will continue to receive the exact biweekly salary received at the time the y-rate is implemented, until such time as the dollar value of the salary

range to which he or she is assigned increases to a level above the y-rate placement, at which time the employee will be again eligible for step and cost of living increases.

4.8 **Out of Class Assignment:** This provision will apply when an employee is specifically assigned and performs, on a temporary basis, the full duties of a higher-level position, in which there is no incumbent or in which the incumbent is on a paid or unpaid leave of absence, or is for some other reason away from the job. Compensation will be at the pay rate of the higher-level position, and will be calculated as though the employee has been promoted to the higher-level position.

A. Employees, except those provided for in B below, will be compensated at the higher rate from the first day provided they work at least five (5) consecutive days in the higher-level position.

B. Employees designated as Mid-Management or Professional shall be compensated after working twenty (20) days in the higher level position.

B. Employees whose job description includes assuming the duties of a higher-level position will be compensated at the higher rate commencing on the sixth consecutive day, provided that the employee is not designated as Mid-Management/Professional or exempt.

C. When an employee is assigned part of the job duties of a higher-level position, the employees will be compensated an equivalent or adequate differential. The compensation will be paid in the manner provided for in subsection A or B above. Differentials will be recommended by the Appointing Authority based upon the amount of higher-level duties assigned to the employee, with final approval by the Personnel Officer. The differential will be a flat amount and may not exceed the amount that would be paid had the employee been promoted.

D. Prior to an authorized out of class assignment, the Appointing Authority must meet with the affected employee(s) and make a determination in writing as to what duties will be performed and the duration of the assignment, if known. The determination and proposed proportionate compensation will then be forwarded to the Personnel Officer for approval.

4.9 **Pay Day:** All employees will be paid on a bi-weekly basis. If a normal bi-weekly pay day falls on a holiday, then the pay day will be the last regular working/business day before the holiday or holidays. The pay period runs from Friday through the following Thursday, paid on the Friday of the following week. Direct deposit is available through the payroll office.

4.10 **Overtime:** Employees may not work overtime except when necessary and required by the Appointing Authority. Overtime will be calculated at the weekly rate. Overtime will not be paid to employees that elect to work an altered work schedule or flextime pursuant to Article 2.23 or 4.2 of this MOU.

A. Weekly Overtime: If a non-FLSA exempt employee is required to work longer than forty (40) hours in a week (including any vacation time and including holiday time), he or she will be paid at time-and-a-half (1.5) for any time worked in excess of the regularly scheduled hours. Call back time as provided for in Section 4.15 shall remain as stated.

B. Vacation Rule: Employees may not take vacations on days which they work if the combined work and vacation time would result in exceeding the employee's regularly assigned non-overtime working hours for the day. In general, the Appointing Authority will not authorize vacation time which could result in daily or weekly overtime, unless

absolutely necessary to meet emergency needs of the department. Sick time does not count towards overtime calculation.

C. Overtime Limitation: Any employee earning less than 130 percent (130%) of the California State minimum wage (presently 10.40 per hour) will not be subject to the provision in this paragraph with respect to applicable overtime penalties. Instead, the more restrictive California Industrial Wage Commission order will apply.

D. Working Conditions: If an FLSA-exempt employee covered by this agreement is required to work more than six (6) days consecutively, or more than sixty (60) hours in a week, time worked in excess will be accrued compensatory time off at a rate of two (2) hours per hour worked on the seventh day or over sixty (60) hours.

4.11 **Compensatory Time Off:** The Appointing Authority will determine whether employees receive overtime pay or compensatory time off ("CTO") for overtime worked, subject to the following conditions:

A. If an FLSA covered non-exempt employee is required to work overtime, above, the Appointing Authority may opt to provide, in lieu of overtime rates, corresponding compensatory time off at the corresponding rate. For example, an hour of time-and-one-half equals one-and-one-half hours of compensatory time off. Employees may accumulate up to 120 hours of compensatory time off, provided that in an emergency, if an employee accrues more than that which is allowed, the Appointing Authority, with the approval of the Personnel Officer, can permit additional hours. Employees entitled to overtime may request CTO in lieu, which should be granted unless inconsistent with operational necessity.

B. Use of Banked CTO: An employee must request the use of CTO in writing, on the provided form. DNSWMA shall grant the employee's request to use CTO within a reasonable period of time, not to exceed sixty (60) days, unless granting the request would unduly disrupt operations, which means, would create an unreasonable burden on the DNSWMA's ability to provide services of acceptable quality and quantity for the public during the time requested without the employee's services. DNSWMA will, to the extent practical, grant requests for particular days off, if it is consistent with operational needs.

4.12 **Travel Time:** Refer to Personnel Rules, Travel and Other Expenses for the complete policy on meal and travel reimbursement.

4.13 **Training Attendance:** Employees may not be required or pressured to attend training sessions or seminars unless DNSWMA pays all actual and necessary costs.

4.14 **Assigned Standby:** Employees who are assigned standby duty by their Appointing Authority on weekends, overnight or on holidays will be compensated or given compensatory time off in accordance with this section. For purposes of this section, "assigned standby" is defined as a period of time during which an employee designated by his/her Appointing Authority must be available to provide services when needed. "Available" means that, during the entire standby period, the employee can be contacted immediately by those in need of services, either by telephone or other means of communication, and that the employee is able to commence providing the services within thirty (30) minutes of the contact. "Commence providing services" means either to give the needed service on the telephone or other means of communication, or to proceed to the location where the services are to be performed.

A. An employee will be compensated at his/her normal rate of pay or be given compensatory time off at a rate of two (2) hours for each eight (8) hours of assigned standby time, excluding any hour during which the employee is paid or given compensatory time off for performing services pursuant to the subsection which follows.

B. When an employee performs services during an assigned period, he or she will be compensated or given compensatory time off at the rate of one (1) hour for each hour worked. When the work performed qualifies for overtime compensation under Section 4.10, compensation or overtime will be granted in accordance with the corresponding overtime rate. However, in all cases the employee will be compensated or given compensatory time off for a minimum of two (2) hours.

C. Exempt employees may receive CTO under this provision.

4.15 **Call Back Time:** Employees will be compensated for call-back time. Call-back time is defined as only those instances when an employee is ordered back to work without prior notice after completing a shift and leaving the worksite. The use of call-back may be resorted to only in emergency situations or unusual instances when it is not possible for the work to be accomplished through normal scheduling or scheduling of overtime. Responses to phone calls or working at home are not considered call-back duty. Travel time will be compensable as provided in the Travel Policy. An employee who is called back will be compensated for a minimum of two (2) hours of work time. The two (2) hours, whether or not actually worked, are subject to the appropriate overtime provisions. Call-back time earned may be compensated by pay or compensatory time off at the option of the appointing authority. Call back time is not considered flex time or an alternative work schedule.

4.16 **Rest Breaks:** All employees are entitled to one paid fifteen (15) minute rest break for each four (4) hours worked. The employee may take the break away from the work station, provided transit time is included in the fifteen (15) minute period. The Appointing Authority should schedule individual employee's rest breaks so as to provide for the proper and efficient administration of DNSWMA's function.

4.17 **Direct Deposit:** All new employees will be required to receive their pay as direct deposit, unless waived by the Personnel Officer for extraordinary circumstances, under procedures established by the Treasurer-Controller.

4.18 **State Disability Insurance:** All qualified employees are covered by the State Disability Insurance Plan (SDI) with the sick leave integrated option, which is administered by the State of California. Qualified employees have a payroll deduction which is based on gross salary. The employee is entitled to use sick leave and/or vacation to supplement the benefit to an amount equal to, but not greater than, the employee's regular salary.

ARTICLE 5
AUTHORIZED ABSENCE

5.1 **Entitlement:** All permanent full-time, permanent part-time employees, and probationary employees are entitled to authorized absence subject to the provisions and exceptions of this article. Paid time addressed in this article illustrates time for full time employees.

A. Permanent part-time employees receive paid holidays, vacation and sick leave based upon the position's allocated percentage of full-time. For example, an allocated position that works twenty (20) hours a work week in a forty (40) hour work week will earn fifty percent (50%) of the amount that is earned by a full-time employee.

B. Employees entitled to holidays, vacation and sick leave will accrue floating holidays, vacation and sick leave from the date of employment. Sick leave and floating holidays may be used upon accrual. Vacation will be available for use after completion of six (6) months of continuous employment.

C. For purposes of scheduling employee time off for vacation, compensatory time off, personal floating holidays or regular holidays, the employee must request time off in writing in advance with the Appointing Authority. Approval of all requests will be governed by the needs of the DNSWMA (subject to FLSA). However, employee requests should not be denied unless operational necessity requires it. A denial will be provided to the employee in writing, and must state the reason for the denial. Once the Appointing Authority or designee and the employee have agreed to a particular day or days off, the employee must be allowed to take those days off, unless an emergency occurs rendering the employee's attendance necessary. This procedure will also apply for scheduling purposes, whenever possible, for family sick leave and medical appointments. The Appointing Authority or designee may require an employee to take off accumulated compensatory time which would exceed the maximum amount which may be accrued in accordance with the provisions of this MOU, by giving an employee not less than forty-eight (48) hours notice. Compensatory time off, which is required to be taken off under this paragraph, must be taken in full day increments.

5.2 **Holidays:** Eligible employees are entitled to the following Holidays with pay up to a maximum of eight (8) hours:

New Year's Day.....January 1
Dr. Martin Luther King's Birthday.....Third Monday in January
Lincoln's Birthday.....February 12
Washington's Birthday.....Third Monday in February
Cesar Chavez Day.....March 31
Memorial Day.....Last Monday in May
Independence Day.....July 4
Labor Day.....First Monday in September
Veteran's Day.....November 11
Thanksgiving Day.....Fourth Thursday in November
Day after Thanksgiving Day.....Fourth Friday in November
Work day before or after the Christmas holiday and
Christmas Day.....December 25th or when:
Dec. 25th falls on a Monday, the paid holidays shall be Monday 12/25 & Tuesday 12/26
Dec. 25th falls on a Tuesday, the paid holidays shall be Monday 12/24& Tuesday 12/25
Dec. 25th falls on a Wednesday, the paid holidays shall be Tuesday 12/24 & Wed. 12/25
Dec. 25th falls on a Thursday, the paid holidays shall be Thursday 12/25 & Friday 12/26

Dec 25th falls on a Friday, the paid holidays shall be Thursday 12/24 & Friday 12/25
Dec 25th falls on a Saturday, the paid holidays shall be Thursday 12/23 & Friday 12/24
Dec 25th falls on a Sunday, the paid holidays shall be Friday 12/23 & Monday 12/26

A. Additionally, eligible employees will accrue three (3) (twenty four (24) hours) floating holidays per fiscal year. Employees hired during the period of July 1 through December 31 are eligible for three (3) (twenty four (24) hours) holidays during the first fiscal year of employment. Employees hired during the period January 1 through March 31 are entitled to two (2) (sixteen (16) hours) floating holidays during the first fiscal year of employment. Employees hired from April 1 through June 30 are not eligible for a floating holiday during the first fiscal year. These holidays may be used at any time with approval of the Appointing Authority. Floating holidays may only be used in full day increments; they may not be taken on an hourly basis. If not taken during the last full pay period in June of each fiscal year during which they are earned, the holidays are forfeited. Floating holidays accrued but not used may not be paid off at the time of termination of employment.

B. If a holiday falls on a Saturday, the preceding Friday will be a holiday. If a holiday falls on a Sunday, the following Monday will be a holiday.

C. Additionally, the Governing Board may declare an additional holiday each day declared by the President of the United States or the Governor of the State of California as a day of mourning, thanksgiving, or other special occasion. Such day will be treated as a holiday.

D. If an employee is required to work on a recognized holiday, or of the employee's regular day off falls on a holiday, the employee will receive up to eight (8) hours of holiday pay on that day. The employee may, if mutually agreeable with the employer, take a holiday on an alternate day within the same pay week.

5.3 **Vacation:** Eligible employees are entitled to paid vacation as follows:

A. No changes to this MOU will reduce vacation accrual rates of current DNSWMA employees.

B. Employees will accrue vacation at a rate equal to the following annual vacation days: five (5) days during the first (1st) year of continuous service; ten (10) days per year for two (2) through (5) years of continuous service; fifteen (15) days per year for six (6) through ten (10) years of continuous service; twenty (20) days per year for eleven (11) through fifteen (15) years of continuous service; and twenty-five (25) days per year for sixteen (16) or more years of continuous service.

C. Employees designated by the Governing Board as mid-management or professional, will be entitled to five (5) days of vacation per year in addition to the time provided under 5.3(B) above.

D. An employee who terminates during the initial six (6) months of service will not be entitled to vacation leave or payment for accrued vacation.

E. At no time may employees accrue more than the number of days of vacation they are entitled to earn in a one-and-a-half year period at their current rate of accrual. Employees who have reached this limit cease accruing vacation until such time as the total number of days accrued is less than this number.

F. Employees eligible for vacation usage will be compensated for unused vacation upon separation from service.

G. Vacation will continue to accrue while an employee is on other paid leave of absence or temporary disability. Accrued vacation may be used to supplement paid leave or temporary disability benefits at the employee's request.

5.4 **Scheduling of Vacation and Floating Holidays:** Employees must request time off in writing in advance with the Appointing Authority. Vacation or floating holiday scheduling is subject to the operational needs of the DNSWMA. Vacation or floating holiday requests should not be denied unless operational needs of the DNSWMA so dictate. A denial will be provided to the employee in writing and must state the reason for the denial. Once the Appointing Authority and the employee have agreed to a particular day or days off, the employee must be allowed to those days off, unless an emergency occurs rendering the employee's attendance necessary.

5.5 **Sick Leave:** All eligible employees are entitled to sick leave with pay. Employees are expected to work a complete designated workday. If an employee cannot report to work, the employee shall notify the Appointing Authority as early as possible but not later than one (1) hour after the workday begins. Sick leave entitlement is as follows:

A. Eligible employees earn a rate of one (1) day of sick leave with pay for each month of service from the date of employment, accrued on a biweekly basis.

B. Sick leave will only be authorized for illness of an employee, his/her immediate family or member of the employee's household. Abuse of this sick leave provision may be cause for discipline. The Appointing Authority is responsible for insuring that the sick leave is not misused.

C. Sick leave may be used for purposes such as: personal illness or injury; medical, mental health or dental appointments; required attendance of the employee upon a sick or injured spouse or other member of immediate family defined in Section 2.26 of this MOU.

D. Those employees separating in good standing between five (5) and ten (10) years of continuous service will be compensated at a rate of ten percent (10%) for accumulated unused sick leave.

E Upon separation from DNSWMA employment in good standing, those employees with ten (10) or more years of continuous service will be compensated at a rate of 25% for accumulated unused sick leave hours. Separation from employment under other conditions does not qualify for payment. The employee will have the option of trading sick leave for vacation at the rate of four (4) days of sick leave for one (1) day of vacation for sick leave accrued in excess of fifty (50) days.

F. Upon retirement, accumulated unused sick leave hours will be eligible for payment at a rate of 50%, or retiring employees may choose to apply 100% of their unused sick leave towards PERS retirement credit. 50% payment for unused sick leave is not available to retiring employees who are qualified for, and elect to receive, the medical insurance plan provided by Del Norte County under provisions 9.3 of this MOU. Retiring employees may choose one benefit or the other, but not both.

5.6 **Vacation and Sick Leave:** Vacation and sick leave will continue to be accrued at the normal rate while an employee remains on temporary disability and continues to supplement the benefit with sick leave and/or vacation. When the accrued sick leave and/or vacation hours are exhausted, the employee may request a leave under Section 5.10 of this MOU.

5.7 **Family Death Leave:** The Appointing Authority will authorize paid leave of up to five (5) days immediately following the death of a member of the immediate family or household as defined in Section 2.26 of this MOU.

5.8 **Jury Duty:** The Appointing Authority must authorize time off as needed for jury duty. If the employee transfers the fees paid for jury duty service to DNSWMA, then full pay will be continued during the leave. If vacation, compensatory time or other paid day off is used, the jury fees need not be paid to the DNSWMA.

5.9 **Military Leave:** In accordance with federal law, employees are entitled to military leave of absence with pay and benefits as provided in Division II, Part I, Chapter VII of the Military and Veterans Code.

5.10 **Leave of Absence Without Pay:** Leaves of absence without pay may be granted only upon specific written request of an eligible employee, and with the approval of the Appointing Authority and the Personnel Officer. Leaves may be granted for:

A. Personal reasons which do not cause inconvenience to the DNSWMA, not to exceed thirty (30) days in duration.

B. Before a personal leave of absence is granted, an employee must exhaust all accrued vacation.

C. An unpaid leave of absence may be extended up to one (1) year, upon finding of unusual or special circumstances, if recommended by the Appointing Authority and approved by the Personnel Officer. Failure to report for duty after a leave of absence has expired, been disapproved or canceled will be considered an automatic resignation.

D. An unpaid leave of absence will cause a break in service, and the employee's anniversary date, evaluation date, and longevity date will be adjusted to reflect the length of time not credited to total service. An employee's seniority will be frozen at the time of the break in service and will continue to accrue at such time as the employee returns to paid status.

E. All paid benefits provided by this MOU will cease during the unpaid leave of absence, except as provided under Section 5.11, below. However the employee may continue to participate in medical, dental and life insurance, and the union provided vision insurance, by paying the monthly premiums at group rates.

F. The Appointing Authority may at his or her discretion approve up to five (5) days unpaid leave per calendar year to an employee for urgent or emergency absences for which the employee has insufficient accrued paid time. This time off will not be subject to approval by the Personnel Officer, and will not cause any seniority adjustment. Unpaid time off beyond the five (5) days in a calendar year is subject to all other provisions of Section 5.10.

5.11 **Family and Medical Leave:** The parties agree that DNSWMA will comply fully with the statutory rights of employees under the California Family Rights Act and the Family Medical Leave Act. Nothing in this paragraph waives any statutory rights of any employee. An employee with at least 12 months of service, who has worked at least 1250 hours during the preceding 12 month period prior to the date for which leave is requested, is eligible to take up to twelve (12) weeks of leave each year.

5.12 **Administrative Leave:** Where an employee has performed meritorious service, the Appointing Authority, may, in his or her discretion, grant up to three (3) days of administrative leave with pay during the fiscal year, in addition to any other holidays or leave available to the employee. Such days must be taken during the same fiscal year.

5.13 **Catastrophic Leave:** Catastrophic leave is a paid leave of absence due to a verifiable, long-term catastrophic illness or injury which clearly disables the employee. Catastrophic leave time is paid from hours donated by other DNSWMA employees.

A. Responsibility:

1. SWMA or its designee will be responsible for the administration of the catastrophic leave program. Administration includes determining employee

eligibility, monitoring usage and balances, and providing the Union with quarterly time balance reports.

2. The Union will be responsible for soliciting donations to the leave bank.

B. Eligibility: All permanent employees may be eligible to withdraw hours from the Catastrophic Leave Bank in two ways. They must either meet the following criteria:

1. Successful completion of twenty-six (26) pay periods in paid status.
2. Have donated a minimum of one-day (8 hours) to the Bank in the preceding twelve (12) months.
3. Provide written documentation of application and qualification of State Disability Insurance.
4. Exhaustion of all available sick leave, compensatory time, vacation time and other accrued paid leaves of absence.
5. Is anticipated to be absent for at least fifteen (15) working days past the date of exhaustion of all of the employees accrued paid time/leave.
6. Provide written documentation of the need for the absence from work by a certified healthcare provider.

OR, they may draw leave that has been donated to the Authority's Catastrophic Leave Bank specifically for their use.

C. Donation of Hours:

1. Employees may donate up to five (5) days per fiscal year total from any of three sources: sick leave, vacation, and compensatory time off.
2. Employees may donate a maximum of three (3) days from any one source per fiscal year.
3. Donations must be made in increments of at least four (4) hours or more.
4. In order to donate sick leave, an employee must have not less than ten (10) days of sick leave available after donation.
5. Donated time will be credited on an hour for hour basis, regardless of wage of either donator or recipient.
6. Donations may be contributed to either the general Catastrophic Leave Bank for general usage, or to an individual employee.
7. Those hours donated to an individual employee, but not used, upon return to work will automatically revert to the Catastrophic Leave Bank for general use.
8. Once made, a donation to the Catastrophic Leave Bank becomes the property of the bank, and may not be recovered by the donating employee.

D. Approval Process for Use of Catastrophic Leave Bank:

1. A request for use of the Catastrophic Leave bank must receive approval through the Personnel Officer.
2. The Personnel Officer will be responsible for determining employee eligibility to make withdrawals from the donation bank. Requesting employees are responsible for providing documentation of the anticipated duration of absence.
3. Donated leave days contained in the general usage bank are available to eligible employees on a first-come, first-served basis. Two (2) or more eligible employees may draw from the bank concurrently, providing available resources exist.

E. Usage of Donated Hours:

1. An employee may use Catastrophic Leave to augment State Disability benefits not to exceed their base salary rate.
2. Catastrophic Leave Bank donations may be used to augment any benefits received due to a work-related illness or injury.
3. While an employee is on Catastrophic Leave using donated hours, the employee will be treated as in pay status, for purposes such as anniversary and longevity dates, health insurance, and other benefits, except that the employee will not accrue any vacation or sick leave.
4. Usage of catastrophic leave may not exceed twelve (12) weeks during any twelve-month period. Extensions may be granted pursuant to Section 5.10 of the MOU.

5.14 **Workers Compensation:** The parties agree that DNSWMA will comply fully with the Workers Compensation Code of the State of California. Nothing in this paragraph is intended to waive any statutory right of any employee. When an employee is injured on the job or becomes ill from job-related causes, the employee is responsible for notifying the Appointing Authority. The Appointing Authority must submit a report of the injury or illness, including the date and time of occurrence and any relevant circumstance, to the Risk Manager's office. The report will be processed in accordance with the Workers Compensation law of the State of California and the procedures of the DNSWMA workers' compensation plan.

A. If an employee loses time because of a workplace injury or industrial illness, the worker will be entitled to the benefits of the Workers Compensation law. This provides payment for medical treatment and hospitalization up to a maximum established by the State's benefit schedule. The employee is entitled to use accrued sick leave, compensatory time off, and/or vacation time to supplement the temporary disability payments to an amount equal to, but no greater than, the employee's full salary. In the event that sick leave, compensatory time off, and/or vacation time are used in this manner, they will be charged first to sick leave, second to compensatory time off, and lastly to vacation.

B. Vacation and sick leave will continue to accrue at the normal rate while the employee remains on temporary disability.

ARTICLE 6
EVALUATION

6.1 **General Provisions:** Each employee is expected to maintain high standards of performance. The work performance of each employee will be evaluated at the midpoint of the probationary period, at the conclusion of the probationary period, and annually thereafter on the employee's anniversary date. A special evaluation may be prepared by the employee's Appointing Authority at any time when warranted by either outstanding work performance or when work performance is unsatisfactory. In addition, a special evaluation will be prepared by an employee's Appointing Authority at an employee's written request but no more frequently than once between annual evaluations. In addition, the Personnel Officer may request a report from the Appointing Authority on the overall performance of any employee, at any time.

A. Evaluation documents become a permanent part of the employee's personnel file.

B. It is the duty of the Appointing Authority during the probationary period of each employee in the department to investigate thoroughly the probationer's adjustment, performance and general acceptability, and to keep the probationer advised of his/her progress and to determine whether or not the probationer is fully qualified for permanent appointment. At least fifteen (15) working days prior to the completion of the probationary period, the Appointing Authority must submit a completed evaluation form to the Personnel Officer and provide a copy to the employee.

C. Violations of this section are subject to the grievance procedure. However, the actual ratings or comments made on an evaluation are not subject to mediation and/or binding arbitration or grievance unless they form the basis for a performance improvement plan or discipline. Employees will not be entitled to union representation at the initial evaluation meeting with the Appointing Authority, unless the previous evaluation received by the employee was less than satisfactory or the employee is on a performance improvement plan.

D. No complaint against an employee may be referred to in an evaluation unless the employee has been made aware of the details of the complaint within thirty (30) days that the DNSWMA became aware of the complaint.

E. The employee will have the right to file a response within ten (10) working days of receipt of the evaluation, including any attachments, witness statements, or the like. The response will be attached to any copy of the evaluation maintained by County or DNSWMA and will also be maintained in the employee's personnel file.

6.2 **Performance Improvement Plan:** If an employee receives a substandard evaluation, the Appointing Authority may prepare a performance improvement plan to provide clear direction to an employee whose performance is substandard. Performance Improvement Plans are described in detail in Article XII.

6.3 **Probationary Period:** All employees in permanent positions will be subject to a probationary period. A probationary period will commence upon the effective date of hire into a permanent position, including promotion. Service prior to a permanent appointment will, upon recommendation of the Appointing Authority and approval by the Personnel Officer, be counted as part of the probationary period, providing the temporary or provisional continuous service was in the same class as the position to which the probationary appointment is made. The regular probationary period will be six (6) months. An employee attains permanent status upon successful completion of the prescribed probationary period, and execution of the appropriate personnel action form.

6.4 **Extension of Probationary Period:** The Appointing Authority may, request an extension of the probationary period up to a total of six (6) additional months for an employee. Written extension requests are to be submitted for review to the Personnel Officer at least fifteen (15) working days prior to the end of the probationary period. The request must contain the reasons and justification for the extension, and the duration of the extension requested. The request must be accompanied by an employee's performance report and, when required by the Personnel Officer, a performance improvement plan. If approved by the Personnel Officer, the employee will be notified in writing by his/her Appointing Authority of the extension of his/her probationary period and the specific reasons for the extension. An employee attains permanent status upon successful completion of the probationary period, and execution of the appropriate personnel action form.

6.5 **Probationary Service:** A newly hired employee is subject to separation from DNSWMA service at any time during the prescribed probationary period, without right of appeal or hearing, except as may otherwise be required by law. In the case of a probationary termination, the Appointing Authority must notify the probationary employee in writing of the fact that he or she is being separated from DNSWMA service. Notice must be provided at least fifteen (15) working days prior to the end of the probationary period. In case of a promoted employee who fails to complete the probationary period following promotion, every reasonable attempt will be made to reinstate the employee to his/her previous position, provided that said position is vacant. If the employee's previous position is not vacant, every reasonable attempt will be made to place the employee in a vacant position that has equivalent pay and benefits to that of the previously held position and for which the employee is duly qualified for.

6.6 **Personnel File:** Upon separation, the DNSWMA will provide the employee with a copy of the employee's personnel file within ten (10) working days of the employee's written request.

ARTICLE 7
TRANSFER, PROMOTION, REASIGNMENT, AND VOLUNTARY DEMOTION

7.1 **Effect of Lateral Transfer:** A permanent employee who is transferred laterally continues to be a permanent employee and does not have to serve a new probationary period in the new position. A probationary employee who is transferred laterally must serve a new probationary period in the new position. A transferred permanent employee retains all of the seniority accrued in the earlier positions(s), but the employee's anniversary date will be changed to reflect the date of assignment to the new position. A transferred permanent employee retains the same salary step placement, including longevity, received in the former position.

7.2 **Effect of the Promotion:** An employee who is promoted must serve a probationary period in the new position. The employee receives a new anniversary date upon promotion. A promoted employee will be placed at the lowest step of the new salary range which provides for a minimum 5% increase in salary. A promoted employee on Step F, G, H or I will remain at their longevity step in the new range.

7.3 **Voluntary Demotion:** An employee may be demoted to a vacant position in a lower class, or to a lower level in the same class series, upon the employee's written request and with the approval of the Appointing Authority and the Personnel Officer. This action will be known as a voluntary demotion and will be noted on all official records.

7.4 **Effect of Demotion:** An employee who is demoted, either voluntarily or involuntarily, will be treated as follows:

A. If the employee is probationary, his/her probationary period will be a continuation of the probationary period being served at the higher level.
B. If the employee is permanent, he or she will not be required to serve a new probationary period in the next lower class.
C. If the employee is returned to a former class in which the employee held permanence, the employee will not be required to serve a new probationary period.
D. The employee receiving a demotion will be placed at a step in the new salary range which provides for the least loss of pay, but will be placed on Step F or G, if that step was held in the previous position.

7.5 **Class Series Advancement:** Employees may move upward in a class series upon the recommendation of the Appointing Authority, and with approval of the Personnel Officer, when the following criteria are met:

A. The employee's qualifications must satisfy the qualifications indicated on the job description in the area of experience, and work performance must be rated above satisfactory.
B. In addition to the above, advancement to a III level requires that the employee provide lead person duties or be the only clerical employee who is responsible for all clerical functions in the department or unit.
C. An employee who receives a class series advancement must serve a new probationary period.

7.6 **Grant Positions:** When a grant position is made a regular position by action of the Governing Board, the individual occupying that position may be appointed to that position by the Appointing Authority and with the approval of the Personnel Officer, without normal recruitment procedures.

7.7 **Reassignment:** Employees may, from time to time, be affected by reorganization, change of assigned worksite, or other factors which result in physical relocation of the employee's worksite or work station. In all such cases, employees will be reassigned to the new worksite or work.

ARTICLE 8
CLASSIFICATION AND RECLASSIFICATION

8.1 Classification: When the DNSWMA classifies a new position, the DNSWMA will notify the union of the compensation proposed for the new position or reclassified position before such classification or reclassification may be posted on the agenda of the Governing Board, and upon written request will meet and discuss on the subject within ten (10) days of the notification to the union in writing by the DNSWMA of the proposed classification.

8.2 Reclassification: If an employee's duties vary from his or her job description sufficiently to warrant a change in classification, either party may request to meet and discuss with the other about reclassification of the position to reflect the actual or proposed job duties of the position.

ARTICLE 9
HEALTH AND WELFARE BENEFITS

9.1 **General Provisions:** All permanent, probationary and grant employees are eligible for full health benefits through a self-funded plan subject to annual deductibles and co-pays. Extra help, limited term, temporary and seasonal employees will receive only those fringe benefits required by law. Employees entitled to health benefits will be eligible for coverage on the first day of the month following completion of sixty (60) days of continuous employment. Any employee whose date of hire falls between the 1st and 15th day of the month will have said month counted in its entirety toward the waiting period. Any employee whose date of hire is the 16th of the month or later will not begin their waiting period until the 1st day of the following month. The health plan includes medical, mental health, life and dental coverage. In addition, the employee may elect to cover dependents by the payment of premiums through payroll deduction. Covered employees and their covered dependents (spouses and children) have the opportunity to temporarily continue their health coverage if coverage is lost under certain qualifying circumstances. Employee's must contribute five percent (5%) of their gross biweekly salary toward their healthcare premium and the DNSWMA shall contribute the remaining amount. See the Health Care Plan Booklet contained in Attachment B for specific benefits, co-pays and continuation coverage provisions.

9.2 **Dependent Coverage Rates:** For specific dependent rate information, refer to Attachment C.

9.3 **Plan Continuation Benefit:**

A. Employees who retire from DNSWMA service may continue their medical coverage at DNSWMA group rates at their option, and subject to all rules and regulations of the DNSWMA's medical benefits carrier at the time. It is understood and agreed that the DNSWMA will not be liable for payment of any premium to its medical carrier. If the retired employee fails for any reason to make a payment when due, the DNSWMA will not make the payment for him/her, and the benefit could be lost in this event. However, employees retiring after the age of fifty-five (55) and serving a minimum of twenty-five (25) continuous years in DNSWMA service will be eligible to continue the DNSWMA Health Care Plan at no premium cost for the retiree until the employee qualifies for Medicare benefits. Continued coverage in the DNSWMA's plan when the retiree qualifies for Medicare will be paid by the retiree at the same rate set by the DNSWMA for retirees. For specific retiree rates, including dependent coverage rates, refer to Appendix C.

B. Effective November 1, 2009, employees hired after November 1, 2009 will not be eligible to continue health insurance coverage as a retiree until they have achieved fifteen (15) years continuous DNSWMA service. Employees hired between January 1, 2007 and October 31, 2009 will not be eligible to continue health insurance coverage as a retiree until they have achieved ten (10) years continuous DNSWMA service. All employees hired prior to January 1, 2007 will be unaffected by this article.

C. The DNSWMA makes available to employees a premium conversion plan under IRS Code Section 125, by which employees who pay for dependent medical care may have their premium contributions paid with pre-tax dollars.

9.4 **Dental Benefits:** The DNSWMA provides dental benefits under its self-insured health plan, a copy of which is attached to this MOU as an exhibit. See the Health Care Plan Booklet contained in Attachment B for specific benefits, co-pays and continuation coverage provisions.

9.5 **Life Insurance:** The DNSWMA also provides a life insurance policy of fifteen thousand ($15,000) at no cost to the employee. Mid-Management and professional employees are also provided a life insurance policy equal to one (1) year's gross pay at no cost to the individual.

9.6 **Voluntary Insurance Plans:** Employees are eligible for a variety of employee and dependent paid insurance plans offered through AFLAC. Union members may participate in a Union sponsored vision plan. For more details, contact an association area representative. Voluntary insurance plans are paid for by the employee through payroll deduction of premiums, at no cost to the DNSWMA.

9.7 **Ground and Air Ambulance Plan:** The DNSWMA provides ground and air ambulance coverage through Del Norte Ambulance and Cal-Ore Life Flight at no charge to permanent employees and their dependents upon eligibility for health benefits.

9.8 **Employee PERS Contribution:**

New Members: Pursuant to the California Public Employees' Pension Reform Act of 2013 (PEPRA), employees hired on or after January 1, 2013, defined as "New" employees, shall pay effective the first full pay period in July 2016, the member contribution established under the CalPERS Agreement, currently six and one quarter percent (6.25%). Should this rate established by CalPERS fluctuate during the term of this Agreement, the employees will pay the established rate.

Classic Members: Pursuant to the California Public Employees' Pension Reform Act of 2013 (PEPRA), employees hired prior to January 1, 2013, defined as "Classic" members, shall pay effective the first full pay period in July 2016, the member contribution established under the CalPERS Agreement, currently seven percent (7%). Should this rate established by CalPERS fluctuate during the term of this Agreement, the employees will pay the established rate.

9.9 **PERS Benefit Calculation:**

Pursuant to the California Public Employees' Pension Reform Act of 2013 (PEPRA), the benefit calculation for employees hired after January 1, 2013 who are not transferred from a CalPERS or CalPERS reciprocal agency or have a break in service of six (6) months or longer shall be the thirty-six (36) highest consecutive months final compensation provision using the 2% @ 62 formula for Miscellaneous Employees.

For employees hired prior to January 1, 2013, the benefit calculation shall be based on the twelve (12) highest paid consecutive months using the 2% @ 55 formula for Miscellaneous Employees.

9.10 **PERS Employer Contribution Cap:**

During the term of this Agreement, DNSWMA shall pay a maximum of twenty percent (20%) for the employer contribution rate. If during the term of this Agreement, the employer share exceeds twenty percent (20%), the employee shall pay fifty percent (50%) of the contribution in excess of the twenty percent (20%) cap, and DNSWMA shall pay the remaining fifty percent (50%). At no time during the term of this Agreement shall member's total contribution exceed eight percent (8%).

9.11 **Employee Discount Program:** The DNSWMA may participate in and pass along employee discounts offered by vendors as they become available, provided said participation does not violate legal or ethical rules. Participation in such discount programs may not hold the DNSWMA liable in any manner. Offers or programs that require DNSWMA staff time to verify employment or in any way assist in the overall management of the discount program will be considered on a case by case basis. Examples of employee discount programs are, but not limited to the following: Microsoft Office software purchase, Verizon Wireless discount, and Dell computer purchasing program. Specific information regarding current discount programs may be obtained from the Personnel Office.

ARTICLE 10
REIMBURSEMENTS

10.1 Employee Attire:

DNSWMA employees will need to dress appropriately for their positions, considering demands of safety, weather, durability and professional appearance. Given that employees are exposed to numerous elements is it essential that staff protect themselves. Clean t-shirts with denim jeans are acceptable clothing. Such items which are not appropriate for work include: athletic wear such as sweat pants, swimsuits, tanktops and no exposed undergarments. All employees who may work as refuse site attendants for all or part of any workday are expected to wear closed-toe shoes.

10.2 Clothing Benefits:

Allowances for clothing and footwear described in the following sections will be issued in August of each year to eligible employees. If an employee becomes eligible for such allowance(s) after August, such allowance(s) will be issued within 90 days of that employee's eligibility.

A. **Generally.** Employees working at the gate or at outdoor collection areas are required to wear: safety vests and closed-toe protective shoes. DNSWMA will provide safety vests, name tags and assigned, clean, fitted and breathable rain coats with reflective safety colors which will be replaced every three years at no cost to employees.

B. **Transfer Station and Landfill.** DNSWMA will provide work gloves, appropriately sized back support brace, hard hats, dust masks, ear plugs, and other appropriate safety equipment for staff as needed in their assigned duties.

C. **Other Protection.** Any member of staff may suggest that DNSWMA administration procure additional safety equipment, supplies, or defensive or protective measures against animals or insects that have the potential to reduce injury or improve workplace safety for any regular aspect of the employee's work responsibilities. All such clothing, equipment, or supplies issued to employees by DNSWMA will be the responsibility of that employee to clean and maintain and must be returned to DNSWMA clean at the end of employment.

D. DNSWMA will provide and replace anti-fatigue mats at the Del Norte County Transfer Station scale house every three years. Prior to replacement, union representatives will be invited to participate in the selection process for anti-fatigue mats.

10.3 Rain and Protective Footwear:

A. Protective footwear is designed to protect the feet from injuries associated with the operation of equipment. The footwear should be above the ankle, heavy weight leather or like material, with steel toed boots. All employees working with heavy equipment, loading vehicles, and the like, must wear protective footwear.

B. If any employee is required to work with heavy equipment, or load vehicles or the like, DNSWMA will provide $150.00 every other fiscal year for protective footwear. The payment will be made in August of every other year. New employee's initial payment will be paid to the new employee within thirty (30) days of employment. It is the responsibility of the employee to ensure compliance with the protective footwear policy.

C. All covered employees required to wear protective footwear must report to work, whether regularly scheduled or called out, with the appropriate footwear on their feet. Failure to

do so will restrict the employee from normal work duties requiring protective footwear and may result in disciplinary action. The employee will be required to obtain the protective footwear. Time away from work to obtain the protective footwear is not work time. Restriction from normal work duties may include assignment of those duties.

D. **Transfer Stations:** Permanent employees who are regularly assigned to work as refuse site attendants will be provided a fifty dollar ($50) allowance every other fiscal year for rain boots or waterproof shoes.

E. **Hazardous Waste collection event and heavy lifting footwear:** Permanent employees who are assigned to work in the 'Hot Zone' during hazardous waste collection events or whom are assigned to tasks requiring lifting 50 pounds or more will be provided an allowance of hundred and fifty dollars ($150) every other fiscal year for steel toed boots or equivalent protective footwear.

10.4 **Mileage:** An employee, who is authorized to use personal motor vehicle in the performance of official work, shall be reimbursed at the current applicable IRS rate for all miles driven.

A. For the purpose of reporting mileage, the mileage shall be as for a one-way trip as calculated by using Google Maps as the primary source and if the ending point of Google Maps does not fully reach the destination Google Earth Pro will be used to extend the route.

ARTICLE 11
LAYOFF AND RE-EMPLOYMENT

11.1 **Reason for Layoff**: Whenever, in the judgment of the Governing Board, it becomes necessary to reduce staffing levels, positions may be abolished and employees may be laid off. The Personnel Officer must notify each employee who is to be laid off, and the Union, in writing not less than thirty (30) calendar days prior to the effective date of layoff. During the thirty (30) day notice period, up to twenty (20) hours paid leave shall be granted to each employee being laid off to be away from work for job search purposes. Upon request of the Union, the Employer shall promptly meet with the Union to discuss the anticipated reduction in force and alternatives thereto.

11.2 **Notice of Reduction in Force**: The Personnel Officer shall send a written notice to each employee affected by a reduction in force at least thirty (30) calendar days prior to the effective date of the action. The notice shall include:

A. Reason for Layoff;
B. Classifications to which the employee has retreat rights to under section 11.6;
C. Effective date of the action;
D. Seniority score of the employee and the number of the employee on the seniority list;
E. Location of the Seniority list so the employee may compare their score with others;
F. Conditions governing retention on and reinstatement from reemployment lists;
G. Rules regarding waiver of reinstatement and voluntary withdrawal from the reemployment list.

11.3 **Seniority:** For the purposes of this section, each employee's seniority score is equal to the total number of hours worked as a permanent employee for this agency, the City of Crescent City or the County of Del Norte, or combination thereof.

11. 4 **Equal Seniority:** If two employees in the same class have the same final seniority score, the DNSWMA and the Union shall meet and confer to determine which employee has the greatest seniority.

11.5 **Temporary Positions:** No employee serving in a temporary extra-help or limited-term position may be retained if an employee in the same class is being laid off. No temporary employee may be hired into a class while permanent employees are on a reemployment list for the same class in the department. Employees on the reemployment list have priority for temporary positions.

11.6 **Retreat Rights:** An employee to be laid off from his/her position may elect to displace the least senior employee in their class. If there is no less senior employee, the employee may displace the least senior employee in a lower class which the employee to be laid off has served in a permanent status, if the employee to be laid off has more seniority than that employee in the lower class. An employee displaced by a more senior employee may likewise exercise retreat rights, in order of seniority. An employee displaced by a more senior employee exercising retreat rights has the same reemployment rights as an employee who is laid off. An employee who is to be laid off who chooses to exercise retreat rights must inform the Personnel Officer of that

decision in writing within five (5) working days of receipt of notice of layoff. Employees who exercise retreat rights will not be required to serve a probationary period in the class they retreat to.

A. An employee who retreats to a lower class will be placed at a step of the appropriate salary range which represents the least loss of pay. An employee may not be advanced to a longevity step (F, G, H or I) unless longevity has already been attained.

11.7 **Re-employment Rights:** Laid off employees, and employees displaced from their positions by more senior employees, and grant employees whose grants are cancelled or expire will be eligible for re-employment in the class held at the time of layoff for a period of eighteen (18) months from the effective date of layoff or displacement. Re-employment will be in the reverse order of layoff. Their employment will take precedence over hiring and transfers when a vacancy in the class of former placement comes available.

A. Employees on a re-employment list will have the same rights as active employees to seek transfers and promotions to vacant positions in other classes throughout the DNSWMA.

B. An employee who is reemployed in the same class from which he or she was laid off or displaces while he or she was on a re-employment list, will be restored to the same salary step held at the time of layoff or displacement. If the employee exercised retreat rights to a lower class at the time of layoff, salary step placement will be adjusted upward upon re-employment as if the employee had served that time in the original class. The time on the re-employment list will not be considered a break in service, except that the employee's original hire and anniversary dates will be adjusted to deduct the time off work.

C. The names of persons laid off or demoted will be entered upon re-employment lists for positions for which they are qualified. The list will be used when a vacancy arises in the same or lower classes before certification is made for an eligibility list.

11.8 **Reemployment Notice:** Whenever there is an active re-employment list, the DNSWMA will provide written notification of appropriate openings to employees on the list by first class mail, addressed to the employee's last known address. It is the employee's responsibility to keep the DNSWMA informed of his/her mailing address. DNSWMA's responsibility to provide notice hereunder is waived if a notice is returned to DNSWMA as undeliverable.

11.9 **Employee Response:** A laid off/displaced employee who accepts a re-employment offer is responsible for notifying the Personnel Officer of that fact in writing within five (5) days of receipt of a re-employment notice. An employee accepting re-employment will return to duty not later than thirty (30) calendar days following the date of intended re-employment announced by the Personnel Officer. The employee is responsible for notifying the Personnel Officer in writing of the time needed to return to duty.

11.10 **Wage, Hour and Working Condition Issues:** DNSWMA and the Union agree that layoffs and displacement may trigger problems among remaining employees in such areas as distribution of work of laid off employees, preservation of bargaining unit work within the unit, classification levels of remaining employees, workload and work scheduling problems, and similar issues. It is agreed that these issues will be addressed on a case-by-case basis, upon receipt by the DNSWMA or a request to meet and confer with the Union.

ARTICLE 12
GRIEVANCE PROCEDURES

12.1 **Purpose:** It is the purpose of this procedure to provide an avenue of communication through which an employee or groups of employees may have their complaint heard and decided in an orderly and timely manner.

12.2 **Definition of a Grievance:** A grievance is a complaint of an employee or group of employees alleging the violation, misinterpretation or misapplication of any provision of this Memorandum of Understanding, or working conditions within the control of the Appointing Authority, including rules and regulations, and disciplinary action for which no other procedure for orderly adjudication of the complaint exists.

12.3 **Definition of a Grievant:** The employee(s) within a bargaining unit represented by the Union alleging a grievance is the grievant.

12.4 **Timeline:** A grievance must be filed (Step Two) within thirty (30) calendar days after the event, or after the grievant becomes knowledgeable of the event, but in no case after sixty (60) days from the event. Time limits set forth herein may be extended by mutual written agreement between the DNSWMA and the grievant, or DNSWMA and the Union, in a represented grievance.

12.5 **Informal Grievance Procedure (Step One):** An employee, or group of employees must first discuss their grievance with the Appointing Authority. If, within five (5) working days, the Appointing Authority has not resolved the grievance to the satisfaction of the employee, the employee may submit his or her grievance in writing formally.

12.6 **Formal Grievance Procedure (Step Two):** The grievant may submit a formal grievance in writing on the form provided by the DNSWMA. Within ten (10) regular working days of receipt of the grievance, the Personnel Officer will investigate and provide a response in writing to the grievant. The response will include a complete statement of the Appointing Authority's position and the facts and evidence upon which it is based, and the remedy or correction which has been offered, if any. The grievance form, and any requests for hearing must be in writing and set forth the specific provision(s) of the MOU the grievant alleges has been violated, misinterpreted, or misapplied, and must set forth facts supporting the allegations and the resolution desired.

12.7 **Step Three:** If, within five (5) regular working days of receipt of the Personnel Officer's written response, the grievant disputes the resolution proposed, the grievant may request that the grievance be heard by a mediator from the California Mediation and Conciliation Service. This request must be in writing or on a form provided by the DNSWMA stating the reasons why the proposed resolution is still disputed. The outcome of this mediation will be advisory in nature.

12.8 **Step Four:** If, within ten (10) regular working days of receipt of the response of the mediator, the grievant disputes the proposed resolution, the grievant may request binding arbitration. The request for binding arbitration must be submitted to the Personnel Officer. An arbitrator may be selected by mutual agreement by the Union and the DNSWMA from local attorneys registered with the State Bar. Should the parties fail to agree on an arbitrator, they shall make a joint request to the State or Federal Conciliation Service for a list of five (5) qualified arbitrators from Del Norte or Humboldt Counties. If five (5) are not available, the remaining slots shall be qualified arbitrators who reside in Northern California or Southern Oregon. The arbitrator shall be selected

from a list by the parties alternately striking names, with the opportunity to strike first determined by chance.

All documentation supporting the parties' positions shall be filed at least ten (10) days before the hearing with the arbitrator.

The arbitrator shall not have the power to alter, amend, change, add to, or subtract any of the terms of this Memorandum of Understanding. The decision of the arbitrator shall be based solely upon the evidence and arguments presented to the arbitrator by the respective parties. The decision of the arbitrator shall be final and binding upon the parties.

The cost of employing the arbitrator shall borne equally by all parties. All other costs such as, but not limited to attorney's fee and witness fees shall be borne only by the party incurring that costs.

Court Report/ Transcript Fee: If a court reporter is requested, the requesting party is obligated to pay for services of the reporter. Cost of transcript copies shall be borne by those parties requesting copies.

12.9 **Non-Retaliation:** Employees who file a grievance or who participate in a grievance in any capacity, including as witnesses, will be free from retaliation as a result of filing or participating in a grievance. Retaliation protection is provided by state and federal laws.

12.10 **Performance Standards:** Employees who file grievances are not excused from performing their jobs to acceptable standards at all times during the processing or following a grievance.

12.11 **Right to Representation:** The Union will have the right to represent employees in grievances. Individual employees may process their own grievances without assistance from the union. Nothing in this MOU shall require the Union to represent a grievant that has filed a formal grievance at step two without Union representation in any subsequent proceeding.

12.12 **Employee Processed Grievances:** DNSWMA will provide the Union with a copy of the proposed resolution(s) to any grievances processed by employees without Union representation, except those grievances containing a confidential component. The Union will be granted five (5) business days to review the proposed resolution(s) prior to implementation, to determine that the proposed resolution(s) are in conformance with the terms of this MOU. Grievances processed without Union representation will not be precedent setting.

12.13 **Release Time for Witnesses:** DNSWMA will release from duty without loss of pay or benefits any employee called as a witness in any grievance hearing by the Union or an individual employee grievant.

ARTICLE 13
DISCIPLINE

13.1 **General Provisions:** Employees not subject to the provisions of Local Agency Personnel Standards (Government Code Title II, Administration, Division 5 [LAPS]), may be disciplined only in accordance with the provisions of this Article. Employees subject to LAPS may be disciplined only in accordance with the provisions of this Article and LAPS. In the event of conflict, the provisions of LAPS take precedence over this Article.

13.2 **Discipline:** Discipline means all personnel actions resulting from acts or omissions on the part of an employee consisting of written warnings, written reprimands, suspension without pay, demotion or dismissal. Permanent employees may be disciplined only for just cause. All reasonable efforts will be made to apply discipline progressively, to afford the employee a reasonable opportunity to correct deficient work practices or conduct. Newly-hired probationary employees may be suspended without pay, demoted or dismissed without the right to appeal or hearing. Promotional probationary employees who have previously achieved permanence in any class enjoy full due process rights established in this Article and in Section 6.5 of this MOU.

A. Written warnings and written reprimands may be challenged through the grievance procedure contained in Article XI of this MOU, but such disputes will not be subject to Step Four.

B. Discipline may not be imposed on a permanent employee for any cause if the Appointing Authority had knowledge of the conduct for more than six (6) months and failed to issue formal charges.

13.3 **Right to Representation:** Whenever disciplinary action is initiated by the Appointing Authority, the employee must be advised that s/he has a right to the presence of a representative, including the Union, at all stages of the proceedings, including, but not limited to, discussions and interrogations involving the employee, and at informal and formal disciplinary hearings.

13.4 **Clearance for Disciplinary Action:** Any proposed disciplinary action must be approved by the Personnel Officer prior to any action being taken, in order to insure conformity with the procedures established in this Article, and consistency in the severity of discipline applied.

13.5 **Leave Pending Investigation:** Only on approval of the Personnel Officer may an employee against whom charges have been served pursuant to Section 12.14, or who is under investigation for possible discipline, be placed on paid administrative leave pending an investigation.

13.6 **Short Suspension:** If formal charges are served on an employee, and the discipline recommended is a suspension without pay for five (5) working days or less, discipline may be imposed immediately. The employee may request a hearing on the charges. If requested, an informal and formal hearing will be conducted as provided for in Sections 12.17 and 12.18. If the charges are not sustained, and/or if the discipline is rejected at Arbitration, the employee will be compensated for those days of suspension without pay not upheld by the Arbitrator.

13.7 **Negative Evaluations:** A negative evaluation may not of itself constitute grounds for discipline of a permanent employee, however, the deficiencies in employee performance including conduct documented in a negative evaluation may constitute grounds for discipline, and may result in charges being brought against an employee under the provisions of this Article.

13.8 **Right to Seal Letter of Reprimand**: An employee has the right to request in writing that a letter of reprimand be sealed within the employee's personnel file if two (2) years has elapsed from the date of any reprimand. The Personnel Officer shall review the request and within fourteen (14) calendar days render a decision on the request. Should the employee disagree with the decision of the Personnel Officer, the employee has the right to pursue a remedy through the grievance procedure at Step 4.

13.9 **Disciplinary Documents:** All documents pertaining to a disciplinary action will become a permanent part of the employee's personnel file, provided that in the event disciplinary charges are not sustained through an appeal process, all references to the discipline will be removed from the personnel file at the written request of the employee.

13.10 **Performance Improvement Plan:** The purpose of a performance improvement plan is to provide the employee with an opportunity to improve performance to an acceptable level and ensure that the DNSWMA is using progressive discipline in all cases except those warranting termination. Accordingly:

A. Performance improvement plans may be prepared when an employee receives an evaluation at less than satisfactory level, and must be prepared when an employee receives a written warning, written reprimand, suspension without pay, or involuntary demotion.

B. The plan must contain clear, objective and measurable performance targets that are both reasonable and designed to help the employee perform at a satisfactory level.

C. The plan should include training if there are any deficiencies in the employee's knowledge or skills, and should not be punitive in nature.

D. The length of the performance improvement plan, and the terms thereof, must, in all cases, demonstrate that the DNSWMA is using a process of progressive discipline which is designed to provide an opportunity to actually correct deficiencies in performance. The Personnel Officer must approve of any performance improvement plan before it is implemented.

E. A performance improvement plan, along with any disciplinary documents, will become a permanent part of the employee's personnel file. The performance improvement plan will be prepared by the appointing authority and be subject to the approval of the Personnel Officer prior to delivery to the employee.

F. The plan will also describe the necessary consequences of failing to abide by the performance improvement plan, failure to improve, or repeating the same violation within the time frame of the plan. A Performance improvement plan may become a basis for progressive discipline if the violation or act that generated the plan is repeated.

G. At the end of the performance improvement plan, the appointing authority will either file a notation in the personnel file that the employee has successfully completed the performance improvement plan, and improved performance to an acceptable level, or if performance has not improved, the Appointing Authority may revise the performance improvement plan for an additional period, or the Appointing Authority may refer the employee to progressive discipline. In no case may a performance improvement plan last longer than six (6) months.

13.11 **Grievability:** The allegations, contents and outcomes of disciplinary action are not grievable. However, alleged procedural violations of this Article must be raised as part of the disciplinary proceedings rather than under the grievance procedure set forth in the previous Article.

13.12 **Grounds for Disciplinary Action:** The following constitute grounds for disciplinary action:

A. Conviction of a felony.
B. Misappropriation of public funds or property.
C. Misconduct.
D. Intentional or neglectful misuse of public property resulting in increased maintenance or repair costs or a reduction in service life of the equipment.
E. Use of DNSWMA property not related to job function or for personal gain.
F. Failure to improve substandard performance.
G. Discourteous, discriminatory, offensive or abusive treatment of the public or fellow employees.
H. Drinking alcoholic beverages or use of controlled substances without a prescription on the job, or arriving on the job under the influence of alcohol or controlled substances without a prescription.
I. Habitual absenteeism or tardiness.
J. Absence without notification as defined in Section 5.5 of this MOU.
K. Abuse of sick leave or any other paid leave.
L. Disorderly conduct.
M. Incompetence or inefficiency in the performance of assigned duties.
N. Being wasteful of material, property or working time.
O. Insubordination, including, but not limited to, refusal to perform assigned tasks.
P. Violation of any lawful, safe and reasonable order or written regulation made or given by an employee's supervisor or higher DNSWMA authority.
Q. Neglect of duty.
R. Dishonesty.
S. Fraud in securing employment.
T. Gross Misconduct.
U. Refusal or failure to comply with safety rules and/or regulations, including drug and alcohol policies, promulgated by any governmental agency with jurisdiction.
V. Refusal to take a medical examination legally required by DNSWMA.
W. Serious physical or mental disability which prevents the employee from performing the essential functions of the position, even with reasonable accommodation for the disability.
X. Failure to maintain any formal licensing or certification required for the employee's position.
Y. Falsification of DNSWMA records.
Z. A violation of another person's constitutional rights.
AA. Knowing and intentional disclosure of information that is confidential by law or written DNSWMA policy.
BB. Engaging in threats or violence, direct, indirect, implied or actual, against co-workers or any other person in connection with DNSWMA business.

13.13 **Disciplinary Procedure:** Discipline may be imposed for the violation of any provision of Section 12.11. A written warning may be given for the first or a relatively minor infraction, and will specify the details of the offense and may include a performance improvement plan. A written reprimand may be given for repeated offenses or an offense of increased severity, and will specify the details of the offense(s) and include a performance improvement plan. If a suspension without pay of five (5) working days or less is proposed, the following procedure and the provisions of Sections 12.6 apply. If suspension without pay for more than five (5) working days, demotion or dismissal is proposed, the following procedure applies.

13.14 **Written Notice of Charges:** When the Appointing Authority determines that sufficient grounds exist for imposing discipline on an employee, and following clearance by the Personnel Officer, the Appointing Authority shall prepare and provide to the employee a written notice of charges five (5) days prior to the proposed effective date. The notice must contain the following information:

A. The provisions of Section 12.11 cited as Grounds for Disciplinary Action.
B. A statement of the specific acts or omissions upon which the discipline is based, including the names, dates, times, locations and circumstances of the alleged offense(s), unless the information is privileged, stated in clear and concise language. The statement must be sufficiently specific as to fully inform the employee of the nature of the charges against him/her.
C. A statement that a copy of all non-privileged materials upon which the discipline is based are attached or available for inspection upon request.
D. A description of the proposed discipline and its effective date(s).
E. A statement advising the employee of the right to request a hearing on the charges, and the time frame in which such a request must be made.
F. A statement advising the employee of the right to representation at any and all disciplinary proceedings.
G. A blank "Response to Charges and Request for Hearing" form, the signing and return of which to the Personnel Officer constitutes activation of the hearing process.

13.15 **Service of Written Notice:** All notices of proposed discipline must be personally served upon the employee, or mailed by certified mail, return receipt requested, to the last known address of the employee. Refusal to acknowledge receipt of the written notice does not preclude response time referenced in Sections 12.15 and 12.16 below.

13.16 **Employee Response:** The employee may deny all of the charges and request a hearing on the charges by delivering a written statement which includes the grounds for denial of charges to the Personnel Officer within five (5) regular working/business days of the date of receipt of the charges. This statement may be made on the form provided for that purpose along with the charges, or on a separate piece of paper, signed and dated by the employee.

13.17 **Failure to Respond:** If the employee fails to request a hearing within five (5) business days of receipt of the charges, the right to a hearing is waived, and the Appointing Authority may impose discipline upon the employee, with the approval of the Personnel Officer.

13.18 **Informal (Skelly) Hearing:** If the employee requests a hearing on the charges, the Personnel Officer will schedule an informal hearing at which the employee may answer and refute the charges, present mitigating evidence or otherwise respond to the charges. The Personnel Officer must issue an opinion and decision within ten (10) business days of the hearing. If the Personnel Officer finds that the discipline proposed is not justified, the Personnel Officer may order the charges rejected and the employee is exonerated with full salary and benefits. The Personnel Officer may also reduce the severity of discipline proposed or imposed under Section 12.6. If this occurs, the employee may still choose to go forward to a formal hearing on the charges. It is the intent of the parties that all disputes be resolved at the lowest administrative level possible.

13.19 **Formal Hearing:** If the employee is dissatisfied with the Personnel Officer's decision, the employee must notify the Personnel Officer within ten (10) business days after the Personnel Officer's decision has been mailed or delivered to the employee. The Personnel Officer will

arrange for a formal hearing on the charges. The Union and DNSWMA may agree to a hearing officer; if they do not, they must select an arbitrator as provided below:

A. The parties may agree to an arbitrator. If they cannot agree on selection of the arbitrator, they will make a joint request to the State Conciliation Service for a list of five (5) qualified arbitrators. The arbitrator will be selected from the list by alternatively striking names, with the opportunity to go first decided by chance.

B. The parties will submit briefs and documents to the arbitrator at least ten (10) business days before the hearing.

C. The arbitrator will not be empowered to alter, amend, change, add to or subtract from any of the terms of this MOU. The decision of the arbitrator must be based solely upon the evidence and arguments presented by the parties to the arbitration. The decision will be final and binding upon the parties.

D. The parties will share equally the cost of the arbitration. Each party will bear its own witness and/or attorney fees. If a court reporter is requested, the party requesting the reporter will bear that cost. Any party requesting a copy of the transcript will bear the costs thereof. Because of the impact of *Florio v. City of Ontario*, (05 CDOS 6192), in cases where the hearing arises directly from imposed or proposed discipline against the employee, DNSWMA will bear the entire cost of the arbitration, but parties will continue to bear their own attorney's fees and/or witness fees.

13.20 **Conduct of Hearing:** The employee may request either an open or closed hearing at his/her discretion. The technical rules of evidence will not apply, but oral testimony will be taken only on oath or affirmation. Any relevant evidence will be admitted if it is the sort of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of this evidence over objection in a civil action. Hearsay evidence may be used for the purposes of supplementing or explaining other evidence, but will not be sufficient to support a finding unless it would be admissible over objection in a civil action under the California Evidence Code. The rules of privilege will be effective to the extent that they are otherwise required by statute to be recognized at the hearing, and irrelevant and unduly repetitious evidence should be excluded.

A. Each party will have these rights: to call and examine witnesses; to introduce exhibits; to cross-examine opposing witnesses on any matter relevant to the issues even though the matter was not covered in the direct examination; to impeach any witness regardless of which party first called him/her to testify; and to rebut the evidence against him. If the employee does not testify on his/her own behalf, he or she may be called and examined as if under cross-examination.

B. DNSWMA will open the case and present evidence in support of the discipline proposed or imposed under Section 12.6. DNSWMA will have the burden of proving charges by a preponderance of the evidence.

C. Relevant documents which are part of the employee's personnel file, and those constituting the disciplinary action being appealed and upon which the DNSWMA intends to rely in presenting its case, may be admitted as evidence in the hearing.

D. The employee may present his/her case in person or through a representative of his/her choice.

E. The hearing must be recorded verbatim by a court reporter, who will be compensated by the DNSWMA. The costs of any transcript ordered will be borne by the party ordering the transcript.

F. The costs of the hearing officer will be borne by County.

G. The decision of the hearing officer will be final and must be submitted within ten (10) business days. The arbitrator will issue a finding on each charge and specification

individually, and on the charges as a whole. The decision will be final and binding on the parties.

13.21 **Negotiated Settlement:** At any point in the proceedings the Personnel Officer and the employee and his/her representatives, if any, may negotiate, compromise, and/or settle any dispute concerning discipline. The employee should be granted a reasonable amount of time to have any proposed settlement reviewed by a representative of his/her choice before agreeing to and signing the settlement. Any negotiated settlement must be reduced to writing, and will become a permanent part of the employee's personnel file.

13.22 **Termination of a Grant or Temporary Extra-Help or Limited-Term Employee:** A grant or extra-help or limited-term temporary employee may be terminated at any time without right of appeal or hearing, except as otherwise may be provided by law. In case of termination the Appointing Authority must provide the employee written notice of the reason for termination.

ARTICLE 14
LABOR-MANAGEMENT

In order to encourage open communications, harmonious relations, and constructive problem solving, the DNSWMA and Union agree to meet on an annual basis to discuss items of mutual concern. To this purpose, two representatives from the Union, one of whom shall be the Union President, and two representatives from the DNSWMA, one of whom shall be the Executive Director, will meet at a time and date set by mutual agreement. Agenda items may be submitted by either party and will be mutually agreed upon. In no case may formal grievances or negotiations proposals be on the agenda. The Labor-Management meeting is advisory and has no authority to add to, delete from, or to modify the current Memorandum of Understanding.

ARTICLE 15
EFFECT OF MEMORANDUM OF UNDERSTANDING

It is understood that the specific provisions of this MOU shall prevail over DNSWMA practices and procedures to the extent permitted by California law, and that in the absence of specific provisions in this MOU, such practices and procedures are discretionary on the part of the DNSWMA. Unless specifically waived in this MOU, DNSWMA specifically reserves its right to make decisions relating to the merits, necessity or organization of any service or activity as authorized in Government Code section 3504.

ARTICLE 16
ARTICLE/SECTION REPLACEMENT PROVISION

If any provisions of this MOU are held to be contrary to the law by agreement of the parties or by a court of competent jurisdiction, those provisions will be deemed severed, except to the extent permitted by law, but all other provisions will remain in force and effect. If the event that any Article or Section of this MOU is held contrary to law, DNSWMA and the Union must meet and confer within thirty (30) days after the holding comes to the attention of the parties for the purpose of arriving at a mutually satisfactory and legally enforceable replacement for that Article or Section.

ARTICLE 17
REOPENER

17.1 **Changes in Law.** DNSWMA may reopen negotiations whenever there is a change in the Public Employees' Pension Reform Act (PEPRA), the Affordable Healthcare Act (ACA) or any other applicable state or federal law that renders, or will render, provisions of this MOU invalid. The reopening of negotiations will be limited to the issue affected by the change in law.

17.2 **Health and Welfare Benefits.** The parties agree to meet and confer as soon as practicable on any substantive changes made to the Health and Welfare Benefits by the County that will directly affect DNSWMA employees.

17.3 **Mutual Consent.** Reopening of this agreement on any issue may also occur by mutual consent of both parties.

ARTICLE 18
NEUTRALITY AGREEMENT

DNSWMA and the Union agree to abide by all applicable California Codes and regulations of PERB, with reference to employee organization. DNSWMA agrees that it will not threaten to impose or impose reprisals on any employees, discriminate or threaten to discriminate against any employees nor otherwise interfere with, restrain or coerce the right of any employee to select a recognized employee organization. DNSWMA will not attempt to dominate or interfere with the formation, selection, administration, or decertification of any employee organization nor contribute financial or any other support to any employee organization nor in any way encourage or attempt to influence employees to join any organization in preference to any other.

The Union agrees that it will not impose or threaten to impose reprisals on employees, to discriminate or threaten to discriminate against any employees, or otherwise interfere with, restrain or coerce employees because of their exercise of rights guaranteed by the California Codes and Federal regulations.

Nothing in this agreement may be construed to limit the freedom of speech or association of any individual. The parties agree that if either party believes that the other has violated, is violating, or is about to violate this neutrality agreement, prior to filing with PERB, the aggrieved party must provide at least four (4) working hours notice of such belief to the administration or leadership of the other party. Neither party may file with PERB unless such notice has been given.

ARTICLE 19
UNION SECURITY

19.1 Agency Shop:

A.) Condition of Employment

All workers in the unit who, as of the effective date of this Agreement, have authorized Union dues shall have such deduction continued.

As a condition of employment, all new workers who become covered by this contract on or after the effective date of the Agreement shall at the time of hire into a classification covered by this agreement elect to be either: (1) member, or (2) an agency fee payer.

As a condition of employment, all existing workers covered by this contract on or after the effective date of this Agreement shall elect to be either: (1) member, or (2) an agency fee payer.

The Employer shall deduct from workers' paychecks and transmit to the Union dues and agency fees at the various rates the Union shall, from time to time, specify. The Employer and the Union shall work cooperatively together to agree upon procedures to implement the agency fee system.

B.) Involuntary Deduction

If any worker fails to authorize one of the above deductions either within thirty (30) days from the time of entry into a classification covered by this bargaining unit, or if an existing worker, within thirty (30) days following the effective date of this Agreement, the Employer shall involuntarily deduct the agency fee from the worker's paychecks beginning with the pay period following entry into the unit, at the rate specified by the Union. The Union shall inform the Employer of any changes to that rate.

C.) Reinstatement

Upon the reinstatement of any worker, or upon the recalling of any worker from layoff status, the Employer will resume or initiate dues, or agency fee deduction, at the rate specified by the Union, for such worker in accordance with Section (b) of this Article.

19. 2 Other Deductions:

The Employer shall make other deductions for insurance programs and COPE from paychecks of workers upon the request of SEIU Local 1021.

DEL NORTE SOLID WASTE
MANAGEMENT AUTHORITY

_____
Tedd Ward, M.S.
Director

_____

_____

_____

EMPLOYEE'S ASSOCIATION/
SEIU Local 1021

_____
Rita Schmitt, Chapter President

_____
Aaron Burton
Field Representative

_____
Lisa Maldonado,
Regional Director

_____
John Stead-Mendez
Executive Director

Approved and adopted this _____ day of _____, 2016 by the Del Norte Solid Waste Management Authority Board of Commissioners.

_____
Martha McClure, Chair
DNSWMA Board of Commissioners

ATTEST:

_____
Katherine Brewer, Clerk of the Board

APPROVED AS TO FORM:

_____
Martha Rice, Legal Counsel

ATTACHMENT A
LIST OF CLASSIFICATIONS COVERED BY THIS MOU

Refuse Site Attendant
Account Clerk – Solid Waste

ATTACHMENT B
Health Care Plan Book

PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM TO:

Delta Health Systems
1234 W. Oak Street
Stockton, CA 95201

We, the Plan Sponsor, recognize that we have full responsibility for the contents of the Benefit Document and that, while the Contract Administrator, its employees and/or subcontractors, may have assisted in the preparation of the document, we are responsible for the final text and meaning. We further certify that the document has been fully read, understood, and describes our intent with regard to our employee welfare plan.

Plan Sponsor/Plan Administrator: County of Del Norte

_____ Date

Signed (authorized representative of Plan Sponsor)

• • • • •

THIS DOCUMENT WAS NOT PREPARED OR REVIEWED BY AN ATTORNEY AND IS NOT INTENDED AS LEGAL ADVICE.

COUNTY OF DEL NORTE

SUMMARY PLAN DESCRIPTION

OF THE

MEDICAL, PRESCRIPTION & DENTAL BENEFITS

NOTE: THESE BENEFITS ARE PART OF THE "COUNTY OF DEL NORTE GROUP HEALTH PLAN" – PLAN # 501

ORIGINAL EFFECTIVE DATE: JANUARY 1, 2007
RESTATED EFFECTIVE: JANUARY 1, 2015

Contract Administrator:
Delta Health Systems
Stockton, California

COBRA NOTIFICATION PROCEDURES

It is a Plan participant's responsibility to provide the following Notices as they relate to COBRA Continuation Coverage:

Notice of Divorce or Legal Separation - Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee from his or her spouse.

Notice of Child's Loss of Dependent Status - Notice of a Qualifying Event that is a child's loss of Dependent status under the Plan (e.g., a Dependent child reaching the maximum age limit).

Notice of a Second Qualifying Event - Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.

Notice Regarding Disability - Notice that: (a) a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the Social Security Administration to no longer be disabled.

Notice Regarding Address Changes – It is important that the Plan Administrator be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become Qualified Beneficiaries.

Notification must be made in accordance with the following procedures. Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Form, Content & Delivery – Notification of a Qualifying Event must be made, in writing, on a "Notification of a COBRA Qualifying Event or Social Security Disability" form. Notification must include evidence that a Qualifying Event or other event allowing extended coverage has occurred (e.g., copy of divorce decree, copy of child's birth certificate, copy of the Social Security Administration's disability determination letter).

Notification of an address change must be provided on an "Address Notification Form."

Notification forms must be sent to and received by:

Delta Health Systems
Eligibility Department
P.O. Box 1147 Stockton, CA 95201-1147

Contact Delta Health Systems at (800) 422-6099 with any questions regarding the above procedures.

Time Requirements for Notification -In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide Notice through the Summary Plan Description or the Plan Sponsor's General COBRA Notice. If Notice is not received within the 60-day period, **COBRA Continuation Coverage** will not be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered Employee or Qualified Beneficiary is advised of the Notice obligation through the SPD or the Plan Sponsor's General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date such Qualified Beneficiary is subsequently determined by the Social Security Administration to no longer be disabled.

The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

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IMPORTANT INFORMATION

WHO TO CONTACT FOR ADDITIONAL INFORMATION

A Plan participant can obtain additional information about coverage of a specific drug, treatment, procedure, preventive service, etc. from the office that handles claims on behalf of the Plan (the "Contract Administrator"). See the first page of the **General Plan Information** section for the name, address and phone number of the Contract Administrator.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

This group health plan believes this plan is a "Grandfathered Health Plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered Health Plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to Other Plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from Grandfathered Health Plan status can be directed to the Plan Administrator at the following address:

County of Del Norte
981 H Street, Suite 250
Crescent City, CA 95531

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to Grandfathered Health Plans.

THE 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 delivery. 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).

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under Federal law, group health plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas.

Plan participants must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the Women's Health and Cancer Rights Act (WHCRA).

DEFINITIONS

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the **Definitions** section. When reading this document, it will be helpful to refer to this section. Becoming familiar with the terms defined therein will provide a better understanding of the benefits and provisions.

NOTICE OF RIGHT TO RECEIVE A CERTIFICATE OF CREDITABLE COVERAGE

Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates, the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

DIRECTORY OF SERVICE PROVIDERS

The following providers render services on behalf of the Plan. A Plan participant can contact the appropriate office when they have a question or needs help.

TYPE OF SERVICE PROVIDER

Plan Sponsor / Plan Administrator Interprets the Plan, answers eligibility questions. Provides claims forms and ID cards. Receives COBRA payments.	**County of Del Norte** 981 H Street, Suite 250 Crescent City, CA 95531 (707) 464-7213
Contract Administrator Handles claims and eligibility determinations. A Plan participant can also obtain additional information about Plan coverage of a specific drug, treatment, procedure, preventive service, etc. from the Contract Administrator.	**Delta Health Systems** 1234 West Oak Street / P. O. Box 551 Stockton, CA 95201-0551 Phone: (209) 948-8483 or (800) 422-6099 www.deltahealthsystems.com
Utilization Management Administers the **Utilization Management Program** (e.g., pre-admission and review requirements).	**Delta TeamCare** P.O. Box 1147 Stockton, CA 95204-1147 (877) 464-1441
Network Provides a Network of providers contracted to provide services at discounted rates. If Covered Person's personal Physician is not a Network provider, application for membership can be made.	**First Health**
Prescription Drug Vendor Provides prior authorization for specific medications. Supplies replacement prescription cards. Processes claims for prescriptions purchased outside of the network. Transfer existing prescriptions from a different pharmacy. Reorder medication(s) previously filled by PPS.	**National Medical Health Card Systems, Inc., (NMHC)** 9343 Tech Center Drive, Suite 200 Sacramento, CA 95826-2592 (800) 777-0074 – Customer Care **Postal Prescription Services (PPS)** P.O. Box 2718 Portland, OR 97208-2718 (800) 552-6694 www.ppsrx.com

UTILIZATION MANAGEMENT PROGRAM

The Plan includes a **Utilization Management Program** as described below. The purpose of the program is to encourage Covered Persons to obtain quality medical care while utilizing the most cost efficient sources.

PRE-SERVICE REVIEW REQUIREMENTS

The Plan Sponsor has contracted with an independent organization to provide pre-service review. The name and phone number of the organization is shown on the Employee's coverage identification card.

Compliance Procedures - The procedures outlined below should be followed to avoid a possible penalty:

Inpatient Admission - Except as noted, prior to any non-emergency admission to a Hospital or Skilled Nursing Facility (including admissions for mental health and substance abuse), the Covered Person or someone acting on their behalf must contact the Utilization Management Organization for pre-service review and authorization.

For an emergency admission, the Utilization Management Organization must be contacted within 72 hours after admission. An emergency admission is one that involves the sudden onset of severe medical symptoms that: (1) could not have been reasonably anticipated, (2) requires immediate medical treatment, or (3) can be considered life-threatening.

If, in the opinion of the patient's Physician, it is necessary for the patient to be confined for a longer time than initially authorized, the Physician may request that additional days be authorized by contacting the Utilization Management Organization no later than the last authorized day.

NOTE: Pre-service review will not be required for an Inpatient admission for Pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. However, if/when the Pregnancy confinement for the mother or newborn is expected to exceed these limits, pre-service review for such extended confinement is required.

Durable Medical Equipment – Prior to the purchase or rental of durable medical equipment where the cost will exceed $500, the Utilization Management Organization should be contacted for pre-service review and authorization.

Home Health Care / Home Hospice Care – Prior to beginning a program of home health care or home Hospice care, the Utilization Management Organization must be contacted for pre-service review and authorization.

Nursing Services – Pre-service review is required prior to receiving services of a registered nurse (RN).

Outpatient Surgery - Prior to any elective (non-emergency) surgery performed in the Outpatient department of a Hospital or an Ambulatory Surgical Facility, the Utilization Management Organization must be contacted for pre-service review and authorization.

NOTE: Pre-Admission review is not required for retirees or Dependents of retirees who are age 65 or older.

Penalty for Non-Compliance -If the above pre-service review requirements are not completed for an Inpatient admission, Home Health Care / Home Hospice Care, Nursing Services or an Outpatient Surgery, then benefits otherwise payable will be reduced by 50%, to a maximum benefit reduction of $500.

No penalty will be applied for failure to pre-authorize Durable Medical Equipment.

Any additional share of expenses that becomes the Covered Person's responsibility for failure to comply with these requirements will not be considered eligible medical expenses and thus will not apply to any deductibles, coinsurance or out-of-pocket maximums of the Plan.

See "Pre-Service Claims" in the **Claims Procedures** section for more information, including information on appealing an adverse decision (i.e. a benefit reduction) under this program.

NOTE: The Plan will not reduce or deny a claim for failure to obtain a prior approval under circumstances that would make obtaining pre-service review impossible or where application of the pre-service review process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time medical treatment is required).

MORE INFORMATION ABOUT PRE-SERVICE REVIEW

It is the **Employee's or Covered Person's responsibility** to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact the review organization to make certain that the facility or attending Physician has initiated the necessary processes.

Pre-service review and authorization is **not a guarantee of coverage**. The **Utilization Management Program** is designed ONLY to determine whether or not a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the **Utilization Management Program** will increase benefits to cover any confinement or service that is not Medically Necessary or that is otherwise not covered under the Plan.

MEDICAL BENEFIT SUMMARY

CHOICE OF PROVIDERS

The Plan Sponsor has contracted with an organization or "Network" of health care providers. When obtaining health care services, a Covered Person has a choice of using providers who are participating in that Network or any other Covered Providers of their choice (Non-Network providers).

Network providers have agreed to provide services to Covered Persons at negotiated rates. When a Covered Person uses a Network provider their out-of-pocket costs may be reduced because they will not be billed for expenses in excess of those rates. The Plan may also include other benefit incentives to encourage Covered Persons to use Network providers whenever possible - see the Schedule of Medical Benefits, below.

The Plan Sponsor will automatically provide a Plan participant with information about how they can access a directory of Network providers. This information will be provided without charge. The directory will be available either in hard copy as a separate document, or in electronic format. Since certain covered services and supplies may not be available through the Network, a Covered Person should refer to the Network list or directory to determine if any particular specialty is included.

Although there may be circumstances when a Network provider cannot be used, Non-Network provider services will be covered at the Non-Network benefit levels. However, if a Covered Person is admitted to a Non-Network Hospital on an emergency basis for a condition which requires immediate treatment to prevent loss of life, any such expenses will be paid at Network benefit levels until the patient's condition has been stabilized to the point that they could be transferred to Network provider care. Thereafter, the Covered Person must be transferred to Network provider care (transfer will be at the Plan's expense) or Non-Network benefit levels will commence.

BALANCE-BILLING

In the event that a claim submitted by a Network or non-Network provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance-billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance-billing is legal in many jurisdictions, and the Plan has no control over non-Network providers that engage in balance-billing practices.

In addition, with respect to services rendered by a Network provider being paid in accordance with a discounted rate, it is the Plan's position that the Covered Person should not be responsible for the difference between the amount charged by the Network provider and the amount determined to be payable by the Plan Administrator, and should not be balance-billed for such difference. Again, the Plan has no control over any Network provider that engages in balance-billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network provider.

The Covered Person is responsible for payment of co-insurances, deductibles, and out-of-pocket maximums and may be billed for any or all of these.

CLAIMS AUDIT

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Benefit Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Benefit Document.

SCHEDULE OF MEDICAL BENEFITS

MAXIMUM LIFETIME BENEFIT	Unlimited
CALENDAR YEAR DEDUCTIBLES	
Individual Deductible	$400
Family Maximum Deductible	$700

Individual Deductible - The Individual Deductible is an amount a Covered Person must contribute toward payment of eligible medical expenses. The Deductible usually applies before the Plan begins to provide benefits.

Family Maximum Deductible - If $700 in eligible medical expenses is incurred collectively by family members during a Calendar Year and is applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and their covered Dependents.

Deductible Carry-Over – Eligible Expenses incurred in the last 3 months of a Calendar Year and applied toward that year's Deductible can be carried forward and applied toward the person's Deductible for the next Calendar Year. Nevertheless, the Individual Deductible amount must be satisfied with expenses incurred within a 12-month period.

Common Accident Provision – If 2 or more Covered Persons who are members of the same family are injured in the same accident, only 1 Individual Deductible will be taken from the total eligible medical expenses incurred as the result of such accident during the Calendar Year in which the accident occurred. The Individual Deductible requirement for each member of the family who is involved in the accident will be credited with a pro-rata share of the 1 Individual Deductible amount applied to accident-related expenses.

OUT-OF-POCKET MAXIMUMS	Network	Non-Network
Individual Out-of-Pocket Maximum	$2,000	$4,000
Family Out-of-Pocket Maximum	$4,000	$7,000

Individual Out-of-Pocket Maximum - Except as noted, a Covered Person will not be required to pay more than $4,000 (or $2,000 for Network services and supplies) toward their share of Eligible Expenses that are not paid by the Plan. Once they have paid their out-of-pocket maximum, their Eligible Expenses will be paid at 100% for the balance of the Calendar Year.

Family Out-of-Pocket Maximum - Except as noted, a covered family (Employee and their Dependents) will not be required to pay more than $7,000 (or $2,000 for Network services and supplies) toward their Eligible Expense obligations. Once the family has paid their out-of-pocket maximum, their Network Eligible Expenses will be paid at 100% for the balance of the Calendar Year.

NOTE: The out-of-pocket maximums do not apply to or include:

amounts applied or paid to satisfy any Deductible or Co-Pay requirements;

expenses which become the Covered Person's responsibility for failure to comply with the requirements of the **Utilization Management Program.**

ELIGIBLE MEDICAL EXPENSES	Network	Non-Network
Chiropractic Care	80%	60%
Limited to 15 visits per Calendar Year.		
Durable Medical Equipment	80%	60%
Home Health Care / Home Hospice Care	80%	60%
Limited to 100 visits per Calendar Year. Each visit by a home care provider will count as 1 visit.		
Hospital Services		
Inpatient Care (non-newborn)	80%	60%
Newborn Nursery Care, Routine	100%	60%
Emergency Room Care, per use – see NOTE	$100 Co-Pay, then 80%	$100 Co-Pay, then 60%
Other Outpatient Services & Supplies	80%	60%
Eligible Expenses for Inpatient room and board are limited: (1) at a Network Hospital, to the Network negotiated rates and, (2) at a Non-Network Hospital, to the Semi-Private Room Charge (see Definitions) or the actual charge for Medically Necessary use of an Intensive Care Unit. NOTE: The emergency room Co-Pay is waived if the Covered Person is admitted to the Hospital directly from the emergency room.		
Learning Impairment	80%	60%
A "benefit period" is a 6-month period that starts on the day a covered child first incurs a treatment charge. The charge must not belong to a prior benefit period. If a child is in a benefit period when their coverage ends, the provisions of this benefit will still apply, but only until the end of the benefit period. A charge is deemed incurred when the treatment is performed or supplies are purchased. If a charge is made for a total treatment program, the charge will be prorated to determine a daily charge.		
Mental Health Care – Inpatient & Outpatient	80%	60%
Physician Services	80%	60%
Pre-Admission Testing	(See "Diagnostic Lab & X-Ray, Outpatient")	
Prescription Drugs, Outpatient		
Retail Feature		
Generic Drug	$15 Co-Pay†	
Formulary Brand-Name Drug	$35 Co-Pay†	
Non- Formulary Brand-Name Drug	$55 Co-Pay†	
Mail-Order Option		
Generic Drug	$20 Co-Pay†	
Formulary Brand-Name Drug	$70 Co-Pay†	
Non- Formulary Brand-Name Drug	$110 Co-Pay†	

ELIGIBLE MEDICAL EXPENSES	Network	Non-Network
Prescription drug coverage involves a program through an independent vendor. To use the retail feature, a Covered Person takes their drug ID card to a participating pharmacy to fill their prescription order. A retail prescription can be purchased in up to a 30-day supply for the Co-Pays shown. A mail-order option is included for maintenance (longer-term) drugs. Mail-order drugs are available in up to a 90-day supply for the Co-Pays shown. If a Covered Person fills a prescription at a non-participating pharmacy, they must pay the full charge of the prescription and submit a claim form to the vendor for reimbursement. A list of covered and excluded drugs is provided elsewhere in this document or is available from the Plan Sponsor. NOTE: The full terms and conditions of the prescription drug program are not described herein but are as determined between the Plan Sponsor and the organization(s) offering the program(s). Further information should be obtained from the Employer's personnel office or the office of the Plan Sponsor.		
Preventive Care	100%†	80%†
Preventive care includes: periodic well child check-ups; immunizations & health screenings; 1 routine Pap smear per 12-month period, or as recommended by a Physician; 1 routine mammogram per 12-month period, or as recommended by a Physician; 1 routine prostate screening per 12-month period, or as recommended by a Physician; an annual flu shot; Colonoscopy is covered under the preventive benefit and is payable at 80% for in network and 60% out of network once the member deductible is met.		
Skilled Nursing Facility		
First 20 Days of Confinement, per Calendar Year	90%	70%
Thereafter	80%	60%
Eligible Expenses for room and board are limited to the facility's Semi-Private Room Charge. Coverage is limited to 120 days per Calendar Year.		
Smoking Cessation	50%	50%
Limited to 1 treatment per Lifetime.		
Speech Therapy	80%	60%
Substance Abuse Care– Inpatient & Outpatient	80%	60%
Weight Control (Bariatric Surgery)	Benefits not to exceed $25,000.00	

ELIGIBLE MEDICAL EXPENSES	Network	Non-Network
Also, benefits for bariatric surgery are available only after an individual has been enrolled in the Plan for at least three (3) years.		
All Other Eligible Medical Expenses	80%	60%

† Calendar Year Deductible does not apply.

ABOUT THE SCHEDULE...

The percentages shown in the schedule reflect the amounts the Plan pays of Eligible Expenses after any required Deductible or Co-Pay has been applied. The percentages apply to "Usual, Customary and Reasonable" charges. For Network providers, this means that the percentages apply to the negotiated rates. See "Usual, Customary and Reasonable" in the **Definitions** section for more information.

A "Co-Pay" is an amount the Covered Person must pay. Co-Pays are usually paid to the provider at the time of service.

THIS IS A SUMMARY ONLY. SEE THE **ELIGIBLE MEDICAL EXPENSES** AND **MEDICAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

IMPORTANT: CERTAIN SERVICES AND/OR SUPPLIES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions that are covered by the Plan. This section must be read in conjunction with the **Medical Benefit Summary** to understand how Plan benefits are determined (e.g., application of Deductible and Co-Pay requirements and benefit sharing percentages). All medical care must be received from or ordered by a Covered Provider.

Except as otherwise noted below or in the **Medical Benefit Summary**, eligible medical expenses are the Usual, Customary and Reasonable charges for the items listed below and that are incurred by a Covered Person - subject to the **Definitions**, **Limitations and Exclusions** and all other provisions of the Plan. In general, services and supplies must be approved by a Physician or other appropriate Covered Provider and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition.

For benefit purposes, medical expenses will be deemed to be incurred on:

the date a purchase is contracted; or

the actual date a service is rendered.

Alcoholism - see "Substance Abuse Care"

Allergy Testing & Treatment - Allergy testing and treatment, including allergy injections.

Ambulance – Medically Necessary ambulance service, including the base charge, mileage and supplies, to transport a Covered Person to and from the nearest Hospital where treatment can be given.

Transport of a Covered Person to the nearest Hospital where special treatment can be given when such treatment is not locally available. Eligible Expense includes charges made by an ambulance service, railroad or regularly scheduled airline.

NOTE: Transportation is not covered when provided outside of the United States or Canada, or when undertaken to secure the services of a Physician or group of Physicians or institution of greater renown or degree of specialization.

Ambulatory Surgical Center - Services and supplies provided by an Ambulatory Surgical Center (see **Definitions**) in connection with a covered Outpatient surgery.

Anesthesia -Anesthetics and services of a Physician or certified registered nurse anesthetist (CRNA) for the administration of anesthesia.

Birthing Center - Services and supplies provided by a Birthing Center (see **Definitions**) in connection with a covered Pregnancy.

Blood -Blood and blood derivatives (if not replaced by or for the patient), including blood processing and administration services.

Chemical Dependency - see "Substance Abuse Care"

Chemotherapy -Professional services and supplies related to the administration of chemical agents in the treatment or control of a Sickness.

Chiropractic Care - Musculoskeletal manipulation and modalities (e.g. hot & cold packs) provided by a chiropractor (DC) to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain.

NOTE: Routine or maintenance treatments are not covered.

Diagnostic Lab & X-ray, Outpatient – Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

Dialysis - Dialysis services and supplies, including the training of a person to assist the patient with home dialysis,

when provided by a Hospital, freestanding dialysis center or other appropriate Covered Provider.

Durable Medical Equipment - Rental of durable medical equipment (but not to exceed the fair market purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or Accidental Injury.

"Durable medical equipment" includes items such as crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment that: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (4) are appropriate for use in the home.

NOTE: Coverage is limited to the least expensive item that is adequate for the patient's needs. Duplicate equipment or excess charges for deluxe equipment or devices will not be covered.

Home Health Care / Home Hospice Care – Medically Necessary services of a Home Health Care Agency or Hospice Agency, including services of registered nurses (RNs), licensed vocational nurses (LVNs), physical therapists, occupational therapists, speech therapists or medical social service workers.

Home health care or home Hospice care must be ordered by a Physician.

Hospital Services - Hospital services and supplies provided on an Outpatient basis and Inpatient care, including daily room and board and ancillary services and supplies.

Learning Impairment – Services and supplies, as listed below, that are provided to a covered Dependent child by a Remedial Clinic (see **Definitions**). The care must be provided in accordance with a learning impairment treatment plan. A "treatment plan" is a program, made up and carried out by a Remedial Clinic, that is intended to: (1) cure or improve any condition (whether functional or organic) which causes or contributes to a learning impairment, and (2) overcome, improve or make up for the learning impairment.

Eligible Expenses include:

up to $200 of expenses for an initial series of physical, neurological, mental, associative memory, lateral dominance and similar standard tests made by a Remedial Clinic to determine the nature and extent of a learning impairment and devise the treatment plan for it;

room and board furnished by a Remedial Clinic on its own premises for a child treated on a resident basis;

educational therapy (i.e., therapeutic training exercises and multi-sensory teaching techniques). The therapy must be meant to reduce the degree of impairment and not to teach specific subject-matter knowledge;

periodic administration of standard achievement tests to determine the child's progress under the treatment plan.

NOTE: Eligible learning impairment expenses will not include:

expenses which exceed Usual, Customary and Reasonable;

expenses which the Covered Person is not legally required to pay;

tutoring in specific subjects;

rental of books, tools, equipment, implements, eye glasses, contact lenses, hearing aids or supplies of any kind;

travel or sports, hobbies, camping and other activities which are mainly recreational (whether or not such travel and activities are deemed part of the treatment plan).

Medical Supplies, Disposable – Disposable medical supplies such as surgical dressings, catheters, colostomy bags and related supplies.

Medicines - Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit, or as part of a home health care or hospice care program.

Mental Health Care - Inpatient and Outpatient treatment of mental health conditions, including counseling for marital problems, family problems or behavioral problems when provided on referral by a Physician (MD).

For Plan purposes, "mental health conditions" include schizophrenic disorders, paranoid disorders, affective disorders (depression, mania, manic-depressive illness), anxiety disorders, somatoform disorders, personality disorders, and disorders of infancy, childhood and adolescence.

NOTE: A mental health condition or covered mental health care will not include:

Inpatient or Outpatient eating disorder programs;

learning disorders including attention deficit disorder, hyperkinetic syndrome, autism or mental retardation;

hypnotherapy;

sex counseling or sex therapy;

vocational testing or training.

Midwife - Services of a certified or registered nurse midwife when provided in conjunction with a covered Pregnancy - see "Pregnancy Care" below.

Newborn Care - Medically Necessary services and supplies for a covered newborn who is sick or injured. See "Pregnancy Care" for well-newborn expenses.

Nursing Services, Private Duty - Private-duty nursing services of a registered nurse (RN) when ordered by a Physician.

Orthotics – Orthopedic (non-dental) braces, casts, splints, trusses and other orthotics that are prescribed by a Physician and are required for support of an injured or deformed part of the body as a result of a congenital condition or an Accidental Injury or Sickness. NOTE: Foot orthotics are not covered.

Oxygen - see "Durable Medical Equipment"

Physical Therapy - Professional services of a licensed physical therapist when ordered by a Physician.

Physician Services - Medical and surgical treatment by a Physician (MD or DO), including office, home or Hospital visits, clinic care and consultations. See "Second (& 3rd) Surgical Opinion" below for requirements applicable to surgery opinion consultations.

Pregnancy Care – Eligible Pregnancy-related expenses of a Covered Person. Eligible Expenses include the following, are covered at least to the same extent as any other Sickness, and may include other care that is deemed to be Medically Necessary by the patient's attending Physician:

pre-natal visits and routine pre-natal and post-partum care;

expenses associated with a normal or cesarean delivery as well as expenses associated with any complications of pregnancy;

genetic testing or counseling when deemed Medically Necessary by a Physician;

newborn Hospital services provided during the mother's confinement for delivery, but not to exceed the minimum requirements of the Newborns' and Mothers' Health Protection Act (see below). This will not apply, however, if the newborn is a Covered Person and the charges are covered as the newborn's own claim.

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section. Also, the **Utilization Management Program** requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending Physician and the mother.

NOTE: Pregnancy coverage will not include: (1) Lamaze and other charges for education related to pre-natal care and birthing procedures, (2) adoption expenses, or (3) expenses of a surrogate mother who is not a Covered Person.

Prescription Drugs -Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit, or as part of a home health care or hospice care program.

Other Outpatient drugs (i.e., pharmacy purchases) are covered through a separate program. See the **Medical Benefit Summary** for additional information.

Preventive Care - Certain preventive services that are provided in the absence of sickness or injury. See the **Medical Benefit Summary** for further information.

Prosthetics – Surgical implants, artificial limbs or eyes, post-mastectomy breast prostheses as required by the Women's Health and Cancer Rights Act, and the first pair of contact lenses or glasses when required as a result of eye surgery.

Penile implants, but only for documented irreversible vascular or neuralgic disease that prevents normal male sexual function.

Radiation Therapy - Radium and radioactive isotope therapy.

Respiratory / Inhalation Therapy -Professional services of a licensed respiratory or inhalation therapist, when specifically prescribed by a Physician or surgeon as to type and duration and to improve respiratory function.

Second (& 3rd) Surgical Opinion - A second surgical opinion consultation following a surgeon's recommendation for surgery. The Physician rendering the second opinion regarding the Medical Necessity of a proposed surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

A third opinion consultation if the second opinion does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

Skilled Nursing Facility -Inpatient care in Skilled Nursing Facility when admission to the facility is Medically Necessary.

Smoking Cessation - Examinations and prescriptions for tobacco cessation treatment (i.e., to assist a Covered Person to quit smoking).

NOTE: Group or individual counseling sessions are <u>not</u> covered. Smoking cessation programs are <u>not</u> covered.

Speech Therapy – Services of a qualified speech therapist when ordered by a Physician.

Sterilization Procedures - A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female).

NOTE: Reconstruction (reversal) of a prior elective sterilization procedure is <u>not</u> covered.

Substance Abuse Care - Inpatient treatment of substance abuse and addiction, including detoxification services.

For Plan purposes, "substance abuse and addiction" is abuse of and physical and/or psychological dependence on drugs, narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

Transplant-Related Expenses – Services and supplies provided in connection with an organ or tissue transplant surgery. Coverage is provided for:

a Covered Person who receives the organ or tissue (i.e., a person who is the transplant recipient);

a Covered Person who donates an organ or tissue;

an organ or tissue donor who is not a Covered Person, provided the transplant recipient is a Covered Person. Donor benefits will be reduced by any amounts paid or payable by the donor's own coverage, if any.

Urgent Care Facility – Eligible Medical Expenses, as defined herein, that are incurred by a Covered Person at an Urgent Care Facility.

Weight Control Surgery – The Plan will cover diagnostic, therapeutic and surgical services associated with Bariatric Surgery for individuals who have a documented, long standing history of clinically severe obesity, a history of failed medically and non-medically supervised weight loss programs and an acceptable surgical-risk status. "Long-standing clinically severe obesity" refers to a cumulative duration of 5 or more years where the individual has a Body Mass Index (BMI) of 35 or higher and currently has a BMI of 40 or higher, and/or is 100 lbs. over ideal body weight as recommended by the attending physician, and has one or more co-morbid life risk medical conditions.

A participant is eligible for one bariatric surgery procedure per lifetime with the maximum paid benefits not to exceed $25,000.00. Eligible participants (includes dependents) must have been continuously enrolled in the Plan for a minimum of three (3) years. All applicable out of pocket and co-pay formulas applies. Generally accepted guidelines from the American Society for Bariatric Surgery only indicate surgery for those 18 years of age or older but also recommends that age 65 and older meet the stringent Medicare criteria for such surgery.

Covered services associated with these procedures will include:

History and complete examination, diagnostic laboratory tests, office visits, psychological evaluation and any other medically necessary tests or services as determined by the attending physician and/or as required by Delta Team Care for determination of medical necessity.

NOTE: Eligible Expenses do not include: Charges for after care lodging, skin modifications, or reversals.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE MEDICAL BENEFIT SUMMARY FOR THAT INFORMATION.

MEDICAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits will be payable for:

Abortion - Elective abortion, unless: (1) the mother's life would be endangered if the Pregnancy were allowed to continue to term, or (2) the procedure is Medically Necessary in order to treat a Sickness or Accidental Injury.

NOTE: Complications arising out of an abortion are covered as any other Sickness.

Acupuncture / Acupressure - Needle puncture or application of pressure at specific points, whether used to cure disease, to relieve pain or as a form of anesthesia for surgery.

Air Purification Units, Etc. - Air conditioners, air-purification units, humidifiers and electric heating units.

Biofeedback - Biofeedback, aversion therapy, recreational or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing.

Complications of Non-Covered Treatment - Care, services or treatments that are required to treat complications resulting from a treatment or surgery that is not or would not be covered under the terms of the Plan, unless expressly stated otherwise.

Contraceptives - Medications, injections, implants, devices (e.g., IUDs or diaphragms), the fitting of devices, or any other services or supplies provided for birth control purposes.

NOTE: Contraceptives may be available through the Plan's prescription drug program. See "Prescription Drugs, Outpatient" in the **Medical Benefit Summary**.

Cosmetic & Reconstructive Surgery, Etc. - Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly, except for:

Medically Necessary treatment to repair or alleviate bodily damage caused by Sickness or Accidental Injury;

coverage required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient;

breast reduction surgery when Medically Necessary and after all other conventional non-surgical therapies have been exhausted;

Medically Necessary surgery for the correction of a medical condition that impairs normal body function.

Custodial & Maintenance Care - Care or confinement primarily for the purpose of meeting personal needs (e.g., bathing or walking) that could be rendered at home or by persons without professional skills or training.

Services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable the patient to live outside of an institution.

Any type of maintenance care that is not reasonably expected to improve the patient's condition within a reasonable period of time, except as may be included as part of a formal Hospice care program.

NOTE: This exclusion is not intended to exclude coverage for Medically Necessary services provided at a transitional living center.

Dental & Oral Care - Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion, except for:

treatment of oral tumors; and

repair of sound natural teeth, and their dependent tissues, that are damaged in an Accidental Injury.

Diagnostic Hospital Admissions -Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

Dietician or Nutritional Counseling – Dietician or nutritional counseling for conditions other than diabetes.

Eating Disorder Programs – Programs to assist individuals who have an obsession with food and weight (e.g., anorexia nervosa, bulimia, etc.).

Ecological or Environmental Medicine -Chelation or chelation therapy, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin that are not specifically approved by the FDA as effective for treatment.

Educational or Vocational Testing or Training - Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation. Training of a Covered Person for the development of skills needed to cope with an Accidental Injury or Sickness, except as may be expressly included.

Exercise Equipment / Health Clubs - Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic or similar clubs.

Foot Care, Routine - Routine and non-surgical foot care services and supplies including, but not limited to:

trimming or treatment of toenails;

foot massage;

treatment of corns, calluses, metatarsalgia or bunions;

treatment of weak, strained, flat, unstable or unbalanced feet;

orthopedic shoes (except when permanently attached to braces) or other appliances for support of the feet.

NOTE: This exclusion does not apply to Medically Necessary treatment of the feet (e.g., the removal of nail roots, other podiatry surgeries, or foot care services necessary due to a metabolic or peripheral-vascular disease).

Genetic Counseling or Testing - Counseling or testing concerning inherited (genetic) disorders. However, this limitation does not apply when such services are determined by a Physician to be Medically Necessary during the course of a covered Pregnancy.

Hair Restoration - Any surgeries, treatments, drugs, services or supplies relating to baldness or hair loss, whether or not prescribed by a Physician.

Hearing Exams & Hearing Aids - Hearing exams, hearing aids or the fitting of hearing aids.

NOTE: This exclusion will not apply to treatment of hearing loss necessitated by an Accidental Injury, provided treatment begins within ninety (90) days of the injury and then limited to expenses incurred within twenty-four (24) months of the injury.

Holistic, Homeopathic or Naturopathic Medicine - Services, supplies, drugs or accommodations provided in connection with holistic, homeopathic or naturopathic treatment.

Hypnotherapy - Treatment by hypnotism.

Impregnation - Artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.

Infertility Testing or Treatment - Diagnostic tests or studies, or procedures, drugs or supplies to correct infertility or to restore or enhance fertility.

Maintenance Care – see "Custodial & Maintenance Care"

Massage Therapy – Massage therapy, except when prescribed by a Covered Provider for treatment of a Sickness or Accidental Injury.

Non-Prescription Drugs - Drugs for use outside of a hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription - except as may be included in the prescription coverages of the Plan.

Drugs for which there is a non-prescription equivalent available.

Not Medically Necessary / Not Physician Prescribed - Any services or supplies that are: (1) not Medically Necessary, and (2) not incurred on the advice of a Physician - unless expressly included herein.

Inpatient room and board when hospitalization is for services that could have been performed safely on an Outpatient basis including, but not limited to: preliminary diagnostic tests, physical therapy, medical observation, treatment of chronic pain or convalescent or rest cure.

Orthognathic Surgery - Surgery to correct a receding or protruding jaw.

Personal Comfort or Convenience Items - Services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) air conditioners, air purifiers, or vacuum cleaners, (2) motorized transportation equipment, escalators, elevators, ramps, (3) waterbeds or non-hospital adjustable beds, (4) hypoallergenic mattresses, pillows, blankets or mattress covers, (5) cervical pillows, (6) swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs, (7) home blood pressure kits, (8) personal computers and related equipment, televisions, telephones, or other similar items or equipment, (9) food liquidizers, or (10) structural changes to homes or autos.

Preventive or Routine Care -Routine exams, physicals or anything not ordered by a Physician or not Medically Necessary for treatment of Sickness, Accidental Injury or Pregnancy, except as may be specifically included in the **Medical Benefit Summary.**

Self-Procured Services - Services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of hospital confinement, that are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of **Eligible Medical Expenses.**

Sex-Related Disorders - Transsexualism, gender dysphoria, sexual reassignment or change, or other sexual dysfunctions or inadequacies except as expressly covered (see "Prosthetics" in the list of **Eligible Medical Expenses**). Excluded services and supplies include, but are not limited to: therapy or counseling, medications, implants, hormone therapy, surgery, and other medical or psychiatric treatment.

TMJ / Jaw Joint Treatment – Treatment of temporomandibular joint dysfunction (TMJ) abnormalities caused by malocclusion, structural jaw abnormalities or any other conditions unrelated to an external traumatic episode.

Vision Care - Eye examinations for the purpose of prescribing corrective lenses.

Vision supplies (e.g., eyeglasses or contact lenses) or their fitting, replacement, repair or adjustment.

Orthoptics, vision therapy, vision perception training, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy, keratomoleusis or any other surgery to correct refractive defects of the eye.

NOTE: This exclusion will not apply to: (1) services necessitated by a Sickness or Accidental Injury, or (2) the initial purchase of glasses or contact lenses following eye surgery.

Vitamins or Dietary Supplements - Prescription or non-prescription organic substances used for nutritional purposes.

Vocational Testing or Training - Vocational testing, evaluation, counseling or training.

Wigs or Wig Maintenance - see "Hair Restoration"

*- (See also **General Exclusions** section) -*

DENTAL BENEFIT SUMMARY

PLAN MAXIMUMS	
Calendar Year Maximum Benefit (non-ortho)	$2,500
Non-Surgical TMJ Lifetime Maximum Benefit	$500
Orthodontia Lifetime Maximum Benefit	$2,000

Plan benefits for each Covered Person will not exceed the maximums shown above.

Orthodontia benefits are limited to covered Dependent children who are under age 18 and who have been continuously covered under the Plan for at least 2 years. Orthodontia benefits do not apply to the Calendar Year Maximum Benefit. The Orthodontia Lifetime Maximum Benefit applies to all periods a child is covered under the Plan.

INDIVIDUAL CALENDAR YEAR DEDUCTIBLE	$25

The Individual Calendar Year Deductible is an amount that a Covered Person must contribute toward payment of eligible dental expenses. Usually, the deductible applies before the Plan begins to provide benefits.

ELIGIBLE DENTAL EXPENSES	Covered Person Pays	Pays Plan Pays
Preventive Services	-0-	100%

Limits applicable to certain Preventive Services:

- routine oral examinations and cleanings are limited to 1 exam/cleaning per 6-month period;
- fluoride treatment is limited to children under age 16 and to 1 application per 6-month period;
- sealants are limited to children under age 16;
- a routine full-mouth X-ray series or a panoramic X-ray is limited to once per 3-year period, unless there is a demonstrated dental need for additional X-rays other than bitewings;
- routine bitewing X-rays are limited to 1 set per 6-month period.

Basic Services	20%	80%

Scaling and root planing is limited to twice per area of the mouth per 12-month period.

Major Services (including non-surgical TMJ treatment & Implants)	50%	50%
Orthodontia	50%	50%

THIS IS A SUMMARY ONLY. PLEASE REFER TO THE **ELIGIBLE DENTAL EXPENSES** AND **DENTAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

DENTAL PRE-TREATMENT ESTIMATE

If extensive dental work is needed (i.e., where the proposed course of treatment will cost more than $200), it is recommended that a pre-treatment estimate be obtained prior to the work being performed. Emergency treatments, oral examinations including prophylaxis, and dental X-rays will be considered part of the "extensive dental work" but may be performed before the pre-treatment estimate is obtained.

A pre-treatment estimate is obtained by having the attending dentist complete a statement listing the proposed dental work and charges. The form is then submitted to the Contract Administrator for review and estimate of benefits. The Contract Administrator may require an oral exam (at Plan expense) or request X-rays or additional information during the course of its review.

A pre-treatment estimate serves two purposes. First, it gives the patient and the dentist a good idea of benefit levels, (e.g., maximums, limitations) that might apply to the treatment program so that the patient's portion of the cost will be known and, secondly, it offers the patient and dentist an opportunity to consider other avenues of restorative care that might be equally satisfactory and less costly.

Most dentists are familiar with pre-treatment estimate procedures and the dental claim form is designed to facilitate pre-treatment estimates.

If a pre-treatment estimate is not obtained prior to the work being performed, the Plan Sponsor reserves the right to determine Plan benefits as if a pre-treatment estimate had been obtained.

NOTES: A pre-treatment estimate is not a guarantee of payment. Payment of Plan benefits is subject to Plan provisions and eligibility at the time the expenses are actually incurred.

The Plan reserves the right to have a Plan participant whose dental expense is the basis for a claim, examined by a independent dentist chosen by the Plan or an entity designated by the Plan. The Plan will pay for any such independent dental exam.

ELIGIBLE DENTAL EXPENSES

Eligible dental expenses are the Usual, Customary and Reasonable charges for the dental services and supplies that are listed below and: (1) incurred while a person is covered under the Plan, and (2) received from a licensed dentist, a qualified technician working under a dentist's supervision or any Physician furnishing dental services for which they are licensed.

For benefit purposes, dental expenses will be deemed incurred as follows:

for an appliance or modification of an appliance, on the date the final impression is taken;

for a crown, inlay, onlay or gold restoration, on the date the tooth is prepared;

for root canal therapy, on the date the pulp chamber is opened; or

for any other service, on the date the service is rendered.

NOTE: Many dental conditions can be effectively treated in more than one way. The Plan is designed to help pay for dental expenses, but not for treatment that is more expensive than necessary for good dental care. If a Covered Person chooses a more expensive course of treatment, the Plan will pay benefits equivalent to the least expensive treatment that would adequately correct the dental condition.

PREVENTIVE SERVICES

Exams & Cleanings - Routine and diagnostic oral examinations and routine cleaning and polishing of the teeth.

Consultation by a dental specialist.

Emergency treatments.

Fluoride - Topical application of stannous or sodium fluoride.

Prophylaxis - see "Exams & Cleanings"

Sealants - Application of sealants to the pits and fissures of the teeth, with the intent to seal the teeth and reduce the incidence of decay. Coverage is limited to application on the occlusal (biting) surface of permanent molars that are free of decay or prior restoration.

Space Maintainers - Fixed and removable appliances to retain the space left by a prematurely lost primary or "baby" tooth and to prevent abnormal movement of the surrounding teeth.

X-rays - Dental X-rays for diagnostic purposes, as well as routine "full mouth" X-rays or a panoramic X-ray, and routine bitewing X-rays.

BASIC SERVICES

Anesthesia - General anesthesia when administered in connection with extraction of impacted teeth or when Medically Necessary to perform oral surgical procedures.

NOTE: Separate charges for pre-medication, local anesthesia, analgesia or conscious sedation are <u>not</u> covered. Such services should be included in the cost of the procedure itself.

Endodontia - Endodontic services including but not limited to: root canal therapy (except for final restoration), pulpotomy, apicoectomy and retrograde filling.

Extraction - see "Oral Surgery"

Fillings, Non-Precious - Amalgam, silicate, composite and plastic restorations, including pins to retain a filling restoration when necessary.

Injections - Injection of antibiotic drugs.

Oral Surgery - Extraction of teeth, including simple extractions and surgical extraction of bone or tissue-impacted teeth. Other surgical and adjunctive treatment of disease, injury and defects of the oral cavity and associated structures.

Periodontia - Treatment of the gums and tissues of the mouth, including periodontal scaling and root planing.

MAJOR SERVICES

Crowns – Initial placement of crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. Coverage for a crown includes a post and core when necessary.

Replacement of a crown, if the existing crown is at least five (5) years old and cannot be made serviceable. Replacement of a crown that is less than five (5) years old will require documented evidence of necessity by the dentist.

Implants - Implants (materials implanted into or on bone or soft tissue to support a crown or prosthetic, including services and supplies necessary for their installation), or the removal of implants.

Inlays, Onlays, Porcelain & Gold Fillings - Initial placement of an inlay, onlay, porcelain or gold filling when a tooth cannot be satisfactorily restored with a less costly filling (e.g., amalgam) restoration.

Replacement of an inlay, onlay, porcelain or gold restoration, if the existing restoration is at least five (5) years old and cannot be made serviceable. Replacement of a restoration that is less than five (5) years old will require documented evidence of necessity by the dentist.

Prosthetics - Initial placement of a denture or bridge to replace one or more natural teeth. Any allowance made for a prosthetic includes necessary adjustments or relining within six (6) months of placement.

Addition of teeth to a partial denture or bridge to replace natural teeth.

Replacement of an existing denture or bridge if the existing denture or bridgework is at least five (5) years old and cannot be made serviceable. Replacement of a denture or bridge that is less than five (5) years old will require documented evidence of necessity by the dentist.

Relines & Adjustments – Relining or adjustment of a denture or prosthetic when necessary and performed more than six (6) months after placement.

TMJ Treatment (Non-Surgical) – Non-surgical treatment of temporomandibular joint dysfunction.

ORTHODONTIA

Services or supplies for the correction of bite or malocclusion or for the alignment or repositioning of teeth, including:

initial consultation, models, X-rays and other diagnostic services;

initial banding or placement of orthodontic appliance(s);

periodic adjustments; and

retainers.

Orthodontia benefits will begin upon submission of proof that the orthodontia treatment program has begun. 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 shown in the "Plan Maximums" in the **Dental Benefit Summary.** This maximum applies to the entire period(s) a person is covered under the Plan.

IMPORTANT: CERTAIN ELIGIBLE DENTAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **DENTAL BENEFIT SUMMARY** FOR THAT INFORMATION.

DENTAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated, no benefits will be payable under this Plan for:

Appliances - Items intended for sport or home use, such as athletic mouthguards or habit-breaking appliances.

Customized Prosthetics – Excess charges for precision or semi-precision attachments, overdentures, denture duplication, or customized prosthetics.

Discoloration Treatment -Teeth whitening or any other treatment to remove or lessen discoloration, except in connection with endodontia.

Excess Care - Services that exceed those necessary to achieve an acceptable level of dental care. If it is determined that alternative procedures, services, or courses of treatment could be (could have been) performed to correct a dental condition, Plan benefits will be limited to the least costly procedure(s) that would produce a professionally satisfactory result.
Duplicate prosthetic devices or appliances.

Experimental & Non-Standard Procedures – Services or supplies which do not meet the standards accepted by the American Dental Association (ADA) or by the Council of Dental Therapeutics of the American Dental Association.

Grafting - Extra oral grafts (grafting of tissue from outside the mouth to oral tissues).

Hospital Expenses – Inpatient or Outpatient Hospital expenses.

Lost or Stolen Prosthetics or Appliances - Replacement of a prosthetic or any other type of appliance that has been lost, misplaced, or stolen.

Medical Expenses - Any dental-related services for which coverage is provided under the terms of the medical benefits of this Plan.

Myofunctional Therapy - Muscle training therapy or training to correct or control harmful habits.

Non-Professional Care - Services rendered by someone other than:

a dentist (DDS or DMD);

a dental hygienist, X-ray technician or other qualified technician who is under the supervision of a dentist; or

a Physician furnishing dental services for which they are licensed.

Occlusal Restoration - Procedures, appliances or restorations that are performed to alter, restore or maintain occlusion (i.e., the way the teeth mesh), including:

increasing the vertical dimension;

replacing or stabilizing tooth structure lost by attrition;

realignment of teeth;

gnathological recording or bite registration or bite analysis;

occlusal equilibration.

Oral Hygiene Instruction & Supplies, Etc. - Dietary or nutritional counseling or related supplies, personal oral hygiene instruction or plaque control. Oral hygiene supplies including but not limited to: toothpaste, toothbrushes, waterpiks, and mouthwashes.

Orthognathic Surgery - Surgery to correct a receding or protruding jaw.

Personalization or Characterization of Dentures

Photographs

Prescription Drugs - see "Prescription Drugs, Outpatient" in the **Medical Benefit Summary**

Prior to Effective Date / After Termination Date - Courses of treatment that began prior to the Covered Person's effective date, including crowns, bridges or dentures that were ordered prior to the effective date.

Expenses incurred after termination of coverage, except that benefits will be extended for up to thirty (30) days for the following:

an appliance, or modification of an appliance when the impression was taken prior to the date of termination;

a crown, inlay, onlay or gold restoration when the tooth was prepared prior to the date of termination;

root canal therapy when the pulp chamber was opened prior to the date of termination.

NOTE: Extended dental benefits will not be provided for a person who is covered or eligible to become covered under another group policy or plan which provides similar benefits.

Splinting - Appliances or restorations for splinting teeth.

Temporary Restorations & Appliances - Excess charges for temporary restorations and appliances. Expenses for the permanent restoration or appliance will be the maximum Eligible Expense.

- *(See also **General Exclusions** section)*-

GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

Alcohol - Charges that arise from a Covered Person taking part in any activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse Care as specified in this Plan, if applicable. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Criminal Activities - Any injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation, or any complications therefrom. This exclusion does not apply where such injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression).

Drugs In Testing Phases - Medicines or drugs that are in the Food and Drug Administration Phases I, II, or III testing, drugs that are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Excess Charges - Charges in excess of the Usual, Customary and Reasonable fees for services or supplies provided.

Experimental / Investigational Treatment - Expenses for treatments, procedures, devices, or drugs that are Experimental or Investigational.

Forms Completion - Charges made for the completion of claim forms or for providing supplemental information.

Government - Charges that the Covered Person obtains, but which is paid, may be paid, is provided or could be provided for at no cost to the Covered Person through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Covered Person to pay for such treatment or service in the absence of coverage. This exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

Government-Operated Facilities - Services furnished to the Covered Person in any veterans hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments.

NOTE: This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government hospital to dependents of active duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where otherwise prohibited by law.

Illegal Drugs or Medications - That are services, supplies, care or treatment to a Covered Person for injury or sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse Care as specified in this Plan. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

Incurred by Other Persons - Charges that are expenses actually incurred by other persons.

Late-Filed Claims - Claims that are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.

Medical Necessity – Charges that are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

Military Service - Conditions that are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Missed Appointments - Expenses incurred for failure to keep a scheduled appointment.

No Charge / No Legal Requirement to Pay - Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved and this Plan is a "secondary" coverage, this exclusion will apply to those amounts a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.

NOTE: This exclusion does not apply to any benefit or coverage that is available through the Medical Assistance Act (Medicaid).

Negligence – Services that are for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Covered Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

No Coverage - Charges that are incurred at a time when no coverage is in force for the applicable Covered Person and/or Dependent.

Not Acceptable - Charges that are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration.

Not Listed Services or Supplies - Any services, care or supplies that are not specifically listed in the Benefit Document as Eligible Expenses.

Nuclear Energy Release - Any injury or illness resulting from the non-therapeutic release of nuclear energy.

Other Coverage - Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payor or Medicaid Priority rules.

Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

Outside United States - Charges incurred outside of the United States if the Covered Person traveled to such a location for the primary purpose of obtaining such services or supplies.

Postage, Shipping, Handling Charges, Etc. - Any postage, shipping or handling charges that may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

Prior Coverages - Services or supplies for which the Covered Person is eligible for benefits under the terms of the document that this Benefit Document replaces.

Prior to Effective Date / After Termination Date - Charges incurred prior to an individual's effective date of coverage under the Plan or after coverage is terminated, except as may be expressly stated.

Relative or Resident Care -Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

Sales Tax, Etc. - Sales or other taxes or charges imposed by any government or entity. However, this exclusion will not apply to surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or similar surcharges imposed by other states.

Self-Inflicted Injury - Any expenses resulting from voluntary self-inflicted injury or voluntary attempted self-destruction, except that, this exclusion will not apply where such self-inflicted injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g., depression).

Subrogation, Reimbursement, and/or Third Party Responsibility - Charges that are for an illness, injury or sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

Telecommunications - Advice or consultation given by or through any form of telecommunication.

Travel - Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included.

Unreasonable – Charges that are not "Reasonable;" and are required to treat illness or injuries arising from and due to a Covered Provider's error, wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Covered Provider whose error caused the loss(es).

War or Active Duty - Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country, to the extent not prohibited by law.

Work-Related Conditions - Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose, whether or not a claim is made for such benefits. If the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

COORDINATION OF BENEFITS (COB)

All health care benefits provided under the Plan are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

DEFINITIONS

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

Other Plan - Any other health plan other than This Plan, including Medicare or other governmental benefits as permitted by law.

NOTES: An "Other Plan" includes benefits that are actually paid or payable or benefits that would have been paid or payable if a claim had been properly made for them.

If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This Plan - The health benefits that are described in this Benefit Document.

Allowable Expense -A health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans (i.e., This Plan or Other Plan(s)) covering the Claimant. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. However, where This Plan is secondary to an "Other Plan" that is a Health Maintenance Organization (HMO), This Plan will coordinate only on copayments and will not assume primary status when services are obtained from non-HMO providers.

Any expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses under This Plan:

the difference in cost between a hospital's semi-private room and a private room unless the private room accommodation is medically necessary in terms of generally accepted medical practice or unless one of the plans routinely provides coverage for private rooms;

any amount in excess of the highest usual and customary allowance, if a person is covered by two (2) or more plans that compute benefits on the basis of usual and customary allowances;

any amount in excess of the lowest of the negotiated fees, if a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees,

the lesser of the amounts, if a person is covered by one plan that calculates its benefits or services on the basis of usual and customary and another plan that provides its benefits or services on the basis of negotiated fees.

NOTE: Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements (e.g., precertification of admissions, second surgical opinion requirements) will not be considered an Allowable Expense.

Claim Determination Period - A period that commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see "Effect on Benefits Under This Plan").

Custodial Parent - A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

EFFECT ON BENEFITS UNDER THIS PLAN

When Other Plan Does Not Contain a COB Provision -If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

When Other Plan Contains a COB Provision - When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

NOTE: The determination of This Plan's "normal liability" will be made for an entire Claim Determination Period (i.e. Calendar Year). If this Plan is "secondary", the difference between the benefit payments that This Plan would have paid had it been the primary plan and the benefit payments that it actually pays as a secondary plan is recorded as a "benefit reserve" for the Covered Person and will be used to pay Allowable Expenses not otherwise paid during the balance of the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

ORDER OF BENEFIT DETERMINATION RULES

Whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules.

No COB Provision – If an Other Plan does not contain a coordination of benefit provision, then the Other Plan will be primary and This Plan will be secondary.

Medicare as an "Other Plan" - Medicare will be the primary, secondary or last payer in accordance with federal law. When Medicare is the primary payer, This Plan will determine its benefits based on Medicare Part A, Part B and Part D benefits that would have been paid or payable, regardless of whether or not the person was enrolled for such benefits.

NOTE: An active Employee (or spouse) age 65 or older who is eligible for Medicare and who chooses to have Medicare as their primary carrier, may not also have coverage under this Plan.

Non-Dependent vs. Dependent - The benefits of a plan that covers the Claimant other than as a dependent will be determined before the benefits of a plan that covers such Claimant as a dependent. However, if the Claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan - When the Claimant is a dependent child, the primary plan is the plan of the parent whose birthday is earlier in the year if: (1) the child's parents are married, (2) the parents are not separated, whether or not they have ever been married, or (3) a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

When the Claimant is a dependent child and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.

When the Claimant is a dependent child whose father and mother are not married, are separated (whether or not they have ever been married) or are divorced, the order of benefits is:

the plan of the Custodial Parent;

the plan of the spouse of the Custodial Parent;

the plan of the noncustodial parent; and then

the plan of the spouse of the noncustodial parent.

Active vs. Inactive Employee - The plan that covers the Claimant as an employee who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an employee who is neither laid off nor retired, is primary. 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.

Continuation Coverage (COBRA) Enrollee - If a Claimant is a COBRA enrollee under This Plan, an Other Plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and This Plan is secondary. 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.

Longer vs. Shorter Length of Coverage - If none of the above rules establish which plan is primary, the benefits of the plan that has covered the Claimant for the longer period of time will be determined before those of the plan that has covered that person for the shorter period of time.

NOTE: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

Right to Receive and Release Necessary Information - For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

Facility of Payment -A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

Right of Recovery - If the amount of the payments made by the Plan is more than it should have paid under this COB section, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid - or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services. (See "Recovery of Payments" provision for additional information).

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT PROVISIONS

Payment Condition -The Plan, in its sole discretion, may elect to conditionally advance payment of medical 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 Covered Persons or their dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Beneficiary") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").

Plan Beneficiary, their attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's 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. By accepting benefits the Plan Beneficiary agrees the Plan shall have an equitable lien on any funds received by the Plan Beneficiary 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 Beneficiary agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Plan Beneficiary settles, recovers, or is reimbursed by any third party or Coverage, the Plan Beneficiary agrees to reimburse the Plan for all benefits paid or that will be paid. If the Plan Beneficiary fails to reimburse the Plan out of any judgment or settlement received, the Plan Beneficiary will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation - As a condition to participating in and receiving benefits under this Plan, the Plan Beneficiary agrees to subrogate the Plan to 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 Beneficiary is entitled, regardless of how classified or characterized.

If a Plan Beneficiary receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Plan Beneficiary may have against any party causing the sickness or injury to the extent of such payment by the Plan plus reasonable costs of collection.

The Plan may in its own name or in the name of the Plan Beneficiary commence a proceeding or pursue a claim against any third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the Plan.

If the Plan Beneficiary fails to file a claim or pursue damages against:

the responsible party, its insurer, or any other source on behalf of that party;

any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

any policy of insurance from any insurance company or guarantor of a third party;

worker's compensation or other liability insurance company; or

any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages;

the Plan Beneficiary authorizes the Plan to pursue, sue, compromise or settle any such claims in the Plan Beneficiary's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Beneficiary 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, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Beneficiary is fully compensated by his/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 subrogation lien. The obligation 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 Beneficiary's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

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, expressed 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 Beneficiary, whether under the doctrines of causation, comparative fault or contributory negligence, or any 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 Beneficiary.

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.

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. The Plan's benefits shall be excess to:

the responsible party, its insurer, or any other source on behalf of that party;

any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

any policy of insurance from any insurance company or guarantor of a third party;

worker's compensation or other liability insurance company; or

any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages.

Separation of Funds - Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(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 Claims - In the event that the Plan Beneficiary dies as a result of their 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 Covered Person(s) and all others that benefit from such payment.

Obligations - It is the Plan Beneficiary's obligation:

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;

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;

to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

If the Plan Beneficiary and/or their 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 Beneficiary 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 Beneficiary.

Offset – If timely repayment is not made, or the Covered Person and/or their 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 Covered Person'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 Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan.

Minor Status - In the event the Plan Beneficiary 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 their 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 anytime 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.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements - Employees
To participate as an Employee in the Plan coverages that are described herein, an individual must be in permanent full-time or part-time active employment for the Employer, performing all customary duties of their occupation at their usual place of employment (or at a location to which the business of the Employer requires the Employee to travel) and regularly scheduled to work at least 35 hours per week as a full-time Employee, or at least 15 hours per week as a part-time Employee.

See "Extension of Coverage for Retirees" in the **Extensions of Coverage** section for retiree coverage information.

An Employee will be deemed in "active employment" on each day the employee is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided they were actively at work on the last preceding regular working day. An Employee will also be deemed in "active employment" on any day on which the employee is absent from work during an approved FMLA leave or solely due to their own health status (see "Non-Discrimination Due to Health Status" in the **General Plan Information** section). An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on their first scheduled workday, the employee will not be considered as having commenced active employment.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

Effective Date - Employees
An Employee's coverage is effective, subject to timely enrollment, upon completion of a waiting period to the first day of the month following 180 days of active employment in an eligible status.

If an Employee fails to enroll within thirty (30) days after completion of the waiting period, their coverage can become effective only in accordance with the "Open Enrollment" or "Special Enrollment Rights" provisions below.

Eligibility Requirements - Dependents
Except as noted at the end of this provision, an eligible Dependent of an Employee is:

a legally married spouse. A "spouse" will mean a person of the opposite sex (i.e., not the same sex as the Employee). "Legally married" means a legal union (as defined by the Employee's state of residence) between one man and one woman as husband and wife;

a child up to age 26. Child shall mean:

- a natural child;
- a stepchild;
- a child who is adopted by the Employee or placed with the Employee for adoption prior to age 18. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun. Placement ends when the legal support obligation ends;
- notwithstanding any residency or main support and care requirements, a child for whom Plan coverage is required due to a Medical Child Support Order (MCSO) that the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (that are incorporated herein by reference and that can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and that satisfies the QMCSO requirements;

NOTES: An eligible Dependent does <u>not</u> include:

any person whose primary employer offers health insurance coverage;

a spouse following legal separation or a final decree of dissolution of marriage or divorce;

any person who is on active duty in a military service, to the extent permitted by law;

a foster child;

any person who is eligible to be covered as an Employee;

any person who is covered as a Dependent of another Employee.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Effective Date - Dependents
A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Dependents acquired later may be enrolled within thirty (30) days of their eligibility date. See the "Special Enrollment Rights" provision for additional details as well as instances when the loss of other coverage and other circumstances can allow a Dependent to be enrolled. Otherwise, a Dependent can be enrolled only in accordance with the "Late Enrollment/Re-Enrollment" provision.

NOTE: In no instance will a Dependent's coverage become effective prior to the Employee's coverage effective date.

Newborn & Adoptive Children - Limited Automatic 31-Day Benefit Period
An Employee's newborn child will be eligible for benefits for Eligible Expenses that are incurred within the first thirty-one (31) days after the child's birth. Benefits for such child will be available for the 31-day period only. The child will be covered after the 31-day benefit period only if the child is enrolled within thirty (30) days of birth – see "Entitlement Due to Acquiring New Dependent(s)" in the **Special Enrollment Rights**.

The 31-day benefit period also applies to child who adopted by or placed with an Employee for adoption. The 31 day period begins on the date the child is placed in the physical custody of the Employee.

NOTE: During the limited 31-day benefit period, a newborn or adoptive child is not a Covered Person. Any extended coverage periods or coverage continuation options that are available to Covered Persons WILL NOT APPLY to a newborn child who is provided with these thirty-one (31) days of limited benefits and who is not enrolled within the 30-day enrollment period.

Special Enrollment Rights
Entitlement Due to Loss of Other Coverage - An individual who did not enroll in the Plan when previously eligible, will be allowed to apply for coverage under the Plan at a later date if:

The individual was covered under another group health plan or other health insurance coverage (including Medicaid) at the time coverage was initially offered or previously available to them. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

the Employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Sponsor required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement;

the individual lost the other coverage as a result of a certain event such as, but not limited to, the following:

- loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment;
- loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual);
- loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
- loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of

eligibility, even if the plan continues to provide coverage to other employees;

- loss of eligibility when employer contributions toward the employee's or dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer;

- loss of eligibility when COBRA continuation coverage is exhausted; and

the Employee requested Plan enrollment within thirty (30) days of termination of the other coverage.

If the above conditions are met, Plan coverage will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application.

NOTES: For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently.

Loss of other coverage for failure to pay premiums on a timely basis or for cause (e.g., making a fraudulent claim or making an intentional misrepresentation of a material fact with respect to the other coverage) will not be a valid loss of coverage for these purposes.

Entitlement Due to Acquiring New Dependent(s) - If an Employee acquires one (1) or more new eligible Dependents through marriage, birth, adoption, or placement for adoption (as defined by Federal law), application for their coverage may be made within thirty (30) days of the date the new Dependent or Dependents are acquired (the "triggering event") and Plan coverage will be effective as follows - see NOTE:

where Employee's marriage is the "triggering event" - the spouse's coverage (and the coverage of any eligible Dependent children the Employee acquires in the marriage) will be effective on the first day of the first calendar month after the Qualifying Event and completed application;

where acquisition of a child is the "triggering event" - the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). The "triggering event" date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within thirty (30) days of birth.

NOTES: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll (i.e., must have satisfied any waiting period requirement) and must enroll concurrently. If the newly-acquired Dependent is a child, the spouse is also eligible to enroll. However, other Dependent children who were not enrolled when first eligible are not considered to be newly acquired and can only be enrolled in accordance with other enrollment allowances of the Plan.

Court or Agency Ordered Coverage - If an Employee or an Employee's spouse is required to provide coverage for a child under a Medical Child Support Order, coverage for the child shall be effective as of the date specified in such order provided that such order is qualified according to the Plan Sponsor's written procedures and provided that a request for coverage is made on a form acceptable to the Plan Sponsor within 31 days from the date such order is determined to be qualified. A request to enroll the child may be made by the Employee, the Employee's spouse, the child's other parent, or by a State Agency on the child's behalf.

If the Employee is not enrolled when the Plan is presented with an MCSO that is determined to be qualified, and the Employee's enrollment is required in order to enroll the child, both must be enrolled. The Employer is entitled to withhold any applicable payroll contributions for coverage from the Employee's pay.

Entitlement Due to The Children's Health Insurance Program Reauthorization Act of 2009 - Employees and Dependents who are or become eligible under the State Children's Health Insurance Program (SCHIP) or Medicaid and then lose such eligibility, may enroll in the Plan (if they are otherwise eligible) within sixty (60) days of the date the Employee (or a Dependent) loses eligibility for the Medicaid of SCHIP program or within sixty (60) days of becoming eligible for premium assistance under Medicaid of SCHIP. This "special enrollment right" exists even though the timing may fall outside of a Plan's open enrollment period and the Employee previously refused Plan coverage. This enrollment allowance also applies to those who lose SCHIP or Medicaid coverage and then want to enroll in the Employer Plan.

Premium Assistance: The State may either (1) reimburse the Employer directly for the cost differential to add family coverage (to add previously uncovered children to the Plan), or (2) require covered beneficiaries to pay the full family coverage cost and reimburse the Employee. However, the Employer/Plan Sponsor can opt out of the first option, and

require the full cost of coverage from the covered Employee. To qualify, residents and their Dependent(s) must be eligible for Plan coverage in which the Employer contributes at least 40% toward the coverage cost.

Open Enrollment
If an individual does not enroll when he is first eligible to do so or if he allows coverage to lapse, he may later enroll during an Open Enrollment period that will be held annually. Plan coverage will be effective on the first of the month following the end of the Open Enrollment period.

Reinstatement / Rehire
If an Employee returns to active employment and eligible status immediately following an approved leave of absence taken in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA) and during the leave Employee discontinues paying their share of the cost of coverage, then the Employee may have coverage reinstated as if there had been no lapse (for the Employee and any Dependents who were covered at the point contributions ceased). However, Employee must request that coverage be restored before their family or medical leave expires and the Plan Sponsor will have the right to require that unpaid coverage contribution costs be repaid.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces, will be reinstated to coverage under the Plan immediately upon returning from military service. See "Extension of Coverage During U.S. Military Service" in the **Extensions of Coverage** section for more information.

NOTES: Except in the above instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

Benefits for any Employee or Dependent who is covered under the Plan, whose employment or coverage is terminated, and who is subsequently rehired or reinstated at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of employment or coverage.

Transfer of Coverage
If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of their eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

Restatement / Replacement of Benefits
This Benefit Document replaces prior benefits offered by the Plan Sponsor but this is not a new Plan. The health coverage(s) described herein are an immediate restatement or replacement of such prior benefits. Except to the extent that benefits are expressly modified, any deductibles satisfied or benefits paid with respect to covered persons under the prior benefits will be deemed to be Deductibles satisfied or benefits paid under the Benefit Document for a person who is eligible as an active enrollee or a COBRA enrollee under the Benefit Document on its effective date. Any contiguous periods a person was covered under the benefits replaced by this document will be deemed to be time covered under this Benefit Document.

TERMINATION OF COVERAGE

Employee Coverage Termination
Except as noted, an Employee's coverage will terminate upon the earliest of the following:

termination of the Plan or Plan benefits as described herein;

termination of participation in the Plan by the Employee;

at the end of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (i.e. Employee shares in the cost);

at midnight on the last day of the month in which the covered Employee leaves or is dismissed from the employment of the Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the **Extensions of Coverage** section;

the date the Employee dies.

NOTE: Unused vacation days or severance pay following cessation of active work will not count as extending the period of time coverage will remain in effect.

An Employee otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services.

Dependent Coverage Termination
Except as noted, a Dependent's coverage will terminate upon the earliest of the following:

termination of the Plan or these Plan benefits or discontinuance of Dependent coverage under the Plan;

termination of the coverage of the Employee;

at midnight of the last day the Dependent meets the eligibility requirements of the Plan, except when coverage is extended under the **Extensions of Coverage** section. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;

on the date the Employee requests that Dependent coverage be terminated or at the end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage that will take effect immediately upon termination.

NOTE: A Dependent otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services.

- *(See **COBRA Continuation Coverage**)* -

EXTENSIONS OF COVERAGE

Coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage will not extend: (1) beyond the date the Plan is terminated, and (2) for a Dependent, beyond the date the Employee's coverage ceases.

Extension of Coverage for Handicapped Dependent Children
If an already covered Dependent child is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and:

such condition commenced on or before the child attained the age that would otherwise terminate their eligibility;

the child's condition has been diagnosed by a Physician as a permanent or long-term dysfunction or condition; and

such child is primarily dependent upon the Employee for support and maintenance;

then such child's status as a "Dependent" will not terminate solely by reason of them having attained the limiting age and he will continue to be considered a covered Dependent under the Plan so long as they remain in such condition, and otherwise conforms to the definition of "Dependent."

The Employee should have a Physician submit proof of the child's incapacity to the Plan Administrator within thirty-one (31) days prior to the child's attainment of the limiting age.

Extended benefits will be continued under the terms of this provision until the earliest of: (1) the date the child ceases to be eligible for reasons other than age, (2) the date the child ceases to be incapacitated, or (3) on the 61st day after the Plan requests additional proof of the child's incapacity and Employee fails to furnish such proof.

Extensions of Coverage During Absence From Work
If an Employee fails to continue in eligible active status but is not terminated from employment (e.g., the employee is absent due to an approved leave or a temporary layoff), the employee may be permitted to continue health care coverages for themselves and their Dependents though they could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis.

Except as noted, any coverage that is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

on the date coverage terminates as specified in the Employer's personnel policies or other Employer communications, if any. Such documents are incorporated into the Plan by reference;

the end of the period for which the last contribution was paid, if such contribution is required;

the date of termination of the Plan.

To the extent that the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), it intends to comply with the Act. The Employer is subject to FMLA if it is engaged in commerce or in any industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year.

In accordance with the FMLA, an Employee is entitled to continued coverage if they: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Except as noted, continued coverage under the FMLA is allowed during up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

the birth of an Employee's child and in order to care for the child;

the placement of a child with the Employee for adoption or foster care;

to care for a spouse, child or parent of the Employee where such relative has a serious health condition;

Employee's own serious health condition that makes the Employee unable to perform the functions of their job; or

the Employee has a "qualifying exigency" (as defined by DOL regulations) arising because the Employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation (a specified military operation).

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of their FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions that are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

NOTE: An eligible Employee will be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the Employee is a spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered service member. A "covered service member" shall mean current service members and covered veterans who are undergoing medical treatment, recuperation, or therapy due to a serious injury or illness, rather than just current service members. A covered veteran is an individual who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to when the eligible employee takes FMLA Leave to care for the covered veteran. A "serious illness or injury" shall mean an illness or injury incurred in the line of duty that may render the service member medically unfit to perform their military duties. A serious injury or illness for a current service member includes an injury or illness that existed before the beginning of the service member's active duty and was aggravated by service in the line of duty on active duty in the armed forces. A serious injury or illness for a covered veteran means an injury or illness that was incurred or aggravated by the service member in the line of duty on active duty in the armed forces and manifested itself before or after the service member became a veteran.

Extension of Coverage During U.S. Military Service
Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

An Employee who is ordered to active military service is (and the Employee's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

Notice Requirements - To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of their military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

If the Employee provides the Employer with advance notice of their military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty (30) days after Employee's departure from employment due to active military service. The Plan Administrator will terminate coverage if Employee's notice to elect coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled "Maximum Period of Coverage" below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

Cost of USERRA Continuation Coverage - The Employee must pay the cost of coverage (herein "premium"). The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost share if the military leave is less than 31 days. If the Employee fails to make timely payment within the same time period applicable to those enrollees of the plan continuing coverage under COBRA, the Plan Administrator will terminate the Employee's coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Administrator will reinstate the Employee to Plan coverage retroactive to the last day premium was paid. The Employee will be responsible for payment of all back premium charges owed.

Maximum Period of Coverage – The maximum period of USERRA continuation coverage is the lesser of:

18 months (or 24 months for elections made on or after December 10, 2004); or

the duration of Employee's active military service.

Reinstatement of Coverage Following Active Duty - Regardless of whether an Employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions.

The Employee must return to employment:

on the first full business day following completion of military service for military leave of 30 days or less; or

within 14 days of completion of military service for military leave of 31-180 days; or

within 90 days of completion of military service for military leave of more than 180 days.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. No waiting period can be imposed on a returning Employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

Extension of Coverage for Retirees
If an Employee retires from active service from the Employer and has:

twenty-five (25) or more years of service (Sheriff's department retirees with twenty (20) or more years of service) for the Employer will be have extended coverage hereunder at no cost (for retiree only);

is under age sixty-five (65):

then, within thirty-one (31) days of the date of the employees retirement, the employee may elect to continue Plan coverage without interruption for themselves and their eligible Dependents (see NOTES below). Later election of this extension will not be permitted.

Except as noted, the retiree will be required to contribute to the Plan at rates determined by the Plan Sponsor. Contributions must be kept current in order for coverage to remain in effect. The requirements for timely payment are the same as those applied to COBRA participants.

NOTES: Only those individuals who were covered under the Plan on the day immediately prior to the Employee's retirement will be eligible for continued Plan coverage under the terms of this provision.

Retirees over age sixty-five (65) have the option of choosing medical and dental coverage or dental only coverage. There is no option for medical only coverage.

Retirees age 65 and over must enroll in Medicare to receive supplemental benefits.

Extension of Coverage for Survivors
If an Employee dies while covered under the Plan, any Dependents covered at the time of the Employee's death will have continued medical benefits hereunder and will not be required to pay the cost of such coverage. However, medical coverage for any such Dependent will terminate on the earlier of:

the 2-year anniversary of the Employee's death;

the date the Dependent spouse remarries;

the date the Dependent ceases to be an eligible Dependent as defined;

the date the Plan ends or is changed to end Dependent coverage for the Employee's class; or

the date the Dependent becomes covered under any other group policy or plan or under an individual policy of medical care coverage offered under any conversion privilege provision. Dependents of a retiree may continue medical coverage beyond the 2-year anniversary of the retiree's death with contribution payments at the retiree status.

- *(See **COBRA Continuation Coverage**)* -

EXTENSION OF BENEFITS DURING TOTAL DISABILITY

If an Employee or Dependent is Totally Disabled on the date their coverage terminates, benefits will be extended but only for the condition causing such Total Disability and only during the uninterrupted continuance of that disability. Extended benefits under the terms of this provision will terminate on the earlier of the following:

upon termination of the Total Disability; one (1) year following the date coverage terminated;

upon the individual's eligibility for coverage in any other group plan, self-insured plan, prepayment plan, HMO or government plan that does not limit coverage for the disabling condition; upon termination of the Plan.

For an Employee, "Total Disability" or "Totally Disabled" means the Employee can perform no duty of their occupation.

For a Dependent, it means the dependent is so disabled that he can engage in none of their usual activities. A Physician (MD or DO) must certify an Employee or Dependent as Totally Disabled. Also, the individual must be under the care of a Physician (MD or DO) in order to be Totally Disabled for Plan purposes.

- *(See **COBRA Continuation Coverage**)* -

CLAIMS PROCEDURES

SUBMITTING A CLAIM

A claim is a request for a benefit determination that is made, in accordance with the Plan's procedures, by a Claimant or their authorized representative. A claim must be received by the person or organizational unit customarily responsible for handling benefit matters on behalf of the Plan so that the claim review and benefit determination process can begin. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

The Plan Administrator has contracted with other entities to handle claims communications and benefit determinations for the Plan. Contact information for such entities ("claims offices") is provided below.

There are two types of health claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

1) **A Pre-Service Claim** is where the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care. See the **Utilization Management Program** section for that information.

   Important: A Pre-Service Claim is only for the purposes of assessing the Medical Necessity and appropriateness of care and delivery. A Pre-Service Claim determination is not a guarantee of Plan benefits. Plan benefits are subject to review of a claim after medical services have been received, and are subject to all related Plan provisions, including exclusions and limitations.

2) **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted to the claims office within ninety (90) days after the date of service or treatment has been rendered or as soon as is reasonably possible, and except in the absence of legal capacity of the Claimant, not later than one (1) year after the end of the ninety (90) day period.

   A Post-Service Claim should be submitted to:

   Delta Health Systems
   1234 W. Oak Street / P. O. Box 551
   Stockton, CA 95201-0551

   NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have three (3) years to submit claims when CMS has paid as the primary plan and the Plan should have been primary.

ASSIGNMENTS TO PROVIDERS

All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign their right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action they may have against the Plan or its fiduciaries.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or their beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (e.g., how quickly the Plan will respond to claims notices, filings and claims appeals and how much time will be allowed for Claimants to respond).

Important: These claims procedures address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval.

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Urgent Claim - defined below	
Claimant Makes Initial Incomplete Claim Request	Within not more than 24 hours (and as soon as possible considering the urgency of the medical situation), Plan notifies Claimant of information needed to complete the claim request. Notification may be oral unless Claimant requests a written notice.
Plan Receives Completing Information	Plan notifies Claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the completing information, or (2) the period of time Claimant was allowed to provide the completing information.
Claimant Makes Initial Complete Claim Request	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), Plan responds with written or electronic benefit determination.
Claimant Appeals	See "Appeal Procedures" subsection. An appeal for an urgent claim may be made orally or in writing.
Plan Responds to Appeal	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), after receipt of claimant's appeal.

An "urgent claim" is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to the Claimant's life or health, or the ability to regain maximum function, or (2) in the judgment of a Physician knowledgeable about the Claimant's condition, severe pain that could not be adequately managed without the care or treatment being claimed.

Where the "Time Limit or Allowance" stated above reflects "or sooner if possible," this phrase means that an earlier response may be required, considering the urgency of the medical situation.

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Concurrent Care Claim - defined below	
Plan Wants to Reduce or Terminate Already Approved Care	Plan notifies Claimant of intent to reduce or deny benefits before any reduction or termination of benefits is made and provides enough time to allow the Claimant to appeal and obtain a response to the appeal before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care that is Medically Necessary, is subject to the urgent claim rules.

Claimant Requests Extension for Urgent Care	Plan notifies Claimant of its benefit determination within 24 hours after receipt of the request (and as soon as possible considering the urgency of the medical situation), provided the Claimant requests to extend the course of treatment at least 24 hours prior to the expiration of the previously-approved period of time or treatment.
A "concurrent care claim" is a Claimant's request to extend a previously-approved and ongoing course of treatment beyond the approved period of time or number of treatments. A decision to reduce or terminate benefits already approved does not include a benefit reduction or denial due to Plan amendment or termination.	
Non-Urgent Claim	
Claimant Makes Initial Incomplete Claim Request	Within 5 days of receipt of the incomplete claim request, Plan notifies claimant, orally or in writing, of information needed to complete the claim request. Claimant may request a written notification.
Plan Receives Completing Information	Plan responds with written or electronic benefit determination within 15 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial Complete Claim Request	Within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeal Procedures" subsection.
Plan Responds to Appeal	Within 30 days after receipt of appeal (or where plan requires 2 mandatory levels of appeal, within 15 days for each appeal).
"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 15-day period.	
"POST-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Claimant Makes Initial Incomplete Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request.
Plan Receives Completing Information	Plan approves or denies claim within 30 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.

Claimant Makes Initial Complete Claim Request	Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeals Procedures" subsection.
Plan Responds to Appeal	Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).
"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.	

Authorized Representative May Act for Claimant
Any of the above actions that can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization. For an urgent claim, a health care professional, with knowledge of a Claimant's medical condition, will be permitted to act as the authorized representative of the Claimant. "Health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Written or Electronic Notices
The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

CLAIMS DENIALS

If a claim is wholly or partially denied, the Claimant will be given written or electronic notification of such denial. The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

the specific reason(s) for the decision to reduce or deny benefits:

specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols that were relied upon in making the decision;

a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the Claimant's claim for benefits;

the identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice, or a statement that the identity of the expert(s) will be provided upon request;

a description of any additional information needed to change the decision and an explanation of why it is needed;

a description of the Plan's procedures and time limits for appealed claims.

APPEAL PROCEDURES

Filing an Appeal
Within 180 days of receiving notice of a claim reduction or denial, a Claimant may appeal their claim, in writing, to a new decision-maker and the claimant may submit new information (e.g., comments, documents and records) in support of their appeal. A Claimant may not take legal action on a denied claim until the member has exhausted the Plan's mandatory (i.e., non-voluntary) appeal procedures - see NOTE.

In response to their appeal, the Claimant is entitled to a full and fair review of the claim and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

At such time as the Claimant appeals a denied claim, the Claimant will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to their claim for benefits.

NOTE: The Plan will not require more than two (2) levels of mandatory appeal. If more than one (1) level of mandatory appeal is required, both will be completed within the time frame applicable to one (1) level.

Decision on Appeal
A decision with regard to the claim appeal will be made within the allowed time frame - see "Claims Time Limits and Allowances."

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

the specific reason(s) for the decision; reference to the pertinent Plan provisions on which the decision is based;

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 claim;

identification of any medical or vocational experts whose advice was obtained in connection with the claim denial;

identification of and access to any guidelines, rules, protocols that were relied upon in making the decision;

a statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Claimant or Dependent on whose behalf such payment was made.

A Claimant, Dependent, Covered Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Claimant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Claimant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Covered Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Claimant, Covered Provider or other person or entity to enforce the provisions of this section, then that Claimant, Covered Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Claimants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Claimant(s) are entitled, for or in relation to facility-acquired condition(s), Covered Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Claimant or by any of his covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

If the Plan seeks to recoup funds from a Covered Provider, due to a claim being made in error, a claim being fraudulent on the part of the Covered Provider, and/or the claim that is the result of the Covered Provider's misstatement, said Covered Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Claimant for any outstanding amount(s).

DEFINITIONS

When capitalized herein, the following items will have the meanings shown below.

Accidental Injury - Any accidental bodily injury that is caused by external forces under unexpected circumstances and that is not excluded due to being employment-related (see **General Exclusions** section). Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination.

Allowable Expenses - Allowable Expenses shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, and eligible items of expense, at least a portion of which is covered under a Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations Section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services instead of cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

Ambulatory Surgical Center - Any public or private establishment that:

complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;

provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and

does not provide services or other accommodations for patients to stay overnight.

Benefit Document – A document that describes one (1) or more benefits of the Plan. This document serves as the Plan's Benefit Document.

Birthing Center - A special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility that:

is in compliance with licensing and other legal requirements in the jurisdiction where it is located;

is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients; has organized facilities for birth services on its premises;

provides birth services by or under the direction of a Physician specializing in obstetrics and gynecology;

has 24-hour-a-day registered nursing services; maintains daily clinical records.

Calendar Year - The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

Claimant - Any Covered Person on whose behalf a claim is submitted for Plan benefits.

Clean Claim - A "Clean Claim" is one that can be processed in accordance with the terms of this document without obtaining additional information from the service provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Covered Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Covered Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other

times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Covered Person has failed to submit required forms or additional information to the Plan as well.

Contract Administrator - A company that performs all functions reasonably related to the administration of one or more benefits of the Plan (e.g., processing of claims for payment) in accordance with the terms and conditions of the Benefit Document and an administration agreement between the Contract Administrator and the Plan Sponsor.

The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not responsible for Plan financing and does not guarantee the availability of benefits under the Plan.

Convalescent Hospital - see "Skilled Nursing Facility"

Covered Expense(s) – Covered Expense(s) means a Usual and Customary fee for, and/or, a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is eligible for coverage under this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

Covered Person - An individual who meets the eligibility requirements as contained herein (e.g., a covered Employee, a covered Dependent, or a Qualified Beneficiary (COBRA)). See **Eligibility and Effective Dates, Extensions of Coverage** and the **COBRA Continuation Coverage** sections for further information.

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

Covered Provider - An individual who is:

licensed to perform certain health care services that are covered under the Plan and who is acting within the scope of their license; or
in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

and who is a/an:

Audiologist
Certified or Registered Nurse Midwife
Certified Registered Nurse Anesthetist (CRNA)
Chiropractor (DC)
Dentist (DDS or DMD)
Dietician
Enterostomal therapist
Licensed Clinical Psychologist (PhD or EdD)
Licensed Clinical Social Worker (LCSW)*
Licensed Practical Nurse (LPN)
Licensed Professional Counselor (LPC)
Licensed Vocational Nurse (LVN)
Marriage Family and Child Counselor (MFCC)*
Nurse Practitioner Occupational Therapist (OTR)
Optometrist (OD)
Physical Therapist (PT or RPT)
Physician - see definition of "Physician"
Physician Assistant (PA)
Podiatrist or Chiropodist (DPM, DSP, or DSC)
Psychiatrist (MD)
Registered Nurse (RN)
Respiratory Therapist
Speech Pathologist

* Coverage is subject to referral by an MD.
A "Covered Provider" will also include the following when appropriately-licensed and providing services that are covered by the Plan:

any practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of their license;

facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers, clinics;

licensed Outpatient mental health facilities;

freestanding public health facilities;

hemodialysis and Outpatient clinics under the direction of a Physician (MD);

enuresis control centers;

home infusion therapy providers;

durable medical equipment providers;

prosthetists and prosthetist-orthotists;

portable X-ray companies;

independent laboratories and lab technicians;

diagnostic imaging facilities;

blood banks;

speech and hearing centers;

ambulance companies.

NOTE: A Covered Provider does not include: (1) a Covered Person treating themselves or any relative or person who resides in the Covered Person's household - see "Relative or Resident Care" in the list of **General Exclusions**, or (2) any Physician, nurse or other provider who is an employee of a Hospital or other Covered Provider facility and who is paid by the facility for their services.

Dependent - see **Eligibility and Effective Dates** section **Eligible Expense(s)** - Expense that is: (1) covered by a specific benefit provision of the Benefit Document and (2) incurred while the person is covered by the Plan.

Emergency - see "Medical Emergency"

Employee - see **Eligibility and Effective Dates** section **Employer(s)** -The Employer or Employers participating in the Plan as stated in the **General Plan Information** section.

Experimental and/or Investigational - Experimental and/or Investigational ("Experimental") shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A Drug, device, or medical treatment or procedure is Experimental:

1. If 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;

2. If reliable evidence shows that the Drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:

    a. Maximum tolerated dose;
    b. Toxicity;
    c. Safety;
    d. Efficacy; and
    e. Efficacy as compared with the standard means of treatment or Diagnosis; or

3. If reliable evidence shows that the consensus among experts regarding the Drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:

    a. Maximum tolerated dose;
    b. Toxicity;
    c. Safety;
    d. Efficacy; and
    e. Efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same Drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same Drug, device, or medical treatment or procedure.

Fiduciary - Any entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures.

Home Health Care Agency - An agency or organization that:

is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to

provide skilled nursing services and other therapeutic services; has policies established by a professional group associated with the agency or organization that includes at least one registered nurse (RN) to govern the services provided;

provides for full-time supervision of its services by a Physician or by a registered nurse;

maintains a complete medical record on each patient;

has a full-time administrator.

In rural areas where there are no agencies that meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

Hospice or **Hospice Agency** -An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and one registered nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital - An institution that is:

licensed as an acute care facility by the proper authority of the state in which it is located; or

recognized as a hospital by the Joint Commission on the Accreditation of Hospitals (JCAH); or

a state licensed and JCAH-recognized mental health or psychiatric facility or an alcoholic or drug treatment facility, provided that any such facility is providing a treatment program for these specific diagnosed conditions and is operating within the scope of its license.

NOTE: A Hospital does <u>not</u> include any institution, or part thereof, that is used primarily as a convalescent home, rest

home, home for the aged, nursing home, custodial care facility, training center, residential care facility or halfway house.

Incurred - A Covered Expense is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Inpatient - A person physically occupying a room and being charged for room and board in a facility (e.g., Hospital, or Skilled Nursing Facility) that is covered by the Plan and to which the person has been assigned on a 24-hour-aday basis without being issued passes to leave the premises. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.

Intensive Care Unit (ICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit - A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, that provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and that is separated from the rest of the Hospital's facilities.

Lifetime - All periods an individual is covered under the Plan, including any prior statements of the Plan. It does not mean a Covered Person's entire lifetime.

Maximum Amount or Maximum Allowable Charge - Maximum Amount and/or Maximum Allowable Charge shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) may be the lesser of:

1. The Usual and Customary amount;
2. The allowable charge specified under the terms of the Plan;
3. The Reasonable charge specified under the terms of the Plan;
4. The negotiated rate established in a contractual arrangement with a Covered Provider; or
5. The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The **Maximum Allowable Charge** will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medical Emergency - An Accidental Injury or the sudden onset of a medical condition, either of which is of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health or, with respect to a pregnancy, the health of the woman or her unborn child, in serious jeopardy, (2) serious impairment of bodily functions, or (3) serious dysfunction of any bodily organ or part.

Medically Necessary - Any health care treatment, service or supply determined by the Plan Administrator to meet each of the following requirements:

it is ordered by a Physician for the diagnosis or treatment of a Sickness or Accidental Injury;

the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;

it is furnished by a provider with appropriate training and experience, acting within the scope of his or her license; and

it is provided at the most appropriate level of care needed to treat the particular condition.

With respect to Inpatient services and supplies, "Medically Necessary" further means that the health condition requires a degree and frequency of services and treatment that can be provided ONLY on an Inpatient basis.

The Plan Administrator will determine whether the above requirements have been met based on: (1) published reports in authoritative medical and scientific literature, (2) regulations, reports, publications or evaluations issued by

government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS), (3) listings in the following compendia: *The American Hospital Formulary Service Drug Information* and *The United States Pharmacopoeia Dispensing Information*; and (4) other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

Medicare - Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 including parts A, B & D and Title XVIII of the Social Security Act, and as amended from time to time.

Outpatient - Services rendered on other than an Inpatient basis at a Hospital or at a covered non-Hospital facility.

Participating Employer - An Employer who is participating in the coverages of the Plan. See **General Plan Information** section for the identity of the Participating Employer(s).

Physician - A Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who is licensed to practice medicine or osteopathy where the care is provided.

NOTE: The term "Physician" will not include the Covered Person themselves or their relatives (see **General Exclusions**) or interns, residents, fellows or others enrolled in a graduate medical education program.

Plan - The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the **General Plan Information** section.

Plan Administrator - see "Plan Sponsor"

Plan Document - A formal written document that describes the Plan and the rights and responsibilities of the Plan Sponsor with regard to the Plan, including any amendments. (See "Benefit Document" definition for additional information).

Plan Sponsor - The entity sponsoring the Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **General Plan Information** section for further information.

Pregnancy - Pre-natal and post-natal care during pregnancy, childbirth, miscarriage or complications arising therefrom. See "Pregnancy Care" in the list of **Eligible Medical Expenses** for further information.

Prior to Effective Date or After Termination Date - Prior to Effective Date or After Termination Date are dates occurring before a Covered Person gains eligibility from the Plan, or dates occurring after a Covered Person loses eligibility from the Plan, as well as charges Incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

Reasonable - "Reasonable" and/or "Reasonableness" shall mean in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating Covered Provider. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Covered Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Covered Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Remedial Clinic - A legally authorized institution (not owed or run by a national or state government) used mainly as a facility for education or training through educational therapy. It must: (1) be supervised 24-hours-a-day by a Doctor of Medicine (MD) or a registered nurse (RN), (2) have the services of an MD available at all times, and (3) be staffed with a legally qualified psychiatrist or psychologist and physical and educational therapists as may be needed to make up and carry out treatment plans.

Semi-Private Room Charge - The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or 90% of the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

Sickness - Bodily illness or disease (other than mental health conditions or chemical dependencies), congenital abnormalities, birth defects and premature birth. A condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.

Skilled Nursing Facility - An institution that:

is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;

is primarily engaged in providing accommodations and skilled nursing care 24-hours-a-day for convalescing persons;

is under the full-time supervision of a Physician or a registered nurse;

admits patients only upon the recommendation of a Physician, maintains complete medical records, and has available at all times the services of a Physician;

has established methods and procedures for the dispensing and administering of drugs;

has an effective utilization review plan;

is approved and licensed by Medicare;

has a written transfer agreement in effect with one or more Hospitals; and

is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

Urgent Care Facility - A facility that is engaged primarily in providing minor emergency and episodic medical care and that has:

a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times;

X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or that is part of a regular Hospital.

Usual and Customary - "Usual and Customary" (U&C) shall mean Eligible Expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Covered Provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the Covered Provider for providing the services, the prevailing range of fees charged in the same "area" by Covered Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Covered Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was Incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with

generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Covered Person by a Covered Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Usual, Customary and Reasonable (UCR) - A charge made by a provider that does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of health conditions comparable in severity and nature to the health condition being treated. 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 the level of charges.

With regard to charges made by a provider of service participating in the Plan's Network program, Usual, Customary and Reasonable will mean the provider's negotiated rate.

GENERAL PLAN INFORMATION

Name of Plan:	**County of Del Norte Group Health Plan**
Plan Sponsor / Plan Administrator: Address:	**County of Del Norte** 981 H Street, Suite 250 Crescent City, CA 95531
Business Phone Number:	(707) 464-7213
Participating Employer(s):	**County of Del Norte**
Plan Sponsor ID Number (EIN):	**94-2254126**
Plan Number:	**501**
Group Plan Designation Number:	**550**
Plan Year:	**December 1 through November 30**
Named Fiduciary: Address:	**County of Del Norte** 981 H Street, Suite 250 Crescent City, CA 95531
(See also definition of "Fiduciary")	
Designated Legal Agent: Address:	**County of Del Norte** 981 H Street, Suite 250 Crescent City, CA 95531

(Legal process may be served upon the Plan Sponsor or a Fiduciary)

Plan Benefits Described Herein:	**Self-Funded Medical and Prescription Drug Benefits**
Type of Administration:	**Contract Administration** – see "Administrative Provisions" for additional information
Applicable Collective Bargaining Agreement(s):	**None**
Contract Administrator: Address:	**Delta Health Systems** 1234 W. Oak Street Stockton, CA 95201
Phone:	(209) 474-5587 or (800) 291-0726

FUNDING - SOURCES AND USES

Employee & Employer Obligations
Plan benefits described herein are paid from the general assets of the Plan Sponsor. Any contributions to be paid by active Employees will be determined by the Plan Sponsor.

See the **COBRA Continuation Coverage** section for more information.

Taxes
Any premium or other taxes that may be imposed by any state or other taxing authority and that are applicable to the coverages of the Plan will be paid by the Plan Sponsor.

NOTE: Should total Plan liabilities in a Plan Year be less than total Employee contributions, any excess will be applied to reduce total Employee contribution requirements in the subsequent Plan Year or, at Plan Sponsor's discretion, may be used in any other manner that is consistent with applicable law.

ADMINISTRATIVE PROVISIONS

Administration (type of)
The Plan benefits described herein are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

Alternative Care
In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan Sponsor elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to provide benefits thereafter in strict accordance with the provisions of the Benefit Document.

Amendment or Termination of the Plan
Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

reduce, modify or terminate retiree health care benefits under the Plan, if any;

alter or postpone the method of payment of any benefit;

amend any provision of these administrative provisions;

make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code; and

terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which the employee has become entitled under the Plan.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of supervisors, or by written amendment that is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

Anticipation, Alienation, Sale or Transfer
Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Applicable Law - Federal and State of California (see "Type of Plan" subsection below for additional information)

Binding Arbitration
Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Covered Person and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Covered Person and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Covered Person waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Covered Person.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Covered Person making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Covered Person and the Plan Administrator, or by order of the court, if the Covered Person and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

Clerical Error
Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Creditable Coverage Certificates
Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits under the Plan), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

Discrepancies
In the event that there may be a discrepancy between any separate booklet(s) provided to Employees ("Summary Plan Descriptions") and the Benefit Document, the Benefit Document will prevail.

Facility of Payment
Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which the Employee can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

Fiduciary Responsibility, Authority and Discretion
Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Benefit Document, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number
Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

Genetic Information Nondiscrimination Act ("GINA")
"GINA" prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a Disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include Dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums

or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

Illegality of Particular Provision
The illegality of any particular provision of the Benefit Document will not affect the other provisions and the Benefit Document will be construed in all respects as if such invalid provision were omitted.

Indemnification
To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions
No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the time written proof of loss is required to be given, or (2) until the Plan's mandatory claim appeal(s) are exhausted. See the **Claims Procedures** section for more information.

Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Loss of Benefits
To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

an employee's cessation of active service for the employer;

a Plan participant's failure to pay their share of the cost of coverage, if any, in a timely manner;

a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);

a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;

a claim for benefits is not filed within the time limits of the Plan.

Material Modification
A Summary of Material Modifications reports changes in the information provided within the Plan. Examples include a change to deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective.

Note: The Patient Protection and Affordable Care Act (PPACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Covered Persons at least 60 days before the effective date of the Material Modification.

Material Reduction
In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days.

"Material reductions" are those which would be construed by the average Plan participant as being "important" reductions in coverage. Examples include reductions in benefits or increases in deductibles or copayments.

Material Reduction disclosure provisions are subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

Mental Health Parity
Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Misstatement / Misrepresentation
If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, their eligibility, benefits or both, will be adjusted to reflect their true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation. (See also "Termination of Fraud" section below).

Misuse of Identification Card
If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that they(and their family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

Non-Discrimination Due to Health Status
An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
- claims experience
- receipt of health care
- medical history
- evidence of insurability
- disability
- genetic information

Not a Contract
This Benefit Document and any amendments constitute the terms and provisions of coverage under this Plan. The Benefit Document is not to be construed as a contract of any type between the Company and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Benefit Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

Physical Examination
The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Plan Administrator Discretion & Authority
The Plan Administrator has the exclusive authority, in its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations thereunder. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Administrator (or the delegated Contract Administrator acting within the scope of its delegated authority on behalf of the Plan) shall make determinations regarding Plan benefits.

Privacy Rules & Security Standards & Intent to Comply

To the extent required by law, the Plan Sponsor certifies that the Plan will: (1) comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health Insurance Portability and Accountability Act (HIPAA) and (2) comply with HIPAA Security Standards with respect to electronic Protected Health Information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

Protection Against Creditors
No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Plan Administrator in its sole discretion may terminate the interest of such Covered Person or former Covered Person in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Covered Person or former Covered Person, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Covered Person or former Covered Person, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care providers.

Purpose of the Plan
The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

Reimbursements
Plan's Right to Reimburse Another Party - Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of their Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of their Dependents.

Rights Against the Plan Sponsor or Employer
Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Statements
All statements made by the Company or by a Covered Person will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Covered Person.

Any Covered Person who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact,

commits a fraudulent act. The Covered Person may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Titles or Headings
Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

Termination for Fraud
An individual's Plan coverage or eligibility for coverage may be terminated if:

the individual submits any claim that contains false or fraudulent elements under state or federal law;

a civil or criminal court finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law;

an individual has submitted a claim that, in good faith judgment and investigation, the individual knew or should have known, contained false or fraudulent elements under state or federal law.

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Covered Person acts fraudulently or intentionally makes material misrepresentations of fact. It is a Covered Person's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Covered Person's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Covered Persons being canceled, and such cancellation may be retroactive.

If a Covered Person, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Covered Person of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Covered Person is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Covered Person and their entire Family Unit of which the Covered Person is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Covered Person whose coverage is being rescinded will be provided a 30 day notice period as described under The Patient Protection and Affordable Care Act (PPACA) and regulatory guidance. 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 under this Plan. (See also "Misstatement / Misrepresentation" above).

Type of Plan
This Plan is not a plan of insurance. This Plan is a self-funded nonfederal governmental group health plan that is exempt from the requirements of the Employee Retirement Income Security Act (ERISA). However, governmental plans are not automatically excluded from the following requirements of Title XXVII of the Public Health Service (PHS) Act: The Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns and Mothers Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA). To be exempt from certain requirements of these laws, the Plan must make an affirmative written election to be excluded. Such election must be filed with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each Plan Year, with notice provided to each Plan participant. Unless such written election is filed and participant notices are made, this Plan intends to fully comply with the above-stated federal laws. Your rights as a Covered Person in the Plan are governed by the plan documents and applicable State law and regulations. This Plan shall be deemed automatically to 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.

Workers' Compensation
The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, that is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

If a retired Employee is covered under the Plan and one of the retired Employees Dependents has a Qualifying Event (e.g., divorce or loss of Dependent child eligibility), such Dependent may be eligible for COBRA Continuation Coverage. Also, certain other COBRA rights apply to such retirees and their covered Dependents with regard to an Employer's bankruptcy. Anywhere "retirees" are referenced herein, it means only those retired Employees who were covered under the Plan.

Definitions - When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse or child of a covered Employee.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverages the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

Qualifying Event - Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;

reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay their portion of the cost of Plan coverage during the FMLA leave;

for an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that their Medicare coverage is in effect;

for an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;

for an Employee's spouse or child, the death of the covered Employee;

for an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit);

for retirees and their Dependent spouses and children, loss of Plan coverage due to the Employer's filing of a bankruptcy proceeding under Title 11 of the U.S. Bankruptcy Code. In order for a Qualifying Event to occur, the Employee must have retired on or before the date of substantial elimination of the Plan's benefits and must be covered under the Plan on the day before the bankruptcy proceedings begin. "Substantial elimination" of the Plan's benefits must occur within 12 months before or after the bankruptcy proceedings begin.

NonCOBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notification Responsibilities – If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within 44 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits the Employee to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his/her spouse. A Qualified Beneficiary is also responsible for other notifications. See the **COBRA Notification Procedures** as included in the Plan's Summary Plan Description (and the Employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary(ies) of their continuation rights within 14 days.

Election and Election Period - COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. See NOTE.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is 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 to be made on the date they are sent to the Employer or Plan Administrator.

Open enrollment rights that allow NonCOBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, the former Qualified Beneficiary does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

Effective Date of Coverage - COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes their waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits - COBRA continuation coverage will be equivalent to coverage provided to similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated NonCOBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to their deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage - The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost that is paid by the Employer for NonCOBRA Beneficiaries. Qualified Beneficiaries can be charged up to 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Sponsor permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase if:

the cost previously charged was less than the maximum permitted by law;

the increase is due to a rate increase at Plan renewal;

the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law that is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or

the Qualified Beneficiary changes their coverage option(s) that results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than $50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTES: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

Maximum Coverage Periods -The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;

if the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee, themselves, experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;

in the case of a bankruptcy Qualifying Event with regard to a retiree, the maximum coverage period is to the date of the retired Employee's death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse or Dependent child of the retired Employee ends on the earlier of: (1) 36 months after the death of the retired Employee, or (2) the date of the Qualified Beneficiary's death;

for any other Qualifying Event, the maximum coverage period ends 36 months after the Qualifying Event.

If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment or a bankruptcy of the Plan Sponsor following any Qualifying Event will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event, except in the case of a bankruptcy Qualifying Event with regard to a retiree where the maximum coverage period is to the date of the retired Employee's death.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension - An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in their family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension themselves.

Termination of Continuation Coverage - Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;

the date on which the Employer ceases to provide any group health plan to any Employee;

the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any preexisting condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;

the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that their Medicare coverage is in effect;

in the case of a Qualified Beneficiary entitled to a disability extension, the later of:

29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated NonCOBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

ADOPTION OF THE DOCUMENT

Adoption
The Plan Sponsor hereby adopts this document on the date shown below.

This document replaces any and all prior statements of the Plan benefits that are described herein and in that respect this document is adopted as the Benefit Document. This Benefit Document represents both the Plan Document and the Summary Plan Description. This Benefit Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

Purpose of the Plan
The purpose of the Plan is to provide certain benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The benefits provided by the Plan are as listed in the **General Plan Information** section.

Conformity with Law
If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Participating Employers
Employers participating in this Plan are as stated in the section entitled **General Plan Information**.

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

Restatement / Replacement of Benefits
This document replaces prior benefits offered by the Plan Sponsor but this is not a new Plan. Except to the extent benefits are expressly added, removed or modified, any benefits provided with respect to covered persons under the prior benefits will be deemed to be benefits provided hereunder for a person who is eligible as an active enrollee or a COBRA enrollee under the document on its effective date. Any contiguous periods a person was covered under the benefits replaced by this document will be deemed to be time covered hereunder.

Acceptance of the Document
IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of January 1, 2014.

County of Del Norte

By: _____

Title: _____

WITNESS:

By: _____

Title: _____

ATTACHMENT C
Health Care Premium Schedule

ATTACHMENT C

Health Care Premium Schedule

DNCEA/SEIU Biweekly

Premium Increase Schedule	*Biweekly Rate*
Employee	5% of Gross
Employee + 1*	$ 99.18
Employee + 2*	$ 152.37
Employee + 3*	$ 159.00
Employee + 4 or more*	$ 165.62

SEA Biweekly

Premium Increase Schedule	*Biweekly Rate*
Employee	5% of Gross
Employee + 1*	$ 99.18
Employee + 2*	$ 152.37
Employee + 3*	$ 159.00
Employee + 4 or more*	$ 165.62

Cobra Rate Schedule

Premium Increase Schedule	*Monthly Rate*
Single	$524.99
Single + 1	$1,018.49
Single + 2 or more	$1,532.99

Retiree Rate Schedule

Retiree's Under 65	*Monthly Rate*
10 to 15 years Single	$ 386.06
10 to 15 years R+1 Dep	$ 748.89
10 to 15 years R+ 2 or more	$ 1,127.20
16 to 20 years Single	$ 257.25
16 to 20 years R+1 Dep	$ 559.76
16 to 20 years R+ 2 or more	$ 875.02
21 to 24 years Single	$ 128.68
21 to 24 years R+1 Dep	$ 343.59
21 to 24 years R+ 2 or more	$ 458.83
25 or more years Single	$ -
25 or more years R+1	$ 214.91
25 or more years R+2 or more	$ 344.50

Retiree's 65 & Over - Full Plan	*Monthly Rate*
10 to 15 years Single	$ 225.00
10 to 15 years R+1 Dep	$ 439.91
10 to 15 years R+ 2 or more	$ 555.15
16 to 20 years Single	$ 200.00
16 to 20 years R+1 Dep	$ 414.91
16 to 20 years R+ 2 or more	$ 530.15
21 to 24 years Single	$ 175.00
21 to 24 years R+1 Dep	$ 389.91
21 to 24 years R+ 2 or more	$ 505.15
25 or more years Single	$ 150.00
25 or more years R+1	$ 364.91
25 or more years R+2 or more	$ 480.15

Retiree's 65 & Over - Dental Only	*Monthly Rate*
10 to 15 years Single	$ 60.00
10 to 15 years R+1 Dep	$ 115.00
10 to 15 years R+ 2 or more	$ 165.00
16 to 20 years Single	$ 60.00
16 to 20 years R+1 Dep	$ 115.00
16 to 20 years R+ 2 or more	$ 165.00
21 to 24 years Single	$ 60.00
21 to 24 years R+1 Dep	$ 115.00
21 to 24 years R+ 2 or more	$ 165.00
25 or more years Single	$ 60.00
25 or more years R+1	$ 115.00
25 or more years R+2 or more	$ 165.00

Resolution No. 2016-02

A RESOLUTION OF THE GOVERNING BOARD OF THE DEL NORTE SOLID WASTE MANAGEMENT AUTHORITY ESTABLISHING BENEFITS FOR UNPREPRESENTED POSITIONS OF ADMINISTRATIVE ASSISTANCE AND FACILITIES AND PROGRAMS COORDINATOR

WHEREAS, the California Government Code requires that the Governing Board shall fix, by resolution or ordinance, the compensation of all appointive officers and employees; and

WHEREAS, the Authority's bargaining has negotiated and approved a Memorandum of Understanding with SEIU Local 1021 that covers the period July 1, 2016 through June 30, 2019;

WHEREAS, the positions of Administrative Assistant and Facilities and Programs Coordinator are exempt positions not covered by the above-referenced Memorandum of Understanding and rather than attempt to negotiate another agreement between the Authority and the two employees filling the unrepresented positions, the parties have agreed that a "me too" resolution that will fulfill the intentions and expectation of both the employees and the Authority.

NOW, THEREFORE, BE IT RESOLVED by the Governing Board of the Del Norte Solid Waste Management Authority that the following benefits are hereby approved for the positions of Administrative Assistant and Facilities and Programs Coordinator.

1. GENRALLY. Benefits provided pursuant to this Resolution that are also provided to employees who are members of the DNSWMA Employees Union / SEIU Local 1021 are subject to the same procedural rules applicable to such benefits as outlined in the MOU.
2. COMPENSATION.
    a. Salary. Salaries for the positions of Administrative Assistant and Facilities and Programs Coordinator are those which have been established by the Governing Board and are stated as bi-weekly amounts attached hereto as Exhibit A.
    b. COLA. Salaries for the positions of Administrative Assistant and Facilities and Programs Coordinator shall be increased by the same cost of living increase which is granted to those employees who are members of the DNSWMA Employees Union / SEIU Local 1021.
    c. Steps and Longevity. The positions of Administrative Assistant and Facilities and Programs Coordinator are entitled to the same step increases, longevity step increases, Y-rating, and out-of-class pay benefits as are provided to other employees under the Memorandum of Understanding with the DNSWMA Employees Association / SEIU Local 1021 so long as they are available to the bargaining unit members.
3. HEALTH AND WELFARE BENEFITS.
    a. Insurance Plans. The positions of Administrative Assistant and Facilities and Programs Coordinator are eligible to receive the same benefits on the same terms as are provided to other employees under the Memorandum of Understanding with the DNSWMA Employees Association / SEIU Local 1021 for the following insurance coverages so long as they are available to the bargaining unit members:

health plan, plan continuation benefits, dental plan, life insurance, ground-air-ambulance plans, and voluntary insurance plans.

b. Retirement. The positions of Administrative Assistant and Facilities and Programs Coordinator are entitled to the same retirement benefits on the same terms as are provided to other employees under the Memorandum of Understanding with the DNSWMA Employees Association / SEIU Local 1021 so long as they are available to the bargaining unit members.

c. Clothing and Footwear. The positions of Administrative Assistant and Facilities and Programs Coordinator are entitled to the same clothing and footwear benefits as are provided to other employees under the Memorandum of Understanding with the DNSWMA Employees Association / SEIU Local 1021 so long as they are available to the bargaining unit members.

d. Leaves. The positions of Administrative Assistant and Facilities and Programs Coordinator are entitled to the same Vacation, Sick Leave, Family Death Leave, Jury Duty, Military Leave, Family Medical Leave, and Administrative Leave on the same terms as are provided to other employees under the Memorandum of Understanding with the DNSWMA Employees Association / SEIU Local 1021 so long as they are available to the bargaining unit members.

e. Travel, Training and Reimbursement. The positions of Administrative Assistant and Facilities and Programs Coordinator are entitled to the same travel, training and reimbursement benefits on the same terms as are provided to other employees under the Memorandum of Understanding with the DNSWMA Employees Association / SEIU Local 1021 so long as they are available to the bargaining unit members.

f. Holidays. The positions of Administrative Assistant and Facilities and Programs Coordinator are entitled to the same designated holidays on the same terms as are provided to other employees under the Memorandum of Understanding with the DNSWMA Employees Association / SEIU Local 1021 so long as they are available to the bargaining unit members.

4. JOB PERFORMANCE.

a. Evaluations, Probation, Grievances and Discipline. The positions of Administrative Assistant and Facilities and Programs Coordinator are subject to the Evaluation, Probation, Grievance, and Disciplinary Procedures on the same terms as are provided to other employees under the Memorandum of Understanding with the DNSWMA Employees Association / SEIU Local 1021 so long as they are available to the bargaining unit members.

b. Layoff & Re-Employment. The positions of Administrative Assistant and Facilities and Programs Coordinator are entitled to the same Layoff and Re-Employment rights on the same terms as are provided to other employees under the Memorandum of Understanding with the DNSWMA Employees Association / SEIU Local 1021 so long as they are available to the bargaining unit members.

APPROVED AND ADOPTED by the Governing Board of the Del Norte Solid Waste Management Authority at a regular meeting thereof on the 21st day of June, 2016, by the following polled vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

Martha McClure, Chair of the Board

ATTEST:

Kathleen Brewer, Clerk of the Board

EXHIBIT A

Bi-Weekly Salary Schedule for Mid-Management Employees

Facilities and Programs Coordinator				Range:	50					
Fiscal year	A	B	C	D	E	F	G	H	I	J
FY 15/16	$1,647.07	$1,729.42	$ 1,815.89	$1,906.68	$2,002.01	$2,102.11	$2,207.22	$2,317.58	$2,433.46	$2,555.13
FY 16/17	$1,778.84	$1,867.77	$ 1,961.16	$2,059.21	$2,162.17	$2,270.28	$2,383.79	$2,502.98	$2,628.13	$2,759.54
FY 17/18	$1,839.32	$1,931.28	$ 2,027.84	$2,129.23	$2,235.68	$2,347.47	$2,464.84	$2,588.08	$2,717.49	$2,853.36
FY 18/19	$1,879.32	$1,971.28	$ 2,067.84	$2,169.23	$2,275.68	$2,387.47	$2,504.84	$2,628.08	$2,757.49	$2,893.36

Administrative Assistant - Solid Waste				Range:	44					
Fiscal year	A	B	C	D	E	F	G	H	I	J
FY 15/16	$1,422.80	$1,493.40	$ 1,568.64	$1,647.07	$1,729.42	$1,815.89	$1,906.69	$2,002.02	$2,102.12	$2,207.23
FY 16/17	$1,536.62	$1,612.87	$ 1,694.13	$1,778.84	$1,867.77	$1,961.16	$2,059.22	$2,162.18	$2,270.29	$2,383.81
FY 17/18	$1,588.87	$1,667.71	$ 1,751.73	$1,839.32	$1,931.28	$2,027.84	$2,129.23	$2,235.70	$2,347.48	$2,464.85
FY 18/19	$1,628.87	$1,707.71	$ 1,791.73	$1,879.32	$1,971.28	$2,067.84	$2,169.23	$2,275.70	$2,387.48	$2,504.85

Del Norte Solid Waste Management Authority

1700 State Street, Crescent City, CA 95531

Phone (707) 465-1100 Fax (707) 465-1300

www.recycledelnorte.ca.gov

The Authority's mission is the management of Del Norte County solid waste and recyclable material in an environmentally sound, cost effective, efficient and safe manner while ensuring 100% regulatory compliance with law.

Staff Report

Date: 16 June 2016
To: Commissioners of the Del Norte Solid Waste Management Authority
From: Tedd Ward, M.S. – Director
File Number: 101503
Topic: Authority meeting date for August, subsequent meetings

Summary / Recommendation: That the Board take each of the following actions:

1. **Determine if there is need to change the date of the August 2016 meeting to some date other than August 16, 2016, and if so, select an alternative meeting date and time.**
2. **If there is need to change the date of the August 2016 meeting, determine if there is need to change the date and time of the regular Authority meetings from the third Tuesday of the month. If so, staff will draft a Resolution for consideration and possible adoption at the August 2016 meeting.**

Background: At the regular June 21 Board meeting, the Authority Board rescheduled the July meeting for July 5th, replacing the regular meeting date (on the third Tuesday of the month) on July 19. At the June meeting, Chair McClure and Commissioner Howard were absent. Commissioner Howard was at a meeting out of town, and alternate Commissioner Hemmingsen attended on behalf of the County. Though staff have sent e-mails to Chair McClure, those have not been answered.

Analysis: For any action by the Authority to be effective, it must be voted by a majority of the Commissioners, including at least one vote from a City Commissioner and at least one vote from a County Commissioner.

Fiscal Impacts: None.

Related Issues: The potential for rescheduling the regular Authority meetings is limited by the dates and times of other meetings scheduled in the Del Norte County Board of Supervisors' chambers.

7.2

REQUEST FOR PROPOSALS FOR

TOWING, STORAGE, RECOVERY AND DISPOSAL OF ABANDONED VEHICLES

FROM THE DEL NORTE ABANDONED VEHICLE ABATEMENT AUTHORITY
DEL NORTE COUNTY, CALIFORNIA
(707) 465-1100
(707) 465-1300 FAX
E-MAIL: TEDD@RECYCLEDELNORTE.CA.GOV

1700 STATE STREET
CRESCENT CITY, CA 95531

PROPOSALS DUE:
09 AUGUST 2016
4:30 P.M.

8

REQUEST FOR PROPOSALS FOR

TOWING, STORAGE, RECOVERY AND DISPOSAL OF ABANDONED VEHICLES

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REQUEST FOR PROPOSALS FOR

TOWING, STORAGE, RECOVERY AND DISPOSAL OF ABANDONED VEHICLES

I. PROJECT OVERVIEW

This is a Request for Proposals (RFP) to provide towing, storage, recovery and disposal of abandoned vehicles in Del Norte County. The details of the services to be provided are included in the Agreement attached as Exhibit 2.

The Board of the Del Norte Abandoned Vehicle Abatement (AVA) Authority is the same as the Board for the Del Norte Solid Waste Management Authority (DNSWMA), and DNSWMA staff are administering this RFP process on behalf of the AVA. Proposals to provide these services must be received at the Del Norte Solid Waste Management Authority office at 1700 State Street, Crescent City, CA 95531, Attention: Director, by 4:30 P.M. on 09 August 2016. .

II. PROPOSAL PROCESS

A. Contact Person

All requests for information regarding this RFP and for information about the Authority's current solid waste operations should be directed to:

Tedd Ward, M.S. – Director
Del Norte Solid Waste Management Authority
1700 State Street
Crescent City, CA 95531
Telephone: (707) 465-1100
Fax: (707) 465-1300
e-mail: tedd@recycledelnorte.ca.gov
website: www.recycledelnorte.ca.gov

The RFP is considered to include all items listed in the Table of Contents, the text of the RFP, the Exhibits, and any addenda issued by the Authority.

Proposer is advised to check that all parts of the RFP package have been received. Proposers are responsible for informing themselves with respect to all conditions that might in any way affect the cost or the performance of any of the work. Each Proposer is responsible for obtaining any and all information it deems necessary to make its proposal. The Authority does not assume any liability for actions taken pursuant to data contained in this RFP. Checking the accuracy and completeness of the information is the responsibility of the Proposer. Failure to do so shall be at the sole risk of the Proposer and no relief shall be given for errors or omissions by the Proposer.

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B. Distribution List for RFP

The initial RFP mailing list is attached as Exhibit 1.

C. Evaluation Process

Each proposal will be evaluated by the Authority for completeness and for compliance with the requirements of this RFP. All determinations with regard to the evaluation of proposals will be at the sole discretion of the Authority. The agreement will be awarded to the proposer determined by the Board to have submitted the proposal that will best meet the needs of the community while assuring the Board that the proposer has the ability and experience to provide the services requested. In determining which proposal is the best fit for the Board, the following criteria may be considered by the AVA: (a) ability to perform the service required within the specified time period; (b) reputation, judgment and experience; (c) quality of performance in previous agreements: (d) previous compliance with laws, permits, licenses and employment practices; (e) financial ability to perform the contract; (f) quality, availability and adaptability of the contractual services and equipment to adaptability of the contractual services and equipment to the particular use required; (g) ability to provide service; (h) whether the proposer is in arrears to the County or the City, in debt on contract, is a defaulter on surety to the County or City or whether the proposer's taxes or assessments are delinquent.

The AVA reserves the right to reject any and all proposals and to waive any informality in the proposals received. The selected Contractor will be expected to sign a copy of the agreement attached as Exhibit 2.

III. PROPOSAL REQUIREMENTS

The Authority invites proposals from companies qualified to provide the requested services described in the previous section and the attached Exhibit 2. The contents and pricing structure of the selected Proposal, this Request for Proposals, and opinions from relevant legal counsels will form the initial basis for negotiating an Agreement for the selected Contractor. The contents of each proposal should address each of the topics from the headings within this Section of the RFP.

1. **TIME:** Submittals shall be received at the offices of the Del Norte Solid Waste Management Authority, 1700 State Street, Crescent City, California 95531 by 4:30 p.m., 09 August 2016. The Authority will not be responsible for a proposal delivered to a person/location other than specified. Proposals must be in ink or typewritten and all changes and/or erasures must be initialed and dated in ink. No facsimile, telegraphic or telephone proposal will be accepted. **LATE PROPOSALS OR UNSIGNED PROPOSALS WILL NOT BE ACCEPTED UNDER ANY CIRCUMSTANCES.**

2. **COPIES:** Three copies of the proposal must be submitted. A transmittal letter containing the original (not photocopied) signature of the proposer shall accompany the required number of copies. The Authority requests that all

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proposals be submitted printed on recycled paper and copied on two sides.

3. **PERMITS:** Copies of all required permits and licenses shall be included and made part of the proposal.

4. **FACILITY DESCRIPTION:** Address, Assessor's Parcel Number, County, and narrative description of Proposers capabilities and capacities, including the number of tow vehicles, storage location, etc.

5. **PRICE PROPOSAL:** The Abatement price per vehicle column of Exhibit B must be completed for all Towing Charges by Zone as well as Additional Charges and submitted, which will be the basis for invoices submitted for the duration of this agreement. Proposers should also closely examine Exhibit B to see how each price proposal will be considered during the evaluation of each proposal.

IV. EXHIBITS AND FORMS

Exhibit 1: Initial Mailing List for this RFP
Exhibit 2: Draft Agreement for Removal of Abandoned Vehicles
Exhibit A: Del Norte Abandoned Vehicle Authority Towing Zones
Exhibit B: Fees for Services Rendered & Map of Del Norte AVA Towing Zones

EXHIBIT 1: INITIAL MAILING LIST FOR THIS REQUEST FOR PROPOSALS

AAA Towing/ Northcrest Auto Center
1165 McNamara Rd, Crescent City, CA
(707) 464-5626

Affordable Tow & Auto Care
1044 Hwy 101 N, Crescent City, CA
(707)464-6464

Bondo Bob & Son
1191 Burtschell St, Crescent City, CA
(707) 464-3496

Budget Towing
1125 Northcrest Dr. Crescent City, CA
(707)464-5903

California Auto Image
215 W Washington Blvd, Crescent City, CA
(707) 464-3354

Robertson's Towing Service
1377 2nd St, Crescent City, CA
(707) 464-2422

EXHIBIT 2: AGREEMENT FOR REMOVAL OF ABANDONED VEHICLES

BETWEEN THE DEL NORTE COUNTY

ABANDONED VEHICLE ABATEMENT SERVICE AUTHORITY

AND _____

THIS AGREEMENT is effective _____ by and between the Del Norte County Abandoned Vehicle Abatement Service Authority (hereinafter referred to as "AVA"), a joint powers authority created by the City of Crescent City and the County of Del Norte, California pursuant to section 22710 of the California Vehicle Code, and _____ (hereinafter referred to as "Contractor"), in accordance with all regulations and guidelines for the abatement of abandoned vehicles as established by the California Highway Patrol (hereinafter "CHP"), and as may be revised from time to time.

RECITALS

WHEREAS, pursuant to California Vehicle Code § 22660, as adopted by Chapters 7.28 and 7.29 of the Del Norte County Code, and § 8.28.070 of the Crescent City Municipal Code, et seq., the County of Del Norte and the City of Crescent City desired to enact a program of abatement, as public nuisances, of all Abandoned, and/or Inoperative Vehicles, or parts thereof, which are left on public or private property in violation of the above referenced code sections; and,

WHEREAS, in 1996 the participating members formed the AVA under the authority of the provisions of the California Vehicle Code § 22710 for the abatement of all Abandoned Vehicles situated within the incorporated and unincorporated areas of Del Norte County California; and,

WHEREAS, the AVA receives a portion of fees paid to the State for vehicle registration to reimburse the costs incurred by the AVA in performing its duties; and,

WHEREAS, pursuant to Sections 22669 (b) and 22710 of the California Vehicle Code the AVA has determined that it is in the furtherance of the public interest to secure the performance of an independent contractor to be charged with the duty to tow, store, recover and dispose of abandoned, wrecked, dismantled, and inoperative motor vehicles on public and private property; and,

WHEREAS, pursuant to Section 22662 of the California Vehicle Code the AVA has determined that commercial channels of disposition are inadequate to fully meet the

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needs of the public interests, and may exercise the right to operate a suitable site for processing as scrap, or other disposition consistent with subdivision (e) of California Vehicle Code section 22661; and,

WHEREAS, Contractor warrants that it is qualified and agrees to render the aforesaid services in the incorporated and the unincorporated areas of Del Norte County.

NOW, THEREFORE, the parties agree as follows:

A. DEFINITIONS. The following definitions apply to this Agreement:

1) "Abandoned Vehicle" means a Vehicle that has been cited and the ten-day period after service of the notice of intention to abate and remove the vehicle per Vehicle Code Section 22661 (d) has expired.

2) "Highway" means a way or place of whatever nature, publicly maintained and open to the use of the public for purposes of vehicular travel. Highway includes Street.

3) "Inoperative Vehicle" means any motor vehicle which is lacking an engine, transmission, wheels, tires, doors, windshield, or any other part or equipment for the safe operation of the Vehicle upon the highway and which has been declared a hazard to public health, safety and welfare by a peace officer or designated employee of Crescent City, Del Norte County, or the AVA.

4) "Owner" as used herein means the person shown to be the last known registered owner, or lien holder, according to Department of Motor Vehicle (DMV) records. When ownership cannot be ascertained from DMV records, owner means the owner of land upon which the Vehicle was abandoned.

5) "Vehicle" means a device by which any person or property may be propelled, moved, or drawn upon a highway except a device moved by human power or used exclusively upon stationary tracks or rails.

B. REQUESTS FOR SERVICE

1) Contractor shall provide all services required to effectuate the removal and disposal of abandoned vehicles and parts thereof in accordance with Chapters 7.28 / 7.29 of the Del Norte County Code, Chapter 8.08 or 8.12 of the Crescent City Municipal Code and Division 11 and Chapter 10 of the California Vehicle Code. AVA's request for service

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may be relied upon by Contractor that the participating member has complied with all procedures required under applicable state and local regulations.

2) All requests for service will be generated by an authorized representative of the AVA, including the Del Norte County Code Enforcement Officer, the Crescent City Code Enforcement Officer, the Crescent City Police Chief or the Del Norte County Sheriff, in writing or by telephone. Written request(s) submitted by the AVA to the Contractor must be on a CHP form #180 (or other form approved by the CHP). The request may be submitted to the contractor in person, by US mail, electronic mail with 'read' receipt, or by Facsimile (FAX). When service is requested by telephone, an authorized representative of AVA shall wait at the service location until Contractor arrives and shall provide Contractor with a written request as described above upon Contractor's arrival. Contractor may NOT perform services under this Agreement until AVA has provided written request/ authorization as described above. Service requested by someone other than an authorized representative of AVA is not a valid charge to the AVA. The AVA representative requesting services shall specify the location of storage or disposal on the written request at the time of submittal.

3) Contractor will be available by phone or messaging service twenty-four hours per day, seven days per week. Contractor will not be eligible for additional fees or payments associated with night, weekend, or holiday service regardless of when service is provided. Whenever possible, Contractor shall respond to telephonic requests for service within 30 minutes. Whenever such response is not possible, Contractor shall as soon as practical notify the requesting AVA representative of the delay and provide an estimated response time. The AVA representative may elect to either wait at the vehicle location or submit the request for service in writing.

4) Within 24 hours of receipt of a written request for service, Contractor must remove, or cause to be removed, such vehicles or parts thereof which are reported to the Contractor as being in violation of the Del Norte County Code Chapters 7.28 or 7.29 and/or Chapter 8.08 or 8.12 of the Crescent city Municipal Code, as described in paragraph 1 herein. Contractor must remove, store and dispose of the vehicle(s) or parts thereof in a lawful manner as directed on the written request for services. Contractor shall transmit a notification whether or not such vehicle(s) or parts thereof have been abated to the applicable participating member from whose jurisdiction the tow originated within 24 hours of towing/abating said Vehicle(s).

C. CONTRACTOR'S RESPONSE TO REQUEST FOR SERVICE

1) All vehicles or parts thereof, removed by Contractor at the request of AVA, as a public nuisance, must be scrapped or demolished at a place and in the manner required by all

applicable laws and regulations and must not be reconstructed or made operable except as provided by California Vehicle Code §§ 5004 and/or 22661 (f). This subsection does not apply to vehicles released by the AVA in accordance with law.

2) Contractor shall equip and maintain tow trucks utilized by Contractor to perform services under this Agreement in accordance with the provisions set forth in the California Vehicle Code, Title 13 of the California Code of Regulations and industry standards and practices. Contractor shall tow all vehicles with tow trucks of sufficient weight and equipment to properly and safely tow the wide variety of Vehicles that may be towed under this Agreement. Contractor shall have a sufficient vehicle force to effect the removal of Abandoned, wrecked, dismantled or Inoperative Vehicles. Contractor shall allow inspection of its tow trucks, upon reasonable notice, by the AVA or the City or County or CHP.

3) Contractor must not use force, violence, threats of force or violence to enter upon private property to remove the Vehicles or parts thereof if entry to the property is refused by such person having possession thereof. If entry is refused by such person, Contractor shall immediately notify the AVA and the participating member's Code Enforcement/Abatement Officer of such refusal.

D. VEHICLE FRACTIONS AND VEHICLE-RELATED DEBRIS

1) Contractor must remove and properly dispose of all vehicle parts as directed by the AVA and provide such other assistance as directed. There will be no additional charge for this assistance.

2) In the event a Vehicle contains trash, rubbish, garbage, or other solid or liquid waste, the Contractor shall notify the applicable participating member's Code Enforcement/Abatement Officer who shall arrange for its disposal. Contractor may assess a flat-rate "Additional Unloading Charge" for delivering and unloading AVA-related materials for disposal when directed to do so by the AVA representative requesting service. The Flat Rate Charge shall not exceed that specified in Exhibit B.

3) Contractor shall prevent the spillage or leakage of automotive fluids or other hazardous wastes while performing services pursuant to this Agreement. Each tow vehicle used under this Agreement will carry a spill response kit. As required by California Vehicle Code, Contractor will contain and remove any spilled fluids upon taking possession of the vehicle.

4) In accordance with California Vehicle Code Sections 2450-2454, inclusive, whenever hazardous wastes have been spilled or deposited upon any Highway within the incorporated or unincorporated areas of Del Norte County, the person discovering such hazardous waste shall immediately notify the CHP and take such actions as the CHP may direct.

E. STORAGE

1) Regulations governing the removal and disposal of Abandoned Vehicles require that some be stored by Contractor. Vehicles stored by Contractor will be stored at the Contractor's facility unless otherwise directed by the AVA representative requesting service. Contractor's employees, agents and subcontractors must be properly trained to conduct business transactions related to towing, storage and release of Vehicles and other property.

2) Contractor must provide adequate storage for Vehicles removed under the terms of this Agreement. Facilities are subject to inspection during regular business hours without notice by the AVA, City, County, or CHP. No such stored Vehicle or parts thereof may be stored upon the public right-of-way, or upon City/County/ State property unless authorized by the proper entity, or upon a property that does not have appropriate County permits for storing and/or processing scrap vehicles.

3) Contractor must provide adequate security for Vehicles, parts and property at its approved facility. At a minimum, the area must be fenced and Contractor is responsible

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for reasonable care, custody and control of all Vehicles, parts and other property in Contractor's possession.

4) Vehicles that are not immediately removed to a licensed dismantler or scrap metal recycling facility may only be stored in a storage area that meets the requirements established by AVA and State and local ordinances.

5) Contractor must prevent the spillage or leakage of automotive fluids or other hazardous wastes while performing services pursuant to this Agreement.

6) All Vehicles removed by Contractor at the request of the AVA and not authorized for immediate disposal by the AVA as a nuisance (per Section 22851.3 of the California Vehicle Code) must be held and stored as prescribed in California Vehicle Code. AVA is not responsible for the payment of storage fees.

7) Vehicles that have been towed by the Contractor from public roads or lands and stored by the Contractor may be released. If the vehicle is claimed by the owner or his or her agent within 15 days of the notice date, the Contractor who is storing the vehicle may collect reasonable fees for services rendered, but may not collect lien sale fees as provided in Section 22851.12 of the Vehicle Code. Storage fees may not be charged if the vehicle was reported stolen prior to the request for service. In the event of a dispute, the storage fee will be determined by the applicable Code Enforcement/Abatement officer. These requirements are not to be construed as requiring a charge when the Contractor would not normally charge for such service. Vehicles may be released only upon presentation of satisfactory proof of ownership in accordance with California Vehicle Code section 22851.3.

8) Vehicles may not be released by the Contractor, without a written release from the AVA stating that the either the towing fees and cost have been paid, or the Vehicle was determined at a hearing to have been towed in error. A CHP Form 180 clearly stating that the vehicle may be released to the Registered Owner or the Registered Owner's designated Agent, upon payment of towing and storage fees to the Contractor will be considered written authorization to release the Vehicle. Whenever a Vehicle is released upon payment directly to the Contractor, there will be no charge from the contractor to the AVA for any services rendered in association with such Vehicle released, and Contractor must immediately notify the AVA representative that requested services that the vehicle was released.

9) Vehicles towed by Contractor and stored at an AVA facility may be released by the AVA in accordance with policies and procedures developed by the AVA. Contractor does not have authority to release Vehicles stored at an AVA facility. Contractor must refer any request for release of a Vehicle stored at an AVA facility to the AVA in accordance with AVA policies.

F. VEHICLE DISPOSAL

1) Contractor has the sole responsibility to process any Vehicle or parts thereof, stored at Contractor's facility. All such Vehicles or parts must be properly disposed of at a licensed auto dismantler or scrap iron recycler in accordance with the California Vehicle Code and this Agreement. Contractor may not impose any additional fees or charges for disposing of a Vehicle or parts thereof at a local disposal facility.

2) Vehicles stored at the AVA facility or on City or County properties are the responsibility of the AVA or the responsible agencies, and the AVA or those agencies shall make arrangements as necessary for their proper disposal.

3) Vehicles that cannot be disposed of locally must be taken to the nearest alternate available facility for proper disposal. Prior approval from the AVA is required before taking any vehicle to an alternate facility. Fees for towing such Vehicles to alternate disposal sites will be as described elsewhere in this Agreement.

4) For Vehicles valued at less than $300.00, the AVA shall issue a "NOTICE OF VEHICLE TO BE DISMANTLED OR JUNKED" (REG. 462), commonly known as a "junk slip", to facilitate their disposal. Vehicles valued at more than $300.00, may be sold for scrap or parts, except as provided by California Vehicle Code §§ 5004 and/or 22661 (f), by Contractor at a lien sale to recover the costs of abatement. Whenever a Vehicle valued at more than $300.00 is sold at a lien sale, there will be no charge to the AVA from the Contractor, unless Contractor submits proof that the monies received from the sale were insufficient to cover the standard costs of abatement.

5) Unless specifically authorized and directed by the AVA representative requesting service, Contractor must not place, cause, allow or suffer the placement of anything into a vehicle, including but not limited to, tires, junk, debris, or any other solid or liquid waste. A violation of this subsection shall constitute an excessive charge pursuant to California Vehicle Code 22658, and a violation of section 4.03 and/or section 4.06 (e) of the Del Norte Solid Waste Management Authority Ordinance 2008-01.

G. DOCUMENTATION AND PERMITS

1) Contractor must maintain records of tow services furnished, including a description of the Vehicle(s), date and nature of service(s), amount billed and amount collected. Contractor shall make these records available for inspection by representatives of AVA during normal business hours.

2) AVA does not require Contractor to comply with the reporting requirements of Section 11520 of the California Vehicle Code; and any fees and penalties which would otherwise be due the Department of Motor Vehicles are hereby waived, provided that a copy of the decision and order authorizing disposition of the vehicle or CE Form 60, Report of Vehicle Abatement, and CHP Form 180, is retained in the Contractor's business record for a period of three (3) years.

3) Excepting the Vehicles stored at an AVA facility or on City or County properties, Contractor must provide for a storage area and a dismantling facility permitted and operating in conformance with all Federal, State and local laws. The storage and dismantling facility must be a California licensed dismantler or scrap metal recycling facility and must be approved by the Del Norte County Community Development Department. Vehicles that cannot be handled by a local facility shall be taken to the nearest alternative lawful disposal facility approved by the AVA. The payment of any State or Federal fees and the procurement of licenses or permits required to transport a Vehicle outside of the State of California for disposal are the responsibility of the Contractor transporting such Vehicle.

H. AVA FURNISHED SERVICES:

1) AVA must provide access to and make provisions for Contractor to enter upon public and private lands as required to perform the services described in this Agreement.

2) AVA will make available all pertinent data and records to Contractor for review.

I. FEES:

1) The fees payable to Contractor for furnishing services under this Agreement will be based upon the zone that the Vehicle or parts thereof were initially acquired in accordance with the fees and service charges set forth in Exhibit B.

2) The map delineating the designated zones is attached hereto as Exhibit "A" and incorporated herein by this reference. The "Special Equipment" fee is a surcharge in addition to the "Zone" fee and will only apply when the Vehicle or parts thereof cannot be towed with a Class A, B, or C tow truck, and must be placed on a "Landhaul" type flatbed trailer and/or towed with a "Class D" tow truck. The application of any additional charges may not exceed those listed in Exhibit B, and must be pre-approved by the Code Enforcement/Abatement Officer.

3) Contractor does not pay and is not reimbursed for disposal charges associated with the services described herein. Disposal charges at the Del Norte County Transfer Station are paid by the AVA. Disposal fees at alternative disposal sites, such as Curry Transfer in Oregon, or other such sites approved by the AVA, are to be billed directly to the AVA, based on receipts and rate sheets for that disposal site. When contractor disposes of a vehicle, Contractor must provide AVA with a legible copy of the weight ticket or receipt showing the date, weight, and cost of disposal.

4) There will be no additional charges, other than the "Special Equipment" fee, to AVA, City or County for mileage, labor, storage or any other costs or expenses of Contractor. Fees cover services rendered from tow to final disposal. In the event that a Vehicle, or parts thereof, is stored by Contractor and disposed of to an auto wrecker, Contractor will be entitled to the salvage value of the scrapped or demolished Vehicle(s) or parts thereof in order to offset the costs to the AVA. If the salvage or sale value of the Vehicles or parts thereof is insufficient to cover the costs of towing/storage/disposal, Contractor will be reimbursed for the actual costs of disposal, less the salvage or sale value, after presenting documentation to the satisfaction of the AVA Board of excessive disposal costs for no fewer than 10 vehicles processed in sequence under this Agreement. In no event will Contractor be entitled to payment in excess of the contract fee schedule and reimbursement of the actual costs of disposal.

5) If a Vehicle is claimed and released to the vehicle owner or their authorized agent, the costs for towing and storage are to be charged to the Owner and not to the AVA. The fees payable for towing and dismantling services pursuant to this Agreement are to be made available to the Owner of a Vehicle or the owner of the land on which the vehicle is located, when the Vehicle has been issued a "Vehicle Abatement Notice" by the AVA.

J. PAYMENT

1) The fees for services under this Contract are due each month within sixty (60) calendar days after receipt by AVA of an invoice covering the service(s) rendered to date. Invoices must be accompanied by proof of delivery to a licensed dismantler or scrap metal recycling facility, or alternative disposal site pre-approved by the AVA. Said proof of deliver must include the date of delivery to the disposal site and include a legible copy of any receipt or scale ticket showing the cost of disposal or value received for scrap.

K. INSURANCE: Contractor must maintain the following minimum levels of insurance from an insurance carrier licensed and authorized to do business in California:

1) Minimum level of financial responsibility (as required by Section 34631.5 of the California Vehicle Code) – Bodily injury and property damage with a combined single limit of not less than one million dollars ($1,000,000.00). These minimum standards must include non-owned and hired auto coverage.

2) Uninsured Motorist—Legal minimum, combined single limit.

3) On-Hook Coverage—Insuring the vehicle in tow with limits based on the size of the tow truck.

   a. Class A tow truck.....$25,000.00

   b. Class B tow truck.....$50,000.00

   c. Class C tow truck.....$100,000.00

   d. Class D tow truck.....$100,000.00

4) Garage liability—Includes premises and operation. Coverage for bodily injury and property damage with a combined single limit of not less than $500,000.00.

5) Garage Keepers Liability—Must be the same minimum as on-hook coverage for vehicles in the care, custody and control of Contractor in the storage facility.

6) Worker's Compensation Insurance—Legal minimum requirement. This carrier must waive the right of subrogation against AVA, City, and County.

7) Removing a Vehicle from a hazardous materials incident to the nearest reasonable and safe stopping location shall be deemed transporting property subject to normal minimum insurance requirements of Section 34631.5 of the California Vehicle Code.

8) Said policies of insurance must remain in force through the life of this Agreement and must be payable on a "per occurrence" basis unless AVA specifically consents to a "claims made" basis. The City of Crescent City, Del Norte County and AVA must be named as additional insureds on all policies. The insurer shall supply a certificate of insurance with endorsements signed by the insurer evidencing such insurance to AVA prior to commencement of work. The certificate shall include an endorsement providing thirty (30) days advance notice to AVA of any termination or reduction in coverage. Policy cancellation or expiration shall immediately nullify Contractor's rights under this Agreement; Contractor's obligation to indemnify, defend and hold harmless the AVA, City and County harmless, however, will survive the expiration or earlier termination of this Agreement.

L. NON DISCRIMINATORY EMPLOYMENT: In connection with the services rendered in this Agreement, the Contractor must not discriminate against any employee or applicant for employment because of race, color, religion, age, sex, national origin,

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political affiliation, ancestry, marital status, or disability. This policy does not require the employment of an unqualified person.

M. INTEREST OF PUBLIC OFFICIALS: No officer, agent or employee of the AVA during their tenure or for one (1) year thereafter may have any interest, direct or indirect, in this Contract or the proceeds thereof.

N. SUBCONTRACTING: The contractor may not subcontract any portion of the work required by this contract without the prior written approval of the AVA.

O. ASSIGNMENT: The rights, responsibilities and duties under this Contract are personal to the Contractor and may not be transferred or assigned without the express prior written consent of the AVA.

P. BOOKS OF RECORD AND AUDIT PROVISION: Contractor shall maintain on a current basis complete books and records relating to personnel, insurance, personnel taxes, payroll, applicable operating authorities, lien sale actions, and Federal Communication Licensing. These Documents and Records must be retained for at least five (5) years after the expiration of this Agreement. Contractor will permit AVA to audit all books, accounts, or records in relation to this contract. Any audit may be conducted on Contractor's premises, or at AVA's option, Contractor shall provide all books and records within a maximum of fifteen (15) days upon receipt of written notice from AVA. Failure of Contractor to comply with the inspection requirements is cause for termination. Contractor must refund any monies erroneously charged.

Q. TERM OF AGREEMENT: Unless notice of termination is given as provided herein, this Agreement will commence on 22 August 2016 and will continue until its expiration on 31 August 2020.

R. TITLE: It is understood that any and all documents, information and reports concerning this project prepared by and/or submitted to the Contractor, will be the property of the AVA. The Contractor may retain copies of drawings and other documents. In the event of termination of this Agreement, for any reason whatever, Contractor shall promptly turn over all information, writing and documents to AVA without exception or reservation.

S. TERMINATION:

1) If the Contractor fails to provide the services required under this Agreement, or otherwise fails to comply with the terms of this Agreement, or violates any ordinance, regulation or other law which applies to Contractor's performance under this Agreement, the AVA may terminate this Agreement by giving fifteen (15) calendar days written notice to Contractor.

2) The Contractor will be excused for failure to perform services under this Agreement if said services are impossible or impracticable to perform as a result

of acts of God, strikes, labor disputes or other forces over which the contractor has no control.

3) Either party may terminate this Agreement for any reason by giving sixty (60) calendar days written notice to the other party. Notice of termination must be by written notice to the other party and be sent by certified mail, return receipt requested.

T. RELATIONSHIP BETWEEN THE PARTIES: It is expressly understood that in the performance of the services herein, Contractor, its agents and employees are acting in an independent capacity and as an independent contractor and not as officers, employees or agents of the City, County, Del Norte Solid Waste Management Authority or AVA.

U. AMENDMENT: This Agreement may be amended or modified only by a written agreement executed by all parties.

V. ASSIGNMENT OF PERSONNEL: The Contractor shall assign only qualified personnel to perform services under this Agreement.

W. JURISDICTION AND VENUE: This Agreement shall be construed in accordance with the laws of the State of California and the parties hereto agree that venue shall be in Del Norte County, California.

X. INDEMNIFICATION: Contractor shall be responsible for any loss or damage arising from the towing, storage, security of and damage to Vehicles, property and bodily injury arising from Contractor's obligations or performance under this Agreement and Contractor shall indemnify, defend and hold harmless the AVA, City of Crescent City, Del Norte County, and the Del Norte Solid Waste Management Authority from any order, demand, determination, levy, assessment, judgment, settlement or other monetary obligation arising from any action or inaction by Contractor in performing the services under this Agreement, excepting the willful misconduct or negligence solely arising from the actions or inaction of AVA, City, or County.

Y. COMPLIANCE WITH APPLICABLE LAWS: Contractor, its employees, subcontractors, agents and assigns shall, at all times, comply with federal, state and local laws and ordinances.

Z. NOTICES:

Notices to AVA:

Del Norte Abandoned Vehicle Abatement Service Authority
c/o Del Norte Solid Waste Management Authority
1700 State Street
Crescent City, CA 95531

Notices to the Crescent City Code Enforcement Official:

City of Crescent City
Attn: Code Enforcement
377 "J" Street
Crescent City, CA 95531

Notices to the Del Norte County Vehicle Abatement Officer:

County of Del Norte
Attn: Code Enforcement
Community Development Department
981 "H" Street, Suite 110
Crescent City, CA 95531

Notices to Contractor:
Name
Address
_____, CA 95531

IN WITNESS WHEREOF, the parties hereto have executed this Agreement this 19th day of August, 2016.

Del Norte County Abandoned Vehicle Abatement Service Authority	**Contractor**
By:_____	By: _____

ATTEST:

_____
AVA CLERK

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APPROVED AS TO FORM:

_____

AVA General Counsel

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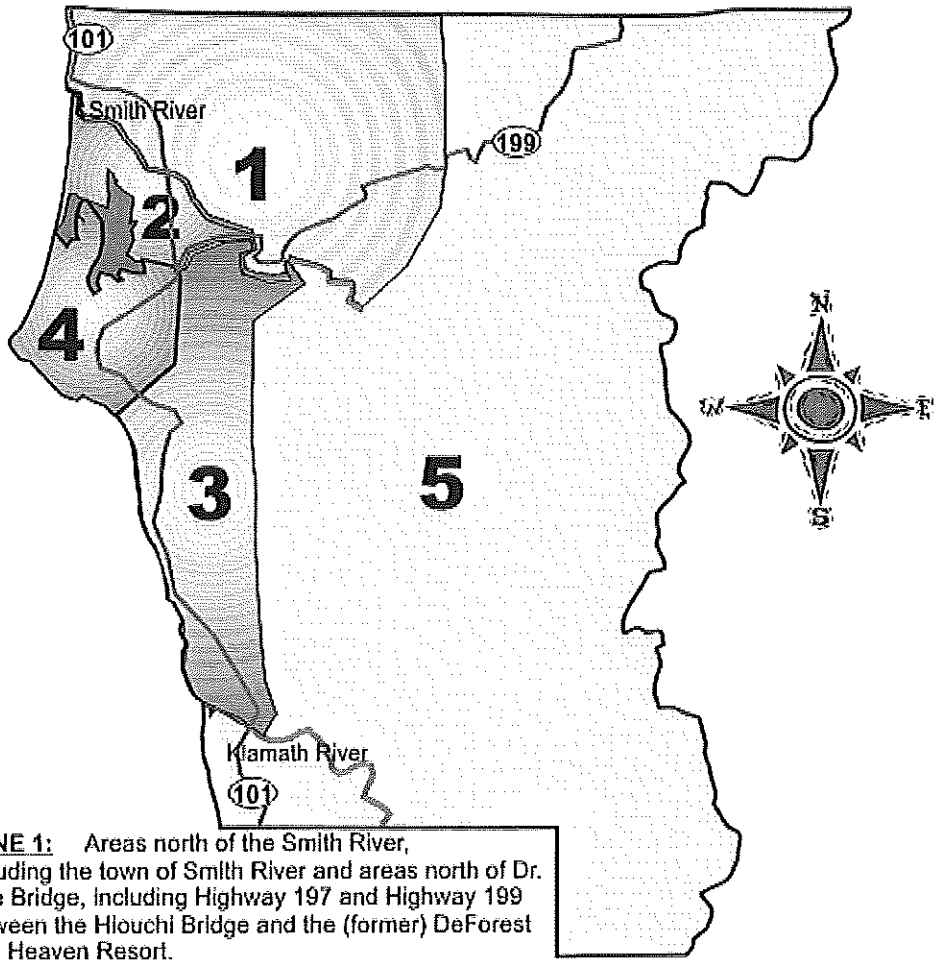
EXHIBIT A : Del Norte Abandoned Vehicle Authority Towing Zones

Del Norte Abandoned Vehicle Abatement Authority Towing Zones



ZONE 1: Areas north of the Smith River, including the town of Smith River and areas north of Dr. Fine Bridge, including Highway 197 and Highway 199 between the Hiouchi Bridge and the (former) DeForest Hog Heaven Resort.

ZONE 2: South of the Smith River and north of Elk Valley X Road, including the areas surrounding Fort Dick, and Highway 199 up to the Hiouchi Bridge.

ZONE 3: The section of Howland Hill Road within Redwood National and State Park, and areas accessed from Mill Creek Road, including the residences within 200 yards from the intersection of Mill Creek Road and South Fork Road, and along South Fork Road between this intersection and Highway 199. Zone 3 also includes all areas accessed from Highway 101 north of the Klamath River and south of Endert's Beach Road, including Requa Road and Hunter Creek, excluding areas along Highway 169 (Klamath Glen Road) more than 0.3 miles from Highway 101.

ZONE 4: The Crescent City area south of Elk Valley X Road, including Highway 101, Endert's Beach Road and the areas surrounding Elk Valley Road.

ZONE 5: All other areas of Del Norte County, including the remaining areas of Klamath, Klamath Glen, and Gasquet.

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EXHIBIT B: Fees for Services

Contractor: _____

Zone	Cars, pickups, motorcycles, vans, mini-motor homes, hitch-mount trailers	5th Wheel Trailers, Motorhomes, Buses, Or Large trucks
	$ per regular vehicle	$ per large vehicle
Zone 1		
Zone 2		
Zone 3		
Zone 4		
Zone 5		

Additional Charges Requiring Pre-Approval by Code Enforcement / Abatement Officer:

1. Winching (after first half-hour): $_____ per hour
2. Extra Man: $ _____ per hour
3. Sublet Costs for Special Equipment or Services %_____ over documented expenses
4. Secondary Tow to Curry Transfer in Brookings (Carpenterville Road): $_____ per tow
5. Secondary Tow for non-motorized trailers and related materials to Del Norte County Transfer Station $_____ per tow
5. Flat-rate Additional Unloading Charge for transportation and unloading of AVA-related trash $_____ per vehicle. Assessment of this flat rate must be pre-approved by the AVA Code Enforcement Officer and does not include disposal charges, which will be paid by the AVA directly.
6. Note that Code Enforcement Officer may specifically request use of and pre-approve payment for use of a "Landhaul" type flat-bed trailer and/or towing with a "Class D" tow truck.
   $ _____ additional per-tow charge for using 'Landhaul' or 'Class D' truck