CITY COUNCIL AGENDA
PORTERVILLE, CALIFORNIA
AUGUST 18, 2009, 6:00 P.M.

Call to Order
Roll Call

Adjourn to a Joint Meeting of the Porterville City Council and Porterville Redevelopment Agency.

JOINT CITY/PORTERVILLE REDEVELOPMENT AGENCY AGENDA

Roll Call: Agency Members

ORAL COMMUNICATIONS
This is the opportunity to address the City Council and/or Redevelopment Agency on any matter scheduled for Closed Session.

REDEVELOPMENT AGENCY CLOSED SESSION:
A. Closed Session Pursuant to:

Adjourn to a meeting of the Porterville City Council.

CLOSED SESSION:
B. Closed Session Pursuant to:
   4- Government Code Section 54957 – Public Employee Performance Evaluation – Title: Golf Course Manager
   6- Government Code Section 54956.9(b) – Conference with Legal Counsel – Anticipated Litigation – One Case.
7- Government Code Section 54956.9(c) – Conference with Legal Counsel – Anticipated Litigation – Three Cases.

7:00 P.M. RECONVENE OPEN SESSION
REPORT ON ANY COUNCIL AND/OR REDEVELOPMENT AGENCY ACTION TAKEN IN CLOSED SESSION

Pledge of Allegiance Led by Vice Mayor Brian Ward
Invocation

PROCLAMATIONS
   Eagle Scout – Tim Hathaway
   Recovery Month – September 2009

PRESENTATIONS
   Employee Service Awards
   Recognition of City Lifeguards

ORAL COMMUNICATIONS
This is the opportunity to address the Council on any matter of interest, whether on the agenda or not. Please address all items not scheduled for public hearing at this time.

CONSENT CALENDAR
All Consent Calendar Items are considered routine and will be enacted in one motion. There will be no separate discussion of these matters unless a request is made, in which event the item will be removed from the Consent Calendar.

1. City Council Minutes of May 5, 2009

2. Sale of Surplus Vehicles to the City of McFarland
   Re: Approval of the sale of twelve surplus vehicles from the City of Porterville to the City of McFarland at a negotiated total price of $16,500.

3. Authorization to Advertise for Bids - Micro Surfacing Project
   Re: Approval of staff’s recommended Plans and Project Manual for the project consisting of a durable thin asphalt, the removal and replacement of distressed asphalt, and sealing of significant cracks on several streets within the City.

4. Award of Contract – Airport Electrical Upgrade Project
   Re: Awarding contract to Royal Electric in the amount of $410,461.00 for the project consisting of the installation of approximately 1,850 feet of electrical conduit, 21,000 feet of conductor wire, repair to the segmented circle, and miscellaneous pavement construction at the Municipal Airport.

5. Award of Contract – Fairway Tract Emergency Water Project
   Re: Awarding contract to 99 Pipeline, Inc. of Lindsay, CA in an amount of $18,401.00 for the project consisting of the installation of approximately 250 feet of 8” water main and related work
for the purpose of providing emergency water to a 64 lot subdivision located along Leggett Street between Isham and Olive Avenues.

6. **Award of Contract - Well No. 31 Project (Pumping Plant)**  
Re: Awarding contract to Valley Pump & Dairy Systems of Tulare in an amount of $573,108.88 for the second phase of the well project which consists of the installation of a 250 HP pump, electrical system, above ground discharge piping and other items of work necessary to provide a complete pumping plant on the West side of Mathew Street, south of Orange Avenue.

7. **Acceptance of Project - Murry & Zalud Park Pavilion Replacement**  
Re: Accepting project as complete from Webb & Son, and authorizing the filing of the Notice of Completion for the project consisting of the installation of 30’ square metal roof structures (two at Murry Park, one at Zalud), concrete footings and patching, electrical light and outlet, and appurtenances.

8. **Acceptance of Project - Fire Station #2 Training Classroom – HVAC**  
Re: Accepting project as complete from Silver Air Conditioning and Heating, and authorizing the filing of the Notice of Completion for the project consisting of installation of HVAC Units, ducts, and all pertinent appurtenances at Fire Station #2 on Newcommb Street.

9. **Acceptance of Quitclaim Deed - Pioneer Water Company**  
Re: Acceptance of Quitclaim Deeds relinquishing Pioneer Water Company’s rights to a Waste Water Ditch, and relinquishing specific surface rights to a portion of the Pioneer Ditch – Park Branch, relative to the sale of the Fairground property for development of a new Courthouse.

10. **Authorization to Execute a Consultant Service Agreement for Surveying Services – Henderson Avenue Rehabilitation Project**  
Re: Authorizing the execution of a Consultant Service Agreement with Winton and Associates at an agreed fee of $5,600 for surveying services on Henderson Avenue from Jaye Street to Indiana Street to aid in designing the Henderson Avenue Rehabilitation Project.

11. **Rule 8061 Compliance Requirements**  
Re: Authorizing staff to send determinations to the San Joaquin Valley Air Pollution Control District, along with a Statement of Financial Hardship, to satisfy reporting requirements of Rule 8061.

Re: Authorizing non-advertising displays commemorating the “Paint the Town” special event to take place on September 5, 2009, subject to the recommended conditions of approval.

13. **Proposition 1A Securitization Program**  
Re: Receipt of an informational report regarding the initiation of a securitization program for the Proposition 1A property tax loan to the State by California Communities, a joint powers authority sponsored by the League of California Cities.
14. **Consideration of Resolution for Energy Efficiency Month**
   Re: Considering approval of a resolution declaring the month of September 2009 as Energy Efficient Month for the purpose of encouraging residents to reduce their energy consumption.

15. **Approval of Restated Health Plan Document**
   Re: Considering approval of a resolution approving the City’s Restated Health Plan Document dated August 1, 2009.

16. **Amendment to Workers Compensation Coverage**
   Re: Considering approval of a resolution amending the City’s workers’ compensation coverage to include non-safety volunteers working for the City with no premium increase.

*A Council Meeting Recess Will Occur at 8:30 p.m., or as Close to That Time as Possible*

**SECOND READINGS**

17. **Ordinance 1757, Pertaining to Noise**
   Re: Giving Second Reading to Ordinance 1757, An Ordinance of the City Council of the City of Porterville Adding to the Municipal Code Chapter 18, Article V Pertaining to Noise, was given first reading on August 4, 2009, and has been printed.

**SCHEDULED MATTERS**

18. **Transit System Overview for Fiscal Year 2008/2009**
   Re: Receipt of the Transit System Overview for FY 08-09 and a summary of the last four fiscal years.

19. **Request for a Temporary Structure Permit for the Storage and Consignment of Equipment (952 West North Grand Avenue)**
   Re: Consideration of a request for a temporary structure permit to allow for the storage and consignment of vehicles and equipment at the northeast corner of Highway 65 and North Grand Avenue.

20. **Consideration of Sample Survey in the Potential Formation of a Mosquito Abatement District in Southeastern Tulare County**
   Re: Consideration of the Lake County survey for prospective comments in the creation of the Southeastern Tulare County survey concerning the formation of a mosquito abatement district.

21. **Council Member Requested Agenda Item – Murry Park Pool Slide Installation**
   Re: Consideration of a request by a Council Member to discuss funding the installation of a slide at Murry Park pool.

22. **Council Member Requested Agenda Item – The Porterville Recorder Agenda Publication**
   Re: Consideration of a request by a Council Member to discuss having the City Council’s Agenda Legal Description Sheet published in The Porterville Recorder prior to City Council meetings.
23. **Council Member Requested Agenda Item – Subjects for Discussion with Local Legislators in Sacramento**  
Re: Consideration of a request by a Council Member to discuss potential subjects for discussion with local area legislators in Sacramento, and authoring Council Member to speak on the subjects on the Council’s behalf.

24. **Council Member Requested Agenda Item – Consideration of Letter of Opposition to SB 802 (Leno)**  
Re: Consideration of a request by a Council Member to oppose SB 802 which proposes to limit the retention of proceeds not to exceed 5% of the payment in contracts between public entities and contractors.

**ORAL COMMUNICATIONS**

**OTHER MATTERS**

**CLOSED SESSION**

Any Closed Session Items not completed prior to 7:00 p.m. will be considered at this time.

**ADJOURNMENT** - to the meeting of September 1, 2009 at 6:00 p.m.

*It shall be the policy of the City Council to complete meetings, including closed sessions, by 11:00 p.m. unless, upon consensus, Council elects to continue past the adjournment hour.*

In compliance with the Americans with Disabilities Act and the California Ralph M. Brown Act, if you need special assistance to participate in this meeting, or to be able to access this agenda and documents in the agenda packet, please contact the Office of City Clerk at (559) 782-7464. Notification 48 hours prior to the meeting will enable the City to make reasonable arrangements to ensure accessibility to this meeting and/or provision of an appropriate alternative format of the agenda and documents in the agenda packet.

Materials related to an item on this Agenda submitted to the City Council after distribution of the Agenda packet are available for public inspection during normal business hours at the Office of City Clerk, 291 North Main Street, Porterville, CA 93257, and on the City’s website at www.ci.porterville.ca.us.
Call to Order at 6:04 p.m.
Roll Call: Vice Mayor McCracken, Council Member Pedro Martinez (arrived at 6:07 p.m.), Council Member Felipe Martinez, Council Member Ward, Mayor Hamilton

ORAL COMMUNICATIONS
None

CLOSED SESSION:
A. Closed Session Pursuant to:
   3- Government Code Section 54956.9(b) – Conference with Legal Counsel – Anticipated Litigation – One Case.
   4- Government Code Section 54956.9(c) – Conference with Legal Counsel – Anticipated Litigation – One Case.

7:00 P.M. RECONVENE OPEN SESSION
REPORT ON ANY COUNCIL ACTION TAKEN IN CLOSED SESSION
City Attorney Lew reported that no action had been taken.

Pledge of Allegiance Led by Vice Mayor Pete McCracken
Invocation – one individual participated.

PROCLAMATIONS
Day of Prayer – May 7, 2009

PRESENTATIONS
Employee of the Month – Irene Anaya
Muscular Dystrophy Association’s Fill-the-Boot Campaign

A brief discussion ensued during which staff confirmed that Fire Department personnel wore their turnouts during the event and collected donations with their helmets and boots. Council Member Pedro Martinez noted the use of fire apparatus such as ladder trucks by other agencies and requested that this be considered by the City. Chief Garcia advised that his department would consider the request.
ORAL COMMUNICATIONS

- Wayne Harris, 583 W. Dexter Avenue, requested that the City budget for moving the utilities underground on Prospect north of Henderson Avenue.
- Greg Shelton, 888 North Williford Drive, voiced concern with the attendance records in Item 15 for the Parks & Leisure Services Commission which reflected he had two tardies. He advised that one was incorrect, and attributed the other to the Christmas parade.
- Nikki Edwards, 1) updated the City Council on the Super Adoption in which Animal Control participated, noting that 8 of the 15 animals taken to the event were adopted out; 2) requested that donations be suggested until such time as shelter fees are established; and 3) spoke in favor of requiring the animals to be spayed/neutered prior to adoption.
- (Name inaudible), 1075 W. Roby, 1) spoke of the success of the recently held Rollin’ Relics Car Show; and 2) spoke of the importance for the lease renewal to continue senior programs at the Santa Fe Depot.
- BJ Motko, Central Valley Rescue Railroad, spoke of the need for proper fees for the animal shelter, provided sample adoption agreements, and spoke of the importance of requiring all animals to be spayed/neutered prior to adoption.
- Dick Eckhoff, business address of 197 North Main Street, thanked the Council and staff for the Mill Street Parking Lot Project.
- Augie Gonzales, Porterville Chamber of Commerce Chair, 1) reported on the success of the Iris Festival noting approximately 25,000 people attended the event; and 2) advised of the upcoming Chamber Mixer to be held at the Bank of the Sierra.

CONSENT CALENDAR

Item Nos. 7, 11, 16, 17 and 21 were removed for further discussion.

1. CITY COUNCIL MINUTES OF APRIL 7, 2009 AND APRIL 14, 2009

Recommendation: That the City Council approve the Minutes of April 7, 2009 and April 14, 2009.

Documentation: M.O. 01-050509
Disposition: Approved

2. CLAIM – ESTEFANIE FORMAN

Recommendation: After consideration and investigation, staff recommends that the Council reject said claim; refer the matter to the City’s insurance adjustor; and direct the City Clerk to give the Claimant proper notification.

Documentation: M.O. 02-050509
Disposition: Approved

3. AUTHORIZATION TO ADVERTISE FOR BIDS – SCRANTON AVENUE AND INDIANA STREET RECONSTRUCTION PROJECT
Recommendation: That the City Council:
1. Approve staffs recommended Plans and Project Manual for the Scranton Avenue and Indiana Street Reconstruction and Storm Drain Project.
2. Authorize staff to advertise for bids on the project; and
3. Authorize the City Engineer to sign the SCE application and issue $29,262.98 payment.

Documentation: M.O. 03-050509
Disposition: Approved

4. AUTHORIZATION TO ADVERTISE FOR BIDS – INDIANA STREET (SOUTH), PROSPECT STREET, AND HENDERSON AVENUE SHOULDER STABILIZATION PROJECT

Recommendation: That the City Council:
1. Approve Staff’s recommended plans and project manual; and
2. Authorize Staff to advertise for bids on the project.

Documentation: M.O. 04-050509
Disposition: Approved

5. AUTHORIZATION TO ADVERTISE FOR BIDS – AIRPORT ELECTRICAL UPGRADE PROJECT

Recommendation: That the City Council:
1. Approve Staff’s recommended Plans and Project Manual; and
2. Authorize staff to advertise for bids on the project.

Documentation: M.O. 05-050509
Disposition: Approved

6. ACCEPTANCE OF IMPROVEMENTS - SIERRA ESTATES (K. HOVANIAN FORECAST HOMES NORTHERN, INC.)

Recommendation: That the City Council:
1. Accept the public improvements of Sierra Estates Subdivision for maintenance;
2. Authorize the filing of the Notice of Completion; and
3. Release the payment guarantee thirty-five (35) days after recordation, provided no liens have been filed.

Documentation: M.O. 06-050509
Disposition: Approved
8. APPROVAL OF MANDATORY RACE CONSCIOUS DISADVANTAGED BUSINESS ENTERPRISE (DBE) PROGRAM

Recommendation: That the City Council:
1. Approve the Race Conscious Disadvantaged Business Enterprise Program;
2. Authorize the Public Works Director to sign the Race Conscious Disadvantaged Business Enterprise Program; and
3. Approve the Resolution of Adoption.

Documentation: Resolution No. 32-2009
Disposition: Approved

9. INTENT TO VACATE A PORTION OF GARDEN AVENUE (CITY OF PORTERVILLE)

Recommendation: That the City Council:
1. Pass a resolution of intent to vacate Garden Avenue between Fig Street and the west right-of-way of the “Rail to Trails” property; and
2. Set the Council meeting of June 2, 2009, as the time and place for a public hearing.

Documentation: Resolution 33-2009
Disposition: Approved

10. ACCEPTANCE OF FINAL SUBDIVISION MAP – MEADOW BREEZE, PHASE THREE (GARY SMEE)

Recommendation: That the City Council:
1. Approve the final map of Meadow Breeze, Phase Three Subdivision;
2. Accept all offers of dedication within the development boundaries defined by the final map;
3. Accept the Irrevocable Offer of Dedication as shown on Parcel Map No. 4451 and as consented by Tulare County Board of Supervisors;
4. Authorize the City Clerk to record a Resolution accepting the offer as shown on Parcel Map No. 4451 with the County Recorder’s Office; and
5. Authorize the City Clerk to file said map with the County Recorder.

Documentation: Resolution 34-2009
Disposition: Approved

12. CODE ENFORCEMENT UPDATE

Recommendation: That the City Council accept the Code Enforcement Update.
13. INTERIM FINANCIAL STATUS REPORTS AND GRANTS SUMMARY REPORT

Recommendation: That the City Council accept the interim financial status reports and grants summary report as presented.

Documentation: M.O. 08-050509
Disposition: Approved

14. QUARTERLY PORTFOLIO SUMMARY

Recommendation: That the City Council accept the quarterly Portfolio Summary.

Documentation: M.O. 09-050509
Disposition: Approved

15. ATTENDANCE REPORT FOR CITY COMMISSIONS, BOARDS AND COMMITTEES – 3RD QUARTER UPDATE


Documentation: M.O. 10-050509
Disposition: Approved

18. LAW ENFORCEMENT JOINT USE HELICOPTER PROGRAM

Recommendation: That the City Council:
1. Approve the Joint Powers Agreement for Airborne Law Enforcement Services; and
2. Authorize the Mayor to execute the agreement on behalf of the City of Porterville.

Documentation: M.O. 11-050509
Disposition: Approved

19. STATUS REPORT ON COSTS FOR CITY-FUNDED SUPPLEMENTAL INSURANCE FOR HISTORICAL PARADES

Recommendation: Informational report only.

Documentation: M.O. 12-050509
Disposition: Approved
20. TULARE COUNTY WORKFORCE INVESTMENT BOARD YOUTH@WORK COMMUNITY IMPROVEMENT PROJECTS PROGRAM IN THE CITY OF PORTERVILLE

Recommendation: Information Only.

Documentation: M.O. 13-050509
Disposition: Approved

COUNCIL ACTION: MOVED by Council Member Felipe Martinez, SECONDED by Council Member Ward that the City Council approve Item Nos. 1 through 6; 8 through 10; 12 through 15; and 18 through 20. The motion carried unanimously.

7. ALERT TC TULARE COUNTY NOTIFICATION SYSTEM

Recommendation: That the City Council
1. Approve the City of Porterville Alert TC Procedural Guidelines on the use of the Alert TC Notification System.
2. Authorize the Mayor to sign documentation related to the User Agreement.

City Manager Lollis introduced the item, and the staff report was waived at the Council’s request.

Council Member Pedro Martinez voiced support for granting the City Council authority to implement emergency messages. A discussion ensued about the Council’s involvement in the implementation of emergency messages, and City Attorney Lew advised that an internal process could be formulated to address any concerns that the Council may have.

COUNCIL ACTION: MOVED by Mayor Hamilton, SECONDED by Council Member Felipe Martinez that the City Council approve the City of Porterville Alert TC Procedural Guidelines on the use of the Alert TC Notification System; authorize the Mayor to sign documentation related to the User Agreement; and direct staff to formulate a policy for local use. The motion carried unanimously.

Disposition: Approved, as amended.

11. STREET PERFORMANCE MEASURE – 3RD QUARTER UPDATE

Recommendation: Information Only.

City Manager Lollis introduced the item, and the staff report was waived at the Council’s request.
Council Member Pedro Martinez expressed concern with the condition of arterial streets within the city and requested that arterials be prioritized.

COUNCIL ACTION: MOVED by Council Member Ward, SECONDED by Council Member M.O. 15-050509 Felipe Martinez that the City Council accept the informational report. The motion carried unanimously.

Disposition: Approved

16. REQUEST TO RETAIN PRAXAIR SERVICES, INC. TO PERFORM ENHANCED LEAK DETECTION FINAL TEST

Recommendation: Authorize the expenditure of $8,160 to perform an On-site Enhanced Leak Detection retest allocating the cost between the Water Department and Porterville Airport.

City Manager Lollis introduced the item, and indicated that staff had requested the item be removed.

Disposition: None.

17. EDWARD BYRNE MEMORIAL JUSTICE ASSISTANCE GRANT FORMULA PROGRAM/MEMORANDUM OF UNDERSTANDING

Recommendation: That the City Council:
1. Approve the City’s participation in the joint request to apply for the Edward Byrne Memorial Justice Assistance Grant Program; and
2. Authorize the Chief of Police to sign the Memorandum of Understanding between the City and County and enter into the agreement.

City Manager Lollis introduced the item, and the staff report was waived at the Council’s request.

Council Member Pedro Martinez inquired about the proposed use of funds for the Animal Control Officer. City Manager Lollis indicated that the City Attorney had advised that the use was appropriate. Police Chief McMillan explained that the funding was not reocurring, and elaborated on the reasoning behind the recommendation.

COUNCIL ACTION: MOVED by Council Member Pedro Martinez, SECONDED by Council Member Felipe Martinez that the City Council approve the City’s participation in the joint request to apply for the Edward Byrne Memorial Justice Assistance Grant Program; and authorize the Chief of Police to sign the Memorandum of Understanding between the City and County and enter into the agreement. The motion carried unanimously.
21. **MEMORANDUM OF UNDERSTANDING WITH COMMUNITY SERVICES EMPLOYMENT TRAINING, INC. (CSET) AS OPERATOR OF PORTERVILLE EMPLOYMENT CONNECTION ONE-STOP CENTER**

Recommendation: That the City Council approve the Memorandum of Understanding with CSET regarding the operation of the ECC in Porterville, and to authorize the Mayor to sign the agreement.

City Manager Lollis introduced the item and presented the staff report.

Council Member Felipe Martinez lauded CSET’s efforts and spoke in favor of approval; and Council Member Pedro Martinez suggested that CSET make a presentation to the Council at a future meeting.

**COUNCIL ACTION:** MOVED by Council Member Pedro Martinez, SECONDED by Council Member Felipe Martinez that the City Council approve the Memorandum of Understanding with CSET regarding the operation of the ECC in Porterville, and to authorize the Mayor to sign the agreement. The motion carried unanimously.

Disposition: Approved

The Council recessed for ten minutes.

**PUBLIC HEARINGS**

22. **ADOPTION OF THE 2009/2010 ACTION PLAN FOR INVESTMENT OF COMMUNITY DEVELOPMENT GRANT BLOCK (CDBG) ENTITLEMENT FUNDS**

Recommendation: That the City Council:

1. Conduct a public hearing to solicit comments on the 2009/2010 Action Plan;
2. Adopt the 2009/2010 Action Plan resolution of approval; and
3. Authorize the City Manager to execute all necessary documents.

City Manager Lollis introduced the item, and Development Associate Denise Marchant presented the staff report. During the report she advised of an additional HUD award of $98,000, an additional $191,000 in Stimulus funds; and indicated that staff would bring back amendments to account for the additional funds. Community Development Director Dunlap elaborated on the amendments and the public participatory timeframes.

The public hearing opened at 8:46 p.m. Seeing no one, the Mayor closed the public hearing at 8:47 p.m.
Mayor Hamilton inquired about the possibility of allocating some of the monies for the Heritage Ballfields. Community Development Director Dunlap spoke about HUD regulations relative to entitlement funds, and provisions for what the money could be expended for. At the Council’s request, he then elaborated on why the Murry Park Improvement Project was no longer being funded from CDBG entitlement.

COUNCIL ACTION: MOVED by Vice Mayor McCracken, SECONDED by Council Member Ward that the City Council adopt the 2009/2010 Action Plan resolution of approval; and authorize the City Manager to execute all necessary documents. The motion carried unanimously.

Disposition: Approved

23. AN EXTENSION OF TIME FOR AN INTERIM ORDINANCE TO DEFER COLLECTION OF CERTAIN DEVELOPMENT IMPACT FEES TO OCCUPANCY – UPDATE REPORT

Recommendation: That the City Council hold the public hearing, consider any and all public testimony, and extend the Interim Urgency Ordinance deferral of certain development fees to occupancy for a period of 3 months and 15 days.

City Manager Lollis introduced the item, and Deputy Public Works Director/City Engineer Mike Reed presented the staff report.

The public hearing opened at 9:03 p.m. Seeing no one, the Mayor closed the public hearing at 9:04 p.m.

COUNCIL ACTION: MOVED by Council Member Pedro Martinez, SECONDED by Council Member Ward that the City Council extend the Interim Urgency Ordinance, being AN INTERIM ORDINANCE OF THE CITY COUNCIL OF THE CITY OF PORTERVILLE ADOPTING INTERIM DEFERRAL OF DEVELOPER IMPACT FEES, for a period of 3 months and 15 days. The motion carried unanimously.

The City Manager read the ordinance by title only.

Disposition: Approved

24. VACATION OF A PORTION OF VILLA STREET NORTH OF OLIVE AVENUE (NOVROZ RAHIM)

Recommendation: That the City Council:
1. Adopt the Resolution of Vacation, including reservations, for a portion of Villa Street north of the Olive Avenue right-of-way;
2. Authorize the City Clerk to record the Resolution of Vacation; and
3. Authorize the Mayor and City Clerk to execute and record a Quitclaim Deed with the County Recorder.

City Manager Lollis introduced the item, and Deputy Public Works Director/City Engineer Reed presented the staff report.

The public hearing was opened at 9:05 p.m. Seeing no one, the Mayor closed the public hearing at 9:06 p.m.

COUNCIL ACTION: MOVED by Council Member Pedro Martinez, SECONDED by Council Member Felipe Martinez that the City Council adopt the Resolution of Resolution 37-2009 Vacation, including reservations, for a portion of Villa Street north of the Olive Avenue right-of-way; authorize the City Clerk to record the Resolution of Vacation; and authorize the Mayor and City Clerk to execute and record a Quitclaim Deed with the County Recorder. The motion carried unanimously.

Disposition: Approved

25. ESTABLISHING FEES FOR ANIMAL CONTROL SERVICES AND SHELTERING

Recommendation: That City Council
1. Conduct a Public Hearing on the proposed Animal Control/Shelter fees; and
2. Adopt the fees as delineated in the Draft Resolution.

City Manager Lollis introduced the item, and Police Captain Silver Rodriguez presented the staff report.

The City Council inquired about various fees and costs associated with services provided by the shelter. Captain Rodriguez and Officer Rick Cooksey provided additional information in response to the Council’s inquiries, and a discussion ensued regarding the difficulty in scheduling spay/neuter procedures during the adoption process.

The hearing was opened to the public at 9:25 p.m.
   o Nikki Edwards, spoke in favor of spay/neuter and micro-chip procedures prior to adoption, and suggested an adoption fee of $80.

The Council requested that licenses be valid for a period longer than one year to save on administrative costs. Officer Cooksey indicated that licenses could be paid for a period of up to 3 years at a discounted rate, but only if the vaccination given to the animal was valid for that same length of time. Council then directed staff to implement a discounted rate as deemed appropriate by the Animal Control Officer.

COUNCIL ACTION: MOVED by Vice Mayor McCracken, SECONDED by Council Member
Resolution 39-2009  
Felipe Martinez that the City Council adopt the fees as delineated in the draft resolution. The motion carried unanimously.

Disposition:  Approved, and direction given.

SCHEDULED MATTERS

26. PRINTING AND DISTRIBUTION OF LEISURE UPDATE

Recommendation:  To be determined by the Council.

City Manager Lollis introduced the item, and Director of Finance Maria Bemis presented the staff report, which presented two options for Council consideration:

1. Council authorize Staff to re-evaluate the specifications, removing the mailing component from the project, and negotiate with the lowest bidder to obtain the best value for the City in a timely matter; or
2. Council direct Staff to re-bid and re-advertise the project, with the understanding that the Leisure Update will not be available to households in the community until approximately July 1.

COUNCIL ACTION:  MOVED by Council Member Ward, SECONDED by Council Member Pedro Martinez that the City Council authorize Staff to re-evaluate the specifications, removing the mailing component from the project, and negotiate with the lowest bidder to obtain the best value for the City in a timely matter. The motion carried unanimously.

Disposition:  Approved

27. REPORT ON CITY PARTICIPATION IN AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

Recommendation:  Information Only

City Manager Lollis introduced the item and presented the staff report. Following the staff report, a discussion ensued with regard to the pursuit, use, and repayment of funds available.

Disposition:  Informational item.

28. COUNCIL MEMBER REQUESTED AGENDA ITEM – REVIEW OF MUNICIPAL CODE REGULATIONS REGARDING OFF STREET PARKING IN RESIDENTIAL ZONES

Recommendation:  As directed by Council.

City Manager Lollis introduced the item and presented the staff report.
Mayor Hamilton requested that staff explain the reasoning behind the prohibition of parking boats in driveways. Code Enforcement Officer Clayton Dignam spoke in favor of the current regulations, and described how complaints are typically addressed.

Community Development Director Brad Dunlap indicated that from a Planning standpoint, staff was not in support of seeing the current standards loosened.

Council Member Pedro Martinez spoke in favor of considering the condition of a boat, and possibly issuing permits during the peak boating season to allow for parking. City Attorney Lew advised that it could get difficult to enforce based on the condition, and staff spoke in favor of the prohibition. Mayor Hamilton suggested that he and Council Member Pedro Martinez meet to research the matter further.

Disposition: No staff direction given.

**OTHER MATTERS**

- Council Member Pedro Martinez: 1) spoke of the Mayor’s Prayer Breakfast scheduled for Thursday at 7:00 a.m.; 2) inquired as to the status of the fence at the Veteran’s Park playground; 3) spoke of the recent Neighborhood Watch presentation and noted that stickers were being sold, and inquired whether the City could obtain some for give away; 4) indicated that a constituent had requested that City Hall be power-washed; and 5) spoke of a recent request by seniors for the ability to utilize more space at the Putnam Community Center and inquired whether the City could set a meeting with the Comision to discuss the matter.

City Manager Lollis advised that with regard to the Veteran’s Park playground fence, Porterville Rotary Club had plans on undertaking the project. Also, as to the cleaning of City Hall’s exterior, Mr. Lollis indicated that it had just been done prior to the Iris Festival.

- Council Member Ward indicated 1) that he was enjoying coaching; 2) that he recently turned 33 years of age, and 3) noted that the accumulated dust on the dais affected his allergies and requested that it be routinely cleaned.
- Council Member Felipe Martinez: 1) spoke of the blighted properties at Union and Indiana, and at Kessing and Orange, and requested both be addressed; 2) inquired about the grant for street improvements/rubberization on Orange Avenue; and 3) inquired whether any stimulus funds could be used for concrete improvements on Olive Avenue, from Porter Street to Indiana.

In response to Council Member Martinez’s question, Deputy Public Works Director Mike Reed updated the Council on the status of the work on Orange Avenue.

- Vice Mayor McCracken made mention of a possible adjourned meeting that might be requested with regard to the mosquito abatement issue.
- Mayor Hamilton elaborated on the recent discussion regarding mosquito abatement and the request for Porterville’s involvement in the formation of the district. He indicated that he would be receptive to scheduling a study session to discuss the
matter of districting, but not participation in the proposed survey.

**ORAL COMMUNICATIONS**

- Dick Eckhoff, address on record, spoke against amending the ordinance to allow for the parking of RVs and boats in residential front yard setbacks as was proposed by Council Member Pedro Martinez.

**ADJOURNMENT**

The Council adjourned at 10:40 p.m. to a Joint Meeting of the City Council and Parks and Leisure Services Commission on May 12, 2009, at 6:00 p.m., in the Community Room, 2nd Floor, Porterville Municipal Library, 41 West Thurman Avenue, Porterville.

______________________________
Luisa Herrera, Deputy City Clerk

SEAL

______________________________
Pete V. McCracken, Mayor
SUBJECT: Sale of Surplus Vehicles to the City of McFarland

SOURCE: Police Department

COMMENT: The City of McFarland is starting up their own police department and desires to purchase surplus vehicles from the City of Porterville. City Manager, Bob Wilburn, of McFarland has engaged in discussion with city staff about the acquisition of surplus vehicles presently being stored at the City Corporation Yard. Twelve (12) vehicles currently awaiting the next auction were identified that would be useful to McFarland's operation. The vehicles have been inspected and found acceptable for their use. Consistent with what we could expect from auction, Staff negotiated a sale price of $1,500 for each vehicle, for total revenue to the City of $16,500. They are listed as follows:

- 2003 Ford Crown Victoria- Marked Police Car
- 2003 Ford Crown Victoria- Marked Police Car
- 2003 Ford Crown Victoria- Marked Police Car
- 2003 Ford Crown Victoria- Marked Police Car
- 2003 Ford Crown Victoria- Marked Police Car
- 1998 Ford Ranger Pick Up- Marked Police Pick-up
- 1998 Ford Ranger Pick Up- Marked Police Pick-up
- 1997 Ford Taurus- Unmarked/Plain Sedan
- 2000 Ford Taurus- Unmarked/Plain Sedan

The Purchasing Agent is authorized to dispose of surplus property through public auction, trade-in or negotiated sale. Staff has determined that it is in the best interest of the City to negotiate with other agencies whenever possible. This allows the vehicles to be transferred "as is" without having to strip the patrol vehicles of emergency equipment and perform costly safety inspections. We also save the cost of the auctioneer's commission.

RECOMMENDATION: That City Council:
1) Approve the sale of the listed surplus vehicles to the City of McFarland; and
2) Authorize the Purchasing Agent to transfer title to the City of McFarland.

Item No. 2
COUNCIL AGENDA: AUGUST 18, 2009

SUBJECT: AUTHORIZATION TO ADVERTISE FOR BIDS – MICRO SURFACING PROJECT

SOURCE: Public Works Department - Engineering Division

COMMENT: The Plans and Project Manual have been prepared for the Micro-Surfacing Project. The project is part of the City's street maintenance program consisting of a durable thin asphalt overlay on several streets within the City. Another important project component is the removal and replacement of badly distressed asphalt concrete, along with the sealing of significant cracks. New pavement markings will be placed once each street receives the thin asphalt overlay. Streets and project limits are as follows:

- Westwood Street – Olive Avenue to Henderson Avenue
- Newcomb Street – Morton Avenue to Henderson Avenue
- Prospect Street – Morton Avenue to Henderson Avenue
- Olive Avenue – Conner Street to Tulsa Avenue (Private Rd.)
- Orange Avenue – Main Street to Plano Street

The Plans and Project Manual have been completed and are available in the La Barca Conference Room for Council's review.

The Engineer’s Estimate for constructing the project is $542,835. An additional $54,283 is necessary for construction contingency (10%) and $27,142 is required for construction management, quality control and inspection. The total estimated cost associated with the project is $624,260.

"Local" Measure 'R' tax revenue is the funding source for the project, as approved in the 2009/2010 budget.

RECOMMENDATION: That the City Council:

1. Approve Staffs recommended Plans and Project Manual for the Micro-Surfacing Project; and

2. Authorize staff to advertise for bids on the project.

ATTACHMENTS: Locator Maps
Engineer’s Estimate

Dir Appropriated/Funded MB CM Item No. 3
## PART "A" - WESTWOOD STREET - OLIVE AVENUE TO HENDERSON AVENUE

<table>
<thead>
<tr>
<th>ITEM NO.</th>
<th>EST. QTY.</th>
<th>UNIT</th>
<th>ITEM</th>
<th>UNIT PRICE</th>
<th>TOTAL PRICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>L.S.</td>
<td>Mobilization and Demobilization</td>
<td>$5,000.00</td>
<td>$5,000.00</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>L.S.</td>
<td>Traffic Control</td>
<td>$4,000.00</td>
<td>$4,000.00</td>
</tr>
<tr>
<td>3</td>
<td>34,847</td>
<td>S.Y.</td>
<td>Micro-Surfacing, including site preparations, all in accordance with the guidelines set forth in the project specifications.</td>
<td>$225</td>
<td>$78,405.75</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>L.S.</td>
<td>Crack Filling per the guidelines set forth in the project specifications.</td>
<td>$14,000.00</td>
<td>$14,000.00</td>
</tr>
<tr>
<td>5</td>
<td>5,385</td>
<td>S.F.</td>
<td>Grind Full Structural Section Depth and Replace with Asphalt Concrete per the guidelines set forth in the project specifications.</td>
<td>$10.00</td>
<td>$53,850.00</td>
</tr>
<tr>
<td>6</td>
<td>10,330</td>
<td>S.F.</td>
<td>Grind Full Pavement Depth &amp; Replace with Asphalt Concrete per the guidelines set forth in the project specifications.</td>
<td>$5.00</td>
<td>$51,650.00</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>E.A.</td>
<td>Remove and Replace Traffic Loop Detector</td>
<td>$2,500.00</td>
<td>$2,500.00</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>L.S.</td>
<td>Striping &amp; Pavement Markings</td>
<td>$21,900.00</td>
<td>$21,900.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>SUBTOTAL</strong></td>
<td><strong>$231,305.75</strong></td>
<td></td>
</tr>
</tbody>
</table>

## PART "B" - NEWCOMB STREET - MORTON AVENUE TO HENDERSON AVENUE

<table>
<thead>
<tr>
<th>ITEM NO.</th>
<th>EST. QTY.</th>
<th>UNIT</th>
<th>ITEM</th>
<th>UNIT PRICE</th>
<th>TOTAL PRICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>L.S.</td>
<td>Mobilization and Demobilization</td>
<td>$5,000.00</td>
<td>$5,000.00</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>L.S.</td>
<td>Traffic Control</td>
<td>$4,000.00</td>
<td>$4,000.00</td>
</tr>
<tr>
<td>3</td>
<td>17,885</td>
<td>S.Y.</td>
<td>Micro-Surfacing, including site preparations, all in accordance with the guidelines set forth in the project specifications.</td>
<td>$225</td>
<td>$40,241.25</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>L.S.</td>
<td>Crack Filling per the guidelines set forth in the project specifications.</td>
<td>$7,250.00</td>
<td>$7,250.00</td>
</tr>
<tr>
<td>4</td>
<td>2,688</td>
<td>S.F.</td>
<td>Grind Full Structural Section Depth and Replace with Asphalt Concrete per the guidelines set forth in the project specifications.</td>
<td>$10.00</td>
<td>$26,880.00</td>
</tr>
<tr>
<td>6</td>
<td>640</td>
<td>S.F.</td>
<td>Grind Full Pavement Depth &amp; Replace with Asphalt Concrete per the guidelines set forth in the project specifications.</td>
<td>$5.00</td>
<td>$3,200.00</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>L.S.</td>
<td>Striping &amp; Pavement Markings</td>
<td>$10,750.00</td>
<td>$10,750.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>SUBTOTAL</strong></td>
<td><strong>$97,321.25</strong></td>
<td></td>
</tr>
</tbody>
</table>

## PART "C" - PROSPECT STREET - MORTON AVENUE TO HENDERSON AVENUE

<table>
<thead>
<tr>
<th>ITEM NO.</th>
<th>EST. QTY.</th>
<th>UNIT</th>
<th>ITEM</th>
<th>UNIT PRICE</th>
<th>TOTAL PRICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>L.S.</td>
<td>Mobilization and Demobilization</td>
<td>$5,000.00</td>
<td>$5,000.00</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>L.S.</td>
<td>Traffic Control</td>
<td>$4,000.00</td>
<td>$4,000.00</td>
</tr>
<tr>
<td>3</td>
<td>16,060</td>
<td>S.Y.</td>
<td>Micro-Surfacing, including site preparations, all in accordance with the guidelines set forth in the project specifications.</td>
<td>$225</td>
<td>$36,135.00</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>L.S.</td>
<td>Crack Filling per the guidelines set forth in the project specifications.</td>
<td>$6,500.00</td>
<td>$6,500.00</td>
</tr>
<tr>
<td>5</td>
<td>1,845</td>
<td>S.F.</td>
<td>Grind Full Structural Section Depth and Replace with Asphalt Concrete per the guidelines set forth in the project specifications.</td>
<td>$10.00</td>
<td>$18,450.00</td>
</tr>
<tr>
<td>6</td>
<td>832</td>
<td>S.F.</td>
<td>Grind Full Pavement Depth &amp; Replace with Asphalt Concrete per the guidelines set forth in the project specifications.</td>
<td>$5.00</td>
<td>$4,160.00</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>L.S.</td>
<td>Striping &amp; Pavement Markings</td>
<td>$9,600.00</td>
<td>$9,600.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>SUBTOTAL</strong></td>
<td><strong>$83,845.00</strong></td>
<td></td>
</tr>
</tbody>
</table>
### PART "D" - OLIVE AVENUE - CONNOR STREET TO TULSA STREET

<table>
<thead>
<tr>
<th>ITEM NO.</th>
<th>EST. QTY.</th>
<th>UNIT</th>
<th>ITEM</th>
<th>UNIT PRICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>L.S.</td>
<td>Mobilization and Demobilization</td>
<td>$5,000.00</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>L.S.</td>
<td>Traffic Control</td>
<td>$4,000.00</td>
</tr>
<tr>
<td>3</td>
<td>10,787</td>
<td>S.Y.</td>
<td>Micro-Surfacing, including site preparations, all in accordance with the guidelines set forth in the project specifications</td>
<td>$2,25</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>L.S.</td>
<td>Crack Filling per the guidelines set forth in these specifications</td>
<td>$4,300.00</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>L.S.</td>
<td>Striping &amp; Pavement Markings</td>
<td>$6,500.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SUBTOTAL</td>
<td>$44,070.75</td>
</tr>
</tbody>
</table>

### PART "E" - ORANGE AVENUE - MAIN STREET TO PLANO STREET

<table>
<thead>
<tr>
<th>ITEM NO.</th>
<th>EST. QTY.</th>
<th>UNIT</th>
<th>ITEM</th>
<th>UNIT PRICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>L.S.</td>
<td>Mobilization and Demobilization</td>
<td>$5,000.00</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>L.S.</td>
<td>Traffic Control</td>
<td>$4,000.00</td>
</tr>
<tr>
<td>3</td>
<td>23,774</td>
<td>S.Y.</td>
<td>Micro-Surfacing, including site preparations, all in accordance with the guidelines set forth in the project specifications</td>
<td>$2.25</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>L.S.</td>
<td>Crack Filling per the guidelines set forth in the project specifications</td>
<td>$9,500.00</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>L.S.</td>
<td>Striping &amp; Pavement Markings</td>
<td>$14,300.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SUBTOTAL</td>
<td>$86,291.50</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATE OF PROBABLE COSTS**

$542,834.25

---

**Estimate Certification**

- **Project Manager**
  - Michael Reed
  - Date: 8-7-09

- **DPWD/City Engineer**
  - Date: 8-7-09

- **Public Works Director**
  - Date: 8/11/09

- **City Manager**
  - Date: 08/10/09
SUBJECT: AWARD OF CONTRACT – AIRPORT ELECTRICAL UPGRADE PROJECT

SOURCE: Public Works Department - Engineering Division

COMMENT: On June 18, 2009, staff received four (4) bids for the Airport Electrical Upgrade project. This project consists of the installation of approximately 1,850 feet of electrical conduit, 21,000 feet of conductor wire, repair to the segmented circle and miscellaneous pavement construction.

The estimated probable cost developed by the City’s consultant was $391,150. The actual low bid for the base bid and “add alternates” A, B, C & D is $410,461. The low bid is 4.9% higher than the engineer’s estimate. The complete list of bidders and cost for the base bid and all add alternates is as follows:

<table>
<thead>
<tr>
<th>Contractor</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Electric</td>
<td>$410,461.00</td>
</tr>
<tr>
<td>RB Development</td>
<td>$417,260.00</td>
</tr>
<tr>
<td>A-C Electric</td>
<td>$446,224.00</td>
</tr>
<tr>
<td>Smith Construction</td>
<td>$521,256.20</td>
</tr>
</tbody>
</table>

On August 3, 2009, the City received notice from the Federal Aviation Administration (FAA) authorizing the City to award the contract for $410,461. Additional funds for contingency purposes are not routinely awarded by the FAA. The FAA takes a case by case approach on all extra work. If the FAA agrees that extra work is warranted due to unforeseen conditions, the contract is supplemented to cover the extra work. If the FAA feels that a poor design or other foreseeable conditions led to “extra work”, the FAA can insist that the extra cost be borne by the City.

Public Works wants Council to be aware of FAA’s policy related to contingency work. If contingency work is required, it will only be done if the FAA approves the contingency. With that said, Public Works respectfully asks that an additional $5,000 (1.2%) be authorized to cover construction administration. Staff has found the low bid acceptable. Funding from the Airport Development Fund is available in the 2009/2010 budget with the expectation of reimbursement from an FAA grant.

Dir [signature] Appropriated/Funded [signature] CM [signature] Item No. 4
RECOMMENDATION: That City Council:

1. Award the Airport Electrical Upgrade Project to the firm of Royal Electric in the amount of $410,461;

2. Authorize progress payments up to 90% of the Contract amount;

3. Authorize Public Works to incorporate “extra” or contingency work up to but not more than 10% of the contract amount provided the FAA approves and agrees to supplement the contract to cover the “extra” or contingency work; and

4. Authorize an additional $5,000 to cover construction administration costs.

ATTACHMENT: Locator Map
COUNCIL AGENDA: AUGUST 18, 2009

SUBJECT: AWARD OF CONTRACT – FAIRWAY TRACT EMERGENCY WATER PROJECT

SOURCE: Public Works Department - Engineering Division

COMMENT: On August 11, 2009 staff received seven (7) bids for the Fairway Tract Emergency Water Project. The project consists of approximately 250 feet of 8" water main and related work. The purpose of the project is to provide emergency water to the Fairway Tract, a 64 lot subdivision located along Leggett Street between Isham Avenue and Olive Avenue.

The Engineer's estimate of probable cost for the project is $32,100. The lowest bid provided is $18,401, 42.7% below the Engineer's estimate. An additional $1,840.10 is required for the construction contingency (10%). An additional $5,000.00 is required for construction management, quality control and inspection. The total estimated cost associated with the project is $25,241.10.

Water Reserve Fund is the funding source for this project, as approved by the 2009/2010 Annual Budget.

The bids are as follows:

<table>
<thead>
<tr>
<th>Contractor</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 99 Pipeline, Inc, Lindsay, CA</td>
<td>$18,401.00</td>
</tr>
<tr>
<td>2. Halopoff &amp; Sons, Inc, Porterville, CA</td>
<td>$19,689.50</td>
</tr>
<tr>
<td>3. Mattos Underground, Inc, Laton, CA</td>
<td>$20,578.70</td>
</tr>
<tr>
<td>4. Todd Engineering, Visalia, CA</td>
<td>$23,997.50</td>
</tr>
<tr>
<td>5. Nelson Underground, Visalia, CA</td>
<td>$27,500.00</td>
</tr>
<tr>
<td>6. HPS Mechanical, Inc, Bakersfield, CA</td>
<td>$30,670.00</td>
</tr>
</tbody>
</table>

Dir F Appropriated/Funded mb CM Item No. 5
RECOMMENDATION: That the City Council:

1. Award the Fairway Tract Emergency Water Project to 99 Pipeline, Inc. in the amount of $18,401.00;

2. Authorize progress payments up to 90% of the contract amount; and

3. Authorize a 10% contingency to cover unforeseen construction costs.

ATTACHMENT: Locator Map
SUBJECT: AWARD OF CONTRACT – WELL NO. 31 PROJECT (PUMPING PLANT)

SOURCE: Public Works Department - Engineering Division

COMMENT: On August 4, 2009, staff received nine (9) bids for Well No. 31 Project (Pumping Plant). The well is located on the west side of Mathew Street, south of Orange Avenue. This is the second phase of the well project and consists of the installation of a 250 HP pump, electrical system, above ground discharge piping and other items of work necessary to provide a complete pumping plant.

The Engineer’s estimate of probable cost for the entire project is $649,900. The low bid is 11.8% below the Engineer’s estimate. An additional $85,966.33 is required for construction contingency (10%), staff time and construction engineering for a total project cost of $659,075.

The bids are as follows:

<table>
<thead>
<tr>
<th>Contractor</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Valley Pump &amp; Dairy Systems</td>
<td>$573,108.88</td>
</tr>
<tr>
<td>Tulare, CA</td>
<td></td>
</tr>
<tr>
<td>2. Halopoff &amp; Sons, Inc.</td>
<td>$611,346.97</td>
</tr>
<tr>
<td>Porterville, CA</td>
<td></td>
</tr>
<tr>
<td>3. Steve Dovali Construction</td>
<td>$629,017.70</td>
</tr>
<tr>
<td>Fresno, CA</td>
<td></td>
</tr>
<tr>
<td>4. Nicholas Construction</td>
<td>$654,598.00</td>
</tr>
<tr>
<td>Shafter, CA</td>
<td></td>
</tr>
<tr>
<td>5. Grizzly Construction</td>
<td>$681,165.00</td>
</tr>
<tr>
<td>Fresno, CA</td>
<td></td>
</tr>
<tr>
<td>6. HPS Mechanical</td>
<td>$703,890.00</td>
</tr>
<tr>
<td>Bakersfield, CA</td>
<td></td>
</tr>
<tr>
<td>7. Smith Construction</td>
<td>$732,402.96</td>
</tr>
<tr>
<td>Fresno, CA</td>
<td></td>
</tr>
</tbody>
</table>
8. Vulcan Construction  $741,768.00
    Fresno, CA

9. Specialty Construction  $748,709.00
    San Luis Obispo, CA

The project was approved in the 09/10 Fiscal Year Budget and the funding source is the California Infrastructure Economic Development Bank (CIEDB) loan recently approved by the State of California and City Council. The State requires cities to prequalify contractors when submitting bids. All bidders listed above have been prequalified and staff has found the low bid acceptable.

RECOMMENDATION: That City Council:

1. Award the Well No. 31 Project (Pumping Plant) to Valley Pump & Dairy Systems in the amount of $573,108.88;

2. Authorize progress payments up to 90% of the contract amount; and

3. Authorize a 10% contingency to cover unforeseen construction costs.

ATTACHMENT: Locator Map

P:\pubworks\Engineering\Council Items\Award of Contract - Well #31 Pumping Plant - 2009-08-18.doc
SUBJECT: ACCEPTANCE OF PROJECT – MURRY & ZALUD PARK PAVILION REPLACEMENT

SOURCE: Public Works Department - Engineering Division

COMMENT: Webb & Son has completed construction of the Murry & Zalud Park Pavilion Replacement project per plans and specifications. The pavilion replacement project included installing new 30' square metal roof structures (two at Murry Park, one at Zalud), concrete footings and patching, electrical light and outlet, and appurtenances.

City Council authorized expenditure of $94,591.20. Final construction cost is $89,151.87. General Fund Carryover and Risk Management Funds were the funding sources for this project, as approved by the 2008/2009 Annual Budget.

Webb & Son requests that the City accept the project as complete. Staff reviewed the work and found it acceptable.

RECOMMENDATION: That City Council:

1. Accept the project as complete;
2. Authorize the filing of the Notice of Completion; and
3. Authorize the release of the 10% retention thirty-five (35) days after recordation, provided no stop notices have been filed.

ATTACHMENTS: Locator Maps

P:\pubworks\Engineering\Council Item\Acceptance of Project - Murry & Zalud Park Pavilion Replacement - 2009-08-18.doc

Dir Appropriated/Funded CM

Item No. 7
SUBJECT: ACCEPTANCE OF PROJECT – FIRE STATION #2 TRAINING CLASSROOM - HVAC

SOURCE: Public Works Department - Engineering Division

COMMENT: Silver Air Conditioning and Heating has completed Fire Station #2 Training Classroom – HVAC project per plans and specifications. The project included the installation of HVAC Units, ducts and all pertinent appurtenances necessary for its proper functioning.

City Council authorized expenditure of $30,954. Final construction cost is $26,800. General Fund Carryover was the funding sources for this project, as approved by the 2008/2009 Annual Budget.

Silver Air Conditioning requests that the City accept the project as complete. Staff reviewed the work and found it acceptable.

RECOMMENDATION: That City Council:

1. Accept the project as complete;
2. Authorize the filing of the Notice of Completion; and
3. Authorize the release of the 10% retention thirty-five (35) days after recordation, provided no stop notices have been filed.

ATTACHMENT: Locator Map
SUBJECT: ACCEPTANCE OF QUITCLAIM DEED – PIONEER WATER COMPANY

SOURCE: Public Works Department - Engineering Division

COMMENT: As Council is aware, the City is negotiating the sale of the Fairground property for development of a new Courthouse. During the title research, it was discovered that certain interest resided with Pioneer Water Company that preclude the conveyance of clear title and complete access rights to the property from Garden Avenue. The following are the contentious issues with the conveyance of the property:

1. Rights to use a Waste Water Ditch across the westerly portion of the Fairgrounds Property, which no longer exists; and

2. The Pioneer Water Company holds the Pioneer Ditch – Park Branch in fee title. A portion of this ditch borders the Fairgrounds' northern boundary line and a smaller segment of this ditch also borders the south side of Garden Avenue.

The relinquishment of the Waste Water Ditch and certain surface rights to the Pioneer Ditch – Park Branch were presented to the Pioneer Water Company during a meeting held July 13, 2009. During this meeting, the company officers agreed to execute Quitclaim Deeds relinquishing these rights. In the case of the Pioneer Ditch – Park Branch, the Pioneer Water Company retained their rights to maintain, replace, repair and convey irrigation water through the existing pipeline bordering the Fairgrounds' northern property line. In turn, all future surface improvements would be restored at the cost of the City of Porterville or subsequent owners should there be a need to repair, restore or maintain the existing irrigation pipe. These responsibilities are described as reservations within the legal description of the Pioneer Ditch – Park Branch Quitclaim Deed.

The Quitclaim Deeds are attached for Council's reference. Recordation of these deeds are extremely important in passing clear title of the Fairgrounds property and for defining access rights to the property from Garden Avenue. Without the Pioneer Ditch – Park Branch Quitclaim Deed, access could legally be denied by the Pioneer Ditch Company.

RECOMMENDATION: That City Council:

1. Accept the Quitclaim Deed relinquishing Pioneer Water Company's rights to a Waste Water Ditch;

Dir Appropriated/Funded CM Item No. 9
2. Accept the Quitclaim Deed relinquishing specific surface rights to a portion of the Pioneer Ditch – Park Branch; and

3. Authorize the City Clerk to record the Quitclaim Deeds with the County Recorder's Office.

ATTACHMENTS: Quitclaim Deeds with Resolutions Locator Map
RECORDING REQUESTED BY
AND WHEN RECORDED MAIL THIS
DEED AND TAX STATEMENTS TO:

City of Porterville
291 N. Main St.
Porterville, CA 93257

NO FEE PURSUANT TO GOVERNMENT
SECTION 27383

QUITCLAIM DEED
(CORPORATION)

<table>
<thead>
<tr>
<th>Atlas</th>
<th>Section</th>
<th>Township</th>
<th>Range</th>
<th>Street/Avenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>F-9</td>
<td>25</td>
<td>21S</td>
<td>27E</td>
<td>Garden Avenue</td>
</tr>
</tbody>
</table>

PIONEER WATER COMPANY a company organized and existing under and by virtue of the Laws of the State of California does hereby relinquish any rights, title, interests and quitclaim, with certain reservations, to the CITY OF PORTERVILLE, a Municipal Corporation all rights to a segment of the PARK BRANCH DITCH in the City of Porterville, County of Tulare, State of California, more particularly described as follows:

SEE EXHIBIT ‘A’ AND SHOWN ON EXHIBIT ‘B’ ATTACHED HERETO AND MADE A PART HEREOF BY REFERENCE.
IN WITNESS WHEREOF, said corporation has caused its corporate name to be hereunto subscribed and its corporate seal to be affixed hereto, this 10th day of August, 2009.

By ____________________________, Al Berra, President

By ____________________________, Bryan Styles, Secretary

[CORPORATE SEAL]

STATE OF CALIFORNIA

County of Tulare } ss

On this the 10th day of August, 2009, before me, Vickie Schulz, Notary Public, Name, Title of Officer-E.G., "Jane Doe, Notary Public"

personally appeared Albert Berra and Bryan Styles, Name(s) of Signer(s)

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that they executed the same in their behalf/these/these, or their authorized capacity(ies), and that by their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Vickie Schulz
(Notary Public's signature in and for said County and State)

(foreign seal or stamp)
Legal Description

Exhibit "A"

A portion of property commonly referred to as the Park Branch of the Pioneer Ditch, hereby being relinquished by the Pioneer Water Company, located in a portion of the Southeast quarter of the Southwest quarter of Section 25, Township 21 South, Range 27 East, Mount Diablo Base and Meridian, in the City of Porterville, County of Tulare, State of California, according to the Official Plat thereof, more particularly described as follows:

BEGINNING AT the intersection of the north line of said Pioneer Ditch with the east line of Murry Street, as shown on that certain map entitled "Map of J.P. Murry's Addition to Porterville", filed for record in Book 3 of Maps at Page 10 in the Office of the Tulare County Recorder;

THENCE, along the north line of said Pioneer Ditch, South 86°45’03” West, 80.39 feet to the intersection with the west line of Murry Street;

THENCE, South 86°45’03” West, a distance of 26.03 feet;

THENCE, North 65°47’31” West, a distance of 79.71 feet;

THENCE, North 75°56’21” West, a distance of 81.25 feet;

THENCE, North 65°33’10” West, a distance of 59.99 feet;

THENCE, North 74°13’52” West, 78.75 feet to the intersection with the south line of Garden Avenue;

THENCE, North 74°13’52” West, a distance of 124.42 feet;

THENCE, North 79°43’01” West, a distance of 168.23 feet;

THENCE, North 82°35’30” West, a distance of 45.43 feet;

THENCE, North 66°55’35” West, a distance of 30.16 feet;

THENCE, North 78°50’00” West, a distance of 33.44 feet;

THENCE, North 43°21’29” West, 70.51 feet to a point in the west line of the Southeast quarter of the Southwest quarter of said Section 25;
THENCE, along said west line, South 01°55'11" East, 22.67 feet to a point in the south line of the Pioneer Ditch;
THENCE, along the south line of the Pioneer Ditch, South 43°21’29” East, a distance of 58.31 feet;

THENCE, South 78°50’00” East, a distance of 36.67 feet;
THENCE, South 66°55’35” East, a distance of 30.66 feet;
THENCE, South 82°35’30” East, a distance of 47.12 feet;
THENCE, South 79°43’01” East, a distance of 167.13 feet;

THENCE, South 74°13’52” East, 68.61 feet to the intersection with the south line of Garden Avenue;

THENCE, South 74°13’52” East, a distance of 133.84 feet;
THENCE, South 63°41’29” East, a distance of 63.25 feet;
THENCE, South 75°53’17” East, a distance of 83.89 feet;
THENCE, South 68°15’14” East, a distance of 76.92 feet;

THENCE, North 88°27’13” East, 106.26 feet to the east line of Murry Street;

THENCE, along said east line, North 02°23’00” East, 17.35 feet to the POINT OF BEGINNING.

RESERVING unto Pioneer Company’s, its successors and assigns, the right to use, maintain, operate, alter, add to, repair, replace, reconstruct, and inspect at any time the existing underground irrigation and storm drain system and appurtenant structures.

RESERVING unto the City of Porterville, its successors and assigns, the right to construct surface improvements over and across this segment of the Park Branch of the Pioneer Ditch described herein and the responsibility of repairing all surface improvements to a like manner should it become necessary to repair or replace the underground irrigation and storm drain system.

END OF DESCRIPTION
This real property description has been prepared by me, or under my direction, in conformance with the Professional Land Surveyors Act.

Signature: Michael K. Reed
Michael K. Reed, Licensed Land Surveyor

Date: 8-10-2009
RESOLUTION NO.________

A RESOLUTION OF THE CITY COUNCIL OF THE CITY
OF PORTERVILLE ACCEPTING A QUITCLAIM DEED
FOR WASTE WATER DITCH RIGHTS FROM THE
PIONEER DITCH COMPANY

BE IT RESOLVED by the City Council of the City of Porterville, that the City of Porterville hereby accepts a Quitclaim Deed from Pioneer Ditch Company for rights to a the Park Branch of the Pioneer Water Company irrigation system, in the City of Porterville, County of Tulare, State of California, to-wit:
See Exhibit ‘A’ and shown on Exhibit ‘B’ attached hereto and made a part thereof.

BE IT FURTHER RESOLVED that the Mayor be authorized to sign all necessary documents, and said Deed be recorded in the office of the Tulare County Recorder.

PASSED, ADOPTED AND APPROVED this 18th day of August, 2009.

______________________________
Pete V. McCracken, Mayor

ATTEST:
John Lollis, City Clerk

______________________________
By: Patrice Hildreth, Chief Deputy City Clerk
Legal Description

Exhibit “A”

A portion of property commonly referred to as the Park Branch of the Pioneer Ditch, hereby being relinquished by the Pioneer Water Company, located in a portion of the Southeast quarter of the Southwest quarter of Section 25, Township 21 South, Range 27 East, Mount Diablo Base and Meridian, in the City of Porterville, County of Tulare, State of California, according to the Official Plat thereof, more particularly described as follows:

BEGINNING AT the intersection of the north line of said Pioneer Ditch with the east line of Murry Street, as shown on that certain map entitled “Map of J.P. Murry’s Addition to Porterville”, filed for record in Book 3 of Maps at Page 10 in the Office of the Tulare County Recorder;

THENCE, along the north line of said Pioneer Ditch, South 86°45’03” West, 80.39 feet to the intersection with the west line of Murry Street;

THENCE, South 86°45’03” West, a distance of 26.03 feet;

THENCE, North 65°47’31” West, a distance of 79.71 feet;

THENCE, North 75°56’21” West, a distance of 81.25 feet;

THENCE, North 65°33’10” West, a distance of 59.99 feet;

THENCE, North 74°13’52” West, 78.75 feet to the intersection with the south line of Garden Avenue;

THENCE, North 74°13’52” West, a distance of 124.42 feet;

THENCE, North 79°43’01” West, a distance of 168.23 feet;

THENCE, North 82°35’30” West, a distance of 45.43 feet;

THENCE, North 66°55’35” West, a distance of 30.16 feet;

THENCE, North 78°50’00” West, a distance of 33.44 feet;

THENCE, North 43°21’29” West, 70.51 feet to a point in the west line of the Southeast quarter of the Southwest quarter of said Section 25;
THENCE, along said west line, South 01°55′11″ East, 22.67 feet to a point in the south line of the Pioneer Ditch;
THENCE, along the south line of the Pioneer Ditch, South 43°21′29″ East, a distance of 58.31 feet;

THENCE, South 78°50′00″ East, a distance of 36.67 feet;
THENCE, South 66°55′35″ East, a distance of 30.66 feet;
THENCE, South 82°35′30″ East, a distance of 47.12 feet;
THENCE, South 79°43′01″ East, a distance of 167.13 feet;

THENCE, South 74°13′52″ East, 68.61 feet to the intersection with the south line of Garden Avenue;
THENCE, South 74°13′52″ East, a distance of 133.84 feet;
THENCE, South 63°41′29″ East, a distance of 63.25 feet;
THENCE, South 75°53′17″ East, a distance of 83.89 feet;
THENCE, South 68°15′14″ East, a distance of 76.92 feet;

THENCE, North 88°27′13″ East, 106.26 feet to the east line of Murry Street;

THENCE, along said east line, North 02°23′00″ East, 17.35 feet to the POINT OF BEGINNING.

RESERVING unto Pioneer Company's, its successors and assigns, the right to use, maintain, operate, alter, add to, repair, replace, reconstruct, and inspect at any time the existing underground irrigation and storm drain system and appurtenant structures.

RESERVING unto the City of Porterville, its successors and assigns, the right to construct surface improvements over and across this segment of the Park Branch of the Pioneer Ditch described herein and the responsibility of repairing all surface improvements to a like manner should it become necessary to repair or replace the underground irrigation and storm drain system.

END OF DESCRIPTION
This real property description has been prepared by me, or under my direction, in conformance with the Professional Land Surveyors Act.

Signature: 

Michael K. Reed, Licensed Land Surveyor

Date: 8-10-2009
PIONEER WATER COMPANY a company organized and existing under and by virtue of the Laws of the State of California does hereby relinquish any rights, title, interests and quitclaim to the CITY OF PORTERVILLE, a Municipal Corporation all rights to a WASTE WATER DITCH in the City of Porterville, County of Tulare, State of California, described as:

Pioneer Water Company's waste ditch along the west line of the land recited in the Deed from Porterville Alfalfa Company, a Corporation, dated December 28, 1918, recorded in Book 268, Page 144 of Deeds.
IN WITNESS WHEREOF, said corporation has caused its corporate name to be hereunto subscribed and its corporate seal to be affixed hereto, this 10th day of August, 2009.

By ______________________, Al Berra, President

By ______________________, Bryan Styles, Secretary

[CORPORATE SEAL]

STATE OF CALIFORNIA
County of Tulare } ss

On this the 10th day of August, 2009, before me, Vickie Schulz, Notary Public

Name, Title of Officer-E.G., "Jane Doe, Notary Public"

personally appeared Albert Berra and Bryan Styles

Name(s) of Signer(s)

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

VICKIE SCHULZ
Commission # 1758701
Notary Public - California
Tulare County

(Notary Public's signature in and for said County and State)

(for notary seal or stamp)
RESOLUTION NO.___________
A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF PORTERVILLE ACCEPTING A QUITCLAIM DEED FOR WASTE WATER DITCH RIGHTS FROM THE PIONEER DITCH COMPANY

BE IT RESOLVED by the City Council of the City of Porterville, that the City of Porterville hereby accepts a Quitclaim Deed from Pioneer Ditch Company for rights to a waste water ditch, in the City of Porterville, County of Tulare, State of California, to wit:

Pioneer Water Company’s waste ditch along the west line of the land recited in the Deed from Porterville Alfalfa Company, a Corporation, dated December 28, 1918, recorded in Book 268, Page 144 of Deeds.

BE IT FURTHER RESOLVED that the Mayor be authorized to sign all necessary documents, and said deed to be recorded in the office of the Tulare County Recorder.

PASSED, ADOPTED AND APPROVED this 18th day of August, 2009.

Pete V. McCracken, Mayor

ATTEST:
John Lollis, City Clerk

By: Patrice Hildreth, Chief Deputy City Clerk
SUBJECT:  AUTHORIZATION TO EXECUTE A CONSULTANT SERVICE AGREEMENT FOR SURVEYING SERVICES – HENDERSON AVENUE REHABILITATION PROJECT

SOURCE:  Public Works Department - Engineering Division

COMMENT:  On August 7, 2009, City staff received four (4) proposals for surveying services on Henderson Avenue from Jaye Street to Indiana Street. The survey will aid City Staff in designing the Henderson Avenue Rehabilitation Project. The selection process was held in conformance with the policy established by City Council for selecting professional consulting firms. The following is a list of the consulting firms and their ranking according to their scores attributed to their proposal:

<table>
<thead>
<tr>
<th>Consultant</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winton and Associates (Porterville, CA)</td>
<td>1</td>
</tr>
<tr>
<td>Dee Jaspar and Associates (Porterville, CA)</td>
<td>2</td>
</tr>
<tr>
<td>Provost and Pritchard (Visalia, CA)</td>
<td>3</td>
</tr>
<tr>
<td>Quad Knopf (Visalia, CA)</td>
<td>4</td>
</tr>
</tbody>
</table>

TASK 1 - TOPOGRAPHY SURVEY AND RAW DATA FILE
The consultant will provide topographic surveying and provide a point file and raw data file of the given project area as specified in the scope of services. Winton and Associates has agreed to perform the following task at a fee of $5,600.00:

Winton and Associates has submitted a schedule to complete all services within one week, with an allotted month’s time for utility manhole coordination. If the agreement is awarded, as presented to Council, the services will be complete by mid-September 2009. Local Transportation Funds is the funding source for this project, as approved by the 2009/2010 Annual Budget.

RECOMMENDATION:  That City Council:

1.  Authorize the Mayor to execute the Consultant Service Agreement with Winton and Associates at an agreed fee of $5,600 for the services described herein;

Item No. 10
2. Authorize progress payments up to 100% of the fee amount; and

3. Authorize a 10% contingency to cover unforeseen survey requirements that relate to our design efforts.

ATTACHMENTS: Locator Map
Service Agreement
Cost Proposal
SUBJECT LOCATION

The area located on Henderson Avenue, between Putnam Street and Jaye Street.

HENDERSON AVE.
REHABILITATION PROJECT
SERVICE AGREEMENT

DATE: August 18, 2009

PARTIES: City of Porterville, a California municipal corporation, hereinafter referred to as "CITY"; and Winton and Associates, hereinafter referred to as "CONSULTANT".

RECITALS: CITY has undertaken a project on which it is seeking assistance from CONSULTANT. Said project which will hereinafter be referred to as "project" is described as follows:

- Project Name: Survey Services for the Henderson Avenue Rehabilitation Project
- Description of Project: Consultant to provide topographic survey along Henderson Avenue between Indiana Street and Jaye Street.

AGreements:

IN CONSIDERATION OF MUTUAL COVENANTS AND AGREEMENTS HEREAFTER set forth the parties hereto do contract and agree as follows:

SECTION 1. CONTRACT SERVICES: CONSULTANT hereby agrees to provide the following services and materials, in a timely manner as described in Exhibit “A”, Scope of Services, in connection with the above described project.
SECTION 2. PAYMENT: In consideration for said services and materials, CITY shall pay CONSULTANT on a time and materials basis, not to exceed **Five thousand six hundred** Dollars, ($5,600.00) (refer to attached fee schedule)

TIME OF PAYMENT: Progress payment requests shall be submitted by the 25th of each month. CONSULTANT should receive payment within 30 days of the date the bill is received.

SECTION 3. COMPLETION DATE: The services to be performed by CONSULTANT will be commenced upon execution of this agreement and all "work directives" shall be completed within five (5) working days to complete the tasks outlined in Exhibit "A". One (1) month will be allotted in order to properly coordinate with utility companies.

The parties agree that time is of the essence under this contract. Inasmuch as it would be difficult to ascertain the actual amount of damages sustained by delay in performance of said contract, the amount of $100 per calendar day shall be deducted from the contract price for liquidated damages for each calendar day beyond the completion date listed above. Said deduction will not be made if CONSULTANT submits proof in writing that delay in completion was due to a cause beyond its control.

SECTION 4. FAMILIARITY WITH PROJECT: CONSULTANT certifies and agrees that it is fully familiar with all of the details of the project required to perform its services. CONSULTANT agrees it will not rely
upon any opinions and representations of CITY unless CITY is the only available source of said information.

SECTION 5. INDEPENDENT CONTRACTOR: It is expressly understood that CONSULTANT is entering into this contract and will provide all services and materials required hereunder as an independent contractor and not as an employee of CITY. CONSULTANT specifically warrants that it will have in full force and effect, valid insurance covering:

(i) Full liability under worker's compensation laws of the State of California; and

(ii) Bodily injury and property damage insurance in the amount not less than One Million Dollars ($1,000,000) per occurrence; and

(iii) Errors and Omissions insurance of One Million Dollars ($1,000,000) minimum per occurrence, if deductible for Errors and Omissions insurance is Fifty Thousand Dollars ($50,000) or more, the City may require a Surety Bond for the deductible; and

(iv) Automotive liability in the amount not less than One Million Dollars ($1,000,000) per occurrence; fully protecting CITY, its elected and appointed officers, employees, agents and assigns, against all claims arising from the negligence of CONSULTANT and any injuries to third parties, including employees of CITY and CONSULTANT. CONSULTANT
agrees to indemnify, defend (at CITY'S election), and hold harmless the CITY against any claims, actions or demands against CITY, and against any damages, liabilities for personal injury or death or for loss or damage to property, or any of them arising out of negligence of CONSULTANT or any of its employees or agents.

SECTION 6. WORKMANSHIP AND MATERIALS: Every part of the work herein described shall be executed in a professional manner with competent, experienced personnel. Finished or unfinished material prepared under the agreement, prepared by CONSULTANT, shall become property of CITY. CONSULTANT hereby warrants that any materials prepared under this agreement shall be fit for the intended use contemplated by the parties.

SECTION 7. ASSIGNMENT OF CONTRACT: It is acknowledged by the parties that CITY has entered into this contract with the express understanding that CONSULTANT will perform all work. CONSULTANT shall not, without the written consent of CITY, assign, transfer or sublet any portion or part of this work, nor assign any payments to others.

SECTION 8. AFFIRMATIVE ACTION. CONSULTANT will not discriminate against any employee, or applicant for employment because of race, color, religion, gender, marital status, or national origin.

SECTION 9. CONFLICT OF INTEREST CODE: CONSULTANT agrees to comply with the regulations of CITY'S “Conflict of Interest Code”. Said
code is in accordance with the requirements of the Political Reform Act of 1974.

CONSULTANT covenants that it presently has no interest, and shall not have any interest, direct or indirect, which would conflict in any manner with the performance of service required hereunder. The term "conflict" shall include, as a minimum, the definition of a "conflict of interest" under the California Fair Political Practices Act and the City of Porterville Conflict of Interest Code, as that term is applied to consultants.

SECTION 10. TERMINATION: Either party for just cause may terminate this contract by giving seven (7) days written notice to the other party. Upon termination by CITY, CITY shall be relieved of any obligation to pay for work not completed including profit and overhead. CONSULTANT may be entitled to just and equitable compensation for satisfactory work completed, except CITY can withhold damages incurred as a result of the termination.

SECTION 11. ENTIRE CONTRACT: It is understood and agreed that this Service Agreement represents the entire Agreement between the parties. Should it be necessary to institute legal proceedings to enforce any and all of the covenants and conditions of this Agreement, the prevailing party shall be entitled to recover attorneys' fees and costs.

SECTION 12. DISPUTES; VENUE: If either party initiates an action to enforce the terms hereof or declare rights hereunder, the parties agree that the venue thereof shall be the County of Tulare, State of California.
CONSULTANT hereby waives any rights it might have to remove any such action pursuant to California Code of Civil Procedure Section 394.

IN WITNESS WHEREOF, the parties have executed this Service Agreement on the date and year first above written.

CITY OF PORTERVILLE                     CONSULTANT

By_____________________________        By_____________________________

Pete V. McCracken, Mayor

Date_____________________________    Date_____________________________

BSR:vs

F:\pubworld\Engineering\Project Files\Daniel Cavente\PROJ # 89-9121 - HENDERSON FROM INDIANA TO JAYE\Winton and Associates Service Agreement.doc
EXHIBIT “A”
Henderson Avenue Rehabilitation Project
“Scope of Services”

The City of Porterville requests proposals from qualified engineering and surveying firms for providing topographic surveying services for the purposes of rehabilitating Henderson Avenue.

Project Limits

For the most part, the new construction will be within existing City rights of way. General project limits are as follows:

- Henderson Avenue from Indiana Street to Jaye Street

Please refer to Exhibit “D”, which illustrates the proposed route in more detail.

Cross-section limits shall be extended to the street rights of way on each side of the proposed route. However, the consultant will not be required to field establish said right of way lines.

Task 1: Topography Survey

The City has digital files of aerial orthophotographs and planimetric drawings that cover the project areas, at a one to one scale. These files will be available to the retained consultant. The City’s aerial photographs were flown in 1998 and tied to a monumented half-mile grid that has an accuracy better than 1 in 50,000. The planimetric drawings include limited topographic features and 2-foot contour interval. The consultant may utilize these drawing files in conjunction with the City record drawings as a planning tool for these municipal street facilities.

Surveying

Surveying services shall include the physical features of the terrain, significant contour changes between cross sections, and the various objects and obstructions that must be considered in the design and construction of the project. Objects, obstructions, etc. that must be included in the survey are, but not limited to:

a. survey monuments
b. valves - gas, water, etc., including top of lid and nut depth
c. manholes - sewer, storm drain, Edison, AT&T, etc., including applicable inverts, top of cone, and bottom of cone/top of first grade ring to determine the size of the cone
d. culverts, storm drain drop inlets, irrigation systems, etc., including applicable inverts
e. curb, gutter, sidewalk, x-gutter, driveways, medians, etc.
f. pavement edges, asphalt dikes

h. utilities - power poles, telephone poles, street lights, etc.

i. landscape - trees, shrubs, etc.

j. all other items that may affect design and construction

The topography survey area shall be cross-sectioned at 50-foot intervals, or close thereof, and shall consist of a survey/control line. Cross-sectioned "shots" need **not** align with one another. Elevations shall be taken at the survey/control line, crown of the street, edge of gutter, edge of pavement, flowline of asphalt dikes, survey limits, ditch banks, ditch flowlines and any contour variation exceeding six (6) inches. Survey/control lines shall be established using existing monumentation located in the area. Elevations shall be tied to the City’s current NAVD88 datum. Please find attached as Exhibit “E”, a map that illustrates the City horizontal control network scheme for both NGVD29 and NAVD88 datums.

**Computerized Topographic Information:**

Data format will be as follows:

- Raw Data File - Includes Survey Field Notes, and all essential Survey Data
- Point File - PNEZD format (Point number, Northing, Easting, Elevation, and Description).

The consultant will submit a complete raw data file and a point file to the City to be reviewed for quality, completeness, and accuracy. Within five (5) working days of receiving the raw data file for review, the City will comment and/or accept the raw data file as being in compliance with the City’s request or, will reject the raw data file for noncompliance with the City’s stated standards and require that it be resubmitted in compliance.

The survey shall be one seamless raw data file and shall include all the essential topographic features necessary for City staff to properly align, design, and prepare digital improvement plans (plan and profile sheets). All topographic features, survey control, existing utilities, etc. must match the City NAD83 coordinate system and again must be one continuous raw data file.

**DELIVERABLES:**

- **Computerized Topographic Information**: Consultant shall provide one complete raw data file and complete point file for City review and comment. Digital submittals are preferred.
City of Porterville
Henderson Avenue Rehabilitation Project
Cost Proposal

Task 1: Topography Survey and Raw Data File
Total Proposal Cost $5,600.00

Authorized Representative Consulting Firm

cc: Mike Reed File
DC
SUBJECT: RULE 8061 COMPLIANCE REQUIREMENTS

SOURCE: Public Works Department – Engineering Division

COMMENT: The Public Works Department was notified by the San Joaquin Valley Air Pollution Control District (SJVAPCD) that the City is required to submit reporting to verify compliance with Rule 8061 – Paved and Unpaved Roads. The purpose of Rule 8061 is to limit fugitive dust emissions from paved and unpaved roads by implementing control measures and design criteria. This rule applies to any new or existing public or private paved or unpaved road, road construction project, or road modification project. The City of Porterville is only responsible for the roads maintained within our City limits and rights of way. SJVAPCD stated that failure to comply with these requirements would result in a Notice of Violation, which can be accompanied by monetary fines. The maximum penalty per day per violation is $1,000,000 depending on the severity of the situation.

As this process entails reporting the status of all streets within City limits, including alleys, it has taken Public Works Staff several months to compile a list of each road segment in the City and identify those that do not meet Rule 8061 requirements. To assure an accurate representation of existing conditions, Staff field verified roads in question throughout the City to determine whether they could be considered “stabilized” per SJVAPCD guidelines. A stabilized road consists of a street that has four or eight feet (depending on traffic volumes) of paved shoulder beyond the edge of a travel lane, curb or curb & gutter at the pavement edge, or road shoulders stabilized with washed gravel, dust stabilizers, roadmix, grasses, watering or other methods that meet the definition and requirements of a stabilized surface per SJVAPCD Rule 8011, Section 3.58 and Appendix B.

After staff's analysis, it has been determined that thirty-eight (38) road segments do not meet Rule 8061 requirements and attached is a preliminary estimate of probable costs defining the financial impact. Nearly all streets on this list are collectors or arterials in the City. The majority of these roads would require both curb & gutter and pavement, with the improvements costing about $5.11 million, but this does not include drainage infrastructure improvements that may trigger additional costs. The few remaining roads that only require a paved shoulder per SJVAPCD guidelines will cost about $515,000. There are other less costly options to “stabilize” the dirt shoulders, as mentioned above, but these options could require more maintenance as they are not long-term improvements when compared to pavement and concrete construction.
The $5.11 million is a large amount and current economic conditions make it nearly impossible to fund projects specific to Rule 8061 requirements. One possible funding source is the Congestion Mitigation and Air Quality (CMAQ) funds, which are federal dollars that become available approximately every five (5) years. These dollars are assigned by our local Council of Governments, Tulare County Association of Government (TCAG) and disbursed via the Federal Governments interaction with the State. It is yet to be determined if our paved and unpaved reporting status with SJVAPCD will influence the City’s ability to obtain additional funds when TCAG reviews City of Porterville applications.

After reporting non-stabilized road segments, Rule 8061 requires agencies to stabilize 50% of the urban road classifications and 25% of the rural road classifications within five years of reporting. Most, if not all, City non-stabilized road segments indentified by staff are urban classified. Agencies are to report annual progress to the SJVAPCD. Rule 8061 also allows agencies to submit a “Statement of Financial Hardship” to the SJVAPCD Board.

RECOMMENDATION: That the City Council:

1. Authorize staff to send determinations to the SJVAPCD to satisfy the reporting requirements of Rule 8061 along with a “Statement of Financial Hardship”; and

2. Contingent upon the Boards denial of the “Statement of Financial Hardship”, direct staff to work with SJVAPCD in establishing a reasonable schedule with a focus on realistic financial goals when considering the current economic situation.

ATTACHMENTS: List of Roads Requiring Improvements/Stabilization and Cost Estimate SJVAPCD Rule 8061 – Paved and Unpaved Roads
<table>
<thead>
<tr>
<th>Road Name/Segment</th>
<th>From Location</th>
<th>To Location</th>
<th>Road Classification</th>
<th>Width(ft)</th>
<th>Year</th>
<th>Length(ft)</th>
<th>No. of Lanes</th>
<th>PM/10 Control Measure Utilized during Construction</th>
<th>Field Work</th>
<th>CAD Cost Estimate Single Side Segment</th>
<th>CAD Cost Estimate Double Side Segment</th>
<th>Paying Cost Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Ave</td>
<td>Jay St</td>
<td>Roseville Ave</td>
<td>Urban Local</td>
<td>14</td>
<td>2008</td>
<td>0.130</td>
<td>2</td>
<td>PM/10 needed on north side</td>
<td>P</td>
<td>171,400.00</td>
<td>332,839.80</td>
<td>150,000.00</td>
</tr>
<tr>
<td>Valley St</td>
<td>31st South of Union Ave</td>
<td>11th South of Slaughter Ave</td>
<td>Urban Local</td>
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<td>2008</td>
<td>0.364</td>
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<td>2PM/10 needed on north side</td>
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<td>167,775.00</td>
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<td>Mississippi Ave</td>
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<td>P</td>
<td>86,326.60</td>
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**Paving with Curb & Gutter Improvements Required to Comply With RULE 8001:** $5,112,247.78 (estimated) **Paving Only Improvements Required to Comply With RULE 8001:** $5,112,247.78 (estimated) **TOTAL Improvements Required to Comply With RULE 8001:** $5,112,247.78 (estimated)
RULE 8061  PAVED AND UNPAVED ROADS (Adopted November 15, 2001; Amended August 19, 2004)

1.0 Purpose

The purpose of this rule is to limit fugitive dust emissions from paved and unpaved roads by implementing control measures and design criteria.

2.0 Applicability

This rule applies to any new or existing public or private paved or unpaved road, road construction project, or road modification project. The provisions of this rule adopted on November 15, 2001 shall remain in effect until October 1, 2004 at which time the amendments adopted on August 19, 2004 shall take effect.

3.0 Definitions

The definitions of terms in Rule 8011 (General Requirements) shall apply to this rule.

4.0 Exemptions

In addition to the exemptions established in Rule 8011, the following exemptions are established for this Rule:

4.1 Any unpaved road segment with less than 26 annual average daily vehicle trips (AADT).

4.1.1 This exemption shall not apply to Section 5.2.3 of this rule.

4.1.2 An owner/operator of any unpaved road segment with 26 or more AADT must provide estimated or actual vehicle trip data to the APCO by July 1, 2005.

4.2 Maintenance and resurfacing of existing paved roads does not apply to section 5.2 of this rule.

4.3 Agricultural sources subject to, or specifically exempt from, Rule 8081 (Agricultural Sources)

4.4 Emergency activities performed to ensure public health and safety as specified in Rule 8011, section 4.1.

4.5 Equipment used to remove debris beyond the capabilities of PM10-efficient street sweepers.
5.0 Requirements

In addition to the requirements of this rule, a person shall comply with all other applicable requirements of Regulation VIII.

5.1 Paved Roads

5.1.1 New or Modified Paved Roads:

5.1.1.1 An owner/operator having jurisdiction over, or ownership of, public or private paved roads shall construct, or require to be constructed, all new or modified paved roads in conformance with the American Association of State Highway and Transportation Officials (AASHTO) guidelines for width of shoulders and for median shoulders as specified in section 5.1.1.2 of this rule as specified below:

5.1.1.1.1 New paved roads or modifications to existing paved roads with projected annual average daily vehicle trips of 500 vehicles or more shall be constructed with paved shoulders that meet following widths:

<table>
<thead>
<tr>
<th>Annual Average Daily Vehicle Trips (AADT)</th>
<th>Minimum Paved or Stabilized Shoulder Width</th>
</tr>
</thead>
<tbody>
<tr>
<td>500-3000</td>
<td>4 feet or limit of right-of-way, whichever is the lesser</td>
</tr>
<tr>
<td>Greater than 3000</td>
<td>8 feet or limit of right-of-way, whichever is the lesser</td>
</tr>
</tbody>
</table>

5.1.1.2 A curbing adjacent to and contiguous with the travel lane or paved shoulder of a road may be constructed, in lieu of meeting the paved shoulder width standard in Section 5.1.1.1

5.1.1.3 Intersections, auxiliary entry lanes, and auxiliary exit lanes may be constructed adjacent to and contiguous with the roadway, in lieu of meeting the paved shoulder width standard in Section 5.1.1.1

5.1.1.4 Where the requirements specified in Section 5.1.1.1 are shown to conflict with the requirements of the California Environmental
Quality Act (CEQA) and National Environmental Policy Act (NEPA) with respect to determinations regarding environmental, cultural, archaeological, historical, or other considerations addressed in such documents, an owner/operator is exempt from the paved shoulder width requirements specified in Section 5.1.1.1.1 of this rule.

5.1.1.2 Whenever any paved road which has projected annual average daily vehicle trips of 500 or more is constructed, or modified with medians, the medians shall be constructed in conformance with the AASHTO guidelines for width of median shoulders, with paved shoulders having a minimum width of four feet adjacent to the traffic lanes unless:

5.1.1.2.1 The medians of roads having speed limits set at or below 45 miles per hour are constructed with curbing; or

5.1.1.2.2 The medians are landscaped and maintained with grass or other vegetative ground cover or chemical/organic dust suppressants/stabilizers to comply with the definition of stabilized surface in Rule 8011.

5.1.2 PM10-Efficient Street Sweepers:

Each city, county, or state agency with primary responsibility for any existing paved road within an urban area shall take the following actions:

5.1.2.1 Effective July 1, 2005, all purchases of street sweeper equipment by such agency or their contractor(s) shall be only PM10-efficient street sweepers.

5.1.2.2 The utilization of PM10-efficient street sweepers by an agency or its contractor(s) shall be prioritized for use on routine street sweeper route(s) with paved curbs which have been determined by an agency to have the greatest actual or potential for dirt and silt loadings.

5.1.2.3 Any agency which conducts or contracts for routine street sweeping activities or services shall purchase, or require their contractor(s) to purchase and place into service, at least one PM10-efficient street sweeper not later than July 1, 2008.
5.1.2.4 Any street sweeping routes with paved curbs covered by PM10-efficient street sweepers pursuant to Section 5.1.2.2 shall conduct routine street sweeping operations over such routes at a frequency of not less than once per month.

5.1.2.5 All PM10-efficient street sweepers shall be operated and maintained according to manufacturer specifications.

5.1.2.6 If the provisions of Sections 5.1.2.1 or 5.1.2.3 cannot be met due to budgetary constraints, the agency may submit a statement of financial hardship to, and approved by, the APCO and US EPA.

5.1.3 Post-Event Clean-Up

Each city, county, or state agency with primary responsibility for any existing paved road shall take the following actions upon discovery by the city, county or state agency of accumulations of mud/dirt [event material] of at least 1 inch thickness over an area of at least 50 square feet on road surface travel lanes as a result of wind/storm/water erosion and runoff:

5.1.3.1 Within 24 hours of discovery by the city, county or state agency of such condition, remove the mud/dirt from the travel lanes or restrict vehicles from traveling over said mud/dirt until such time as the material can be removed from the travel lanes.

5.1.3.2 Follow dust minimizing practices during the removal of such mud/dirt from the travel lanes.

5.1.3.3 In the event unsafe travel conditions would result from restricting vehicle traffic pursuant to Section 5.1.3.1, and removal of such material is not possible within 72 hours due to weekend or holiday conditions, the provisions of Section 5.1.3.1 can be extended upon notification to and approval by the APCO.

5.1.3.4 As soon a practicable, removal of mud/dirt from paved shoulders should also occur through the use of dust minimizing practices.

5.2 Unpaved Road Segment

5.2.1. On any unpaved road segment with 26 or more AADT, the owner/operator shall limit VDE to 20% opacity and comply with the
requirements of a stabilized unpaved road by application and/or re-application/maintenance of at least one of the following control measures, or shall implement an APCO-approved Fugitive PM10 Management Plan as specified in Rule 8011 (General Requirements):

5.2.1.1 Watering;

5.2.1.2 Uniform layer of washed gravel;

5.2.1.3 Chemical/organic dust stabilizers/suppressants in accordance with the manufacturer's specifications;

5.2.1.4 Roadmix;

5.2.1.5 Paving;

5.2.1.6 Any other method that can be demonstrated to the satisfaction of the APCO that effectively limits VDE to 20% opacity and meets the conditions of a stabilized unpaved road.

5.2.2 Within an urban area, the construction of any new unpaved road is prohibited unless the road meets the definition of a temporary unpaved road as specified in section 3.60 of Rule 8011.

5.2.3 Requirements for Existing Unpaved Public Roads in Urban and Rural Areas:

5.2.3.1 Each city, county, or state agency with primary responsibility for any existing unpaved road within urban and rural areas shall take the following actions:

5.2.3.1.1 By January 1, 2005 provide the District with a list of all unpaved roads under its jurisdiction in any urban area(s), including data on length of, and AADT on, each unpaved road segment.

5.2.3.1.2 By July 1, 2005 provide the District with a list of all unpaved roads under its jurisdiction in any rural area, including data on length of, and AADT on, each unpaved road segment.

5.2.3.1.3 By January 1, 2010, pave an average of 20% annually of all unpaved roads identified in Section 5.2.3.1.1 up to a maximum of 5 cumulative miles within any one
urban area, with priority given to roads with the highest AADT levels. In meeting this requirement, each jurisdiction must show incremental progress.

5.2.3.1.4 By April 1 of each year, 2006 through 2010, submit to the District the total number of unpaved road miles which were paved during the previous calendar year, and the percentage of cumulative miles paved relative to the list provided pursuant to Section 5.2.3.1.1.

5.2.3.1.5 If the provisions of Section 5.2.3.1.3 cannot be met due to budgetary constraints, the agency may submit a statement of financial hardship to, and approved by, the APCO and US EPA.

5.2.4 Requirements for Existing Paved Public Roads with Unpaved Shoulders in Urban and Rural Areas:

5.2.4.1 Each city, county, or state agency with primary responsibility for any existing paved public road with unpaved shoulders in urban and rural areas shall take the following actions:

5.2.4.1.1 By January 1, 2005 provide the District with a list of all paved public roads with unpaved shoulders in any urban and rural area, including data on length of, and AADT on, each segment of paved public road with unpaved shoulders.

5.2.4.1.2 In Urban areas, by January 1, 2010, pave or stabilize 4-foot shoulders on 50% of existing paved public roads with the highest AADT in urban areas identified in Section 5.2.4.1.1. In meeting this requirement, each jurisdiction must show incremental progress.

5.2.4.1.3 In Rural areas, by January 1, 2010, pave or stabilize 4-foot shoulders on 25% of existing paved public roads with the highest AADT in rural areas identified in Section 5.2.4.1.1. In meeting this requirement, each jurisdiction must show incremental progress.

5.2.4.1.4 If the provisions of Sections 5.2.4.1.2 or 5.2.4.1.3 cannot be met due to budgetary constraints, the agency may submit a statement of financial hardship to, and approved by, the APCO and US EPA.
5.2.5 Requirements for Establishing and Posting Maximum Speed Limits on Unpaved Roads

Each owner/operator shall establish a maximum speed limit of 25 mph on each unpaved road with 26 AADT or more and shall post speed limit signs, one in each direction, per mile of road segment in urban areas, and per two miles of road segment in rural areas. This provision shall become effective one year from the date of adoption of this rule amendment.

6.0 Administrative Requirements

6.1 Test Methods

The applicable test methods specified in Rule 8011 shall be used to determine compliance with this rule.

6.2 Recordkeeping and Reporting

In addition to complying with the recordkeeping requirements specified in Rule 8011 and Sections 5.2.3 and 5.2.4 of this rule, city, county and state agencies responsible for the maintenance and operation of public paved and unpaved roads, shall prepare and submit a written report to the District documenting compliance with the provisions of this rule. This report shall be prepared for the years 2003 and 2004, and no less frequently than each two (2) year period thereafter. The reports shall be transmitted to the District no later than 90 days after the end of the calendar year and shall include:

6.2.1 The total miles of paved and unpaved roads under the jurisdiction of the owner or agency and the miles of roads constructed or modified during the reporting period subject to the requirements of this regulation.

6.2.2 For newly constructed or modified roads, a summary of actions taken during the reporting period to prevent or mitigate PM10 emissions, with miles specified for each type of control measure used to reduce PM10 emissions.

6.2.3 For all roads under the agency’s jurisdiction, a summary of actions taken to reduce PM10 emissions from roads during the reporting period. The total miles of roads for which these procedures were enforced and the estimated traffic volume on the affected roads shall be provided.
6.2.4 Other information that may be needed by the APCO for compliance with the United States Environmental Protection Agency's requirements.
SUBJECT: REQUEST FOR PROMOTIONAL DISPLAY ON PUBLIC RIGHT-OF-WAY (RELAY FOR LIFE 2009)

SOURCE: COMMUNITY DEVELOPMENT DEPARTMENT

COMMENT: In August of 2008, the City Council authorized local American Cancer Society's Relay for Life event for "Paint the Town Purple." The applicants are now making the request again to bring public awareness to the Relay for Life yearly event held each fall at Granite Hills High School. This year's theme of "Paint the Town Purple" is an opportunity for all those involved to conduct public outreach and public awareness of cancer.

The applicants will conduct a procession along Henderson Avenue, Main Street, and Olive Avenue on September 5, 2009. The procession will be held from 9 a.m. to 12 p.m. and be confined to the sidewalk areas along the said streets. Along the route, ribbons and balloons are proposed to be tied around public trees, lights, signs and within public planter areas (Attachment 2).

Section 2014 B-2 of the Zoning Ordinance requires authorization by the City Council prior to pasting, posting, noticing, promoting, or commemorating special events in the public right-of-way. The Porterville Municipal Code and Zoning Ordinance contains a process for granting a temporary use public right-of-way for promoting events "with the City Council's approval." The Council is authorized to include conditions of approval if so desired.

Staff has prepared the following recommended conditions of approval for the promotional event "Paint the Town" by the American Cancer Society Relay for Life:

1. The participants shall comply with all applicable Municipal Code and City Ordinances pertaining to pedestrians and traffic.
2. The procession shall be restricted to sidewalk areas along Henderson Avenue, Main Street and Olive Avenue.
3. The applicants shall be responsible for removal and cleanup of any and all ribbons, balloons, promotional signs and material within 30 days of pasting, posting, noticing, promoting and or commemorating the September 5, 2009 event.
4. The applicants shall receive permission from any other utility or public service provider prior pasting, posting, or promoting and materials on corresponding utility poles or service cabinets.
5. The hours of assembly and procession shall be limited to a one day event from 9 a.m. to 12 p.m. on September 5, 2009.
RECOMMENDATION: That the City Council authorize the non-advertising displays commemorating the “Paint the Town” special event subject to the recommended conditions of approval.

ATTACHMENTS:

1. Letter of Request to City Council
2. Photo examples of promotional material
August 6, 2009

Porterville City Council
291 North Main Street
Porterville, CA 93257

Dear Porterville City Council,

We are having the American Cancer Society’s Relay for Life Paint the Town Purple on September 5th, 2009. I have presented the items to Jose Ortiz, which we would like the people and other businesses to put up in support of the people that have won, lost and are fighting the battle with cancer. The group event is to put up as much purple in the support of the Battle against cancer and display our support for 1 month. On October 5th or 6th the businesses owners/personnel and other volunteers will be removing the items from the town where they were proudly displayed for the month.

We appreciate all that anyone is able to do for the Fight against Cancer.

Thank you very much,

Cynthia Galvan
Friends & Family Forever, Porterville Relay for Life Team Co-captain
mommy_on_the_go_93258@yahoo.com
559-756-1186

---

ATTACHMENT
ITEM NO. 1
SUBJECT: PROPOSITION 1A SECURITIZATION PROGRAM

SOURCE: City Manager

COMMENT: California Communities, a joint powers authority (JPA) sponsored by the League of California Cities and the California State Association of Counties (CSAC), has announced its plans to initiate a securitization program for the Proposition 1A property tax loan to the State. The program is intended to replace one hundred percent (100%) of the funds loaned by local agencies to the State. California Communities is currently soliciting proposals to establish the financing team for the project. The goal of the program is that local agencies would not be harmed by the lost portion of property tax. For the City of Porterville, the expected eight percent (8%) borrow of local property taxes is approximately $600,000.

It is the intent of California Communities to sell bonds with the proceeds of the sale going to the local agencies by the end of November, the approximate normal payment schedule. In return, California Communities would collect the participating agencies future receivables from the State. Due to the State paying interest on the bonds plus the cost of issuance, the full amount of funds will be available to participating local agencies. Agencies that choose not to participate in the securitization program will forego the portion of property tax payment until the State repays the loan in 2013, which will be paid with interest at that time. The State is currently determining the approved interest rate, which must be greater than the Pooled Money Investment Account rate (currently 1.9%) but not more than six percent (6%), and such rate will be announced by September 28th. Once the approved interest rate is defined, then local agencies can determine whether their agency will hold their receivable as an investment or participate in the securitization program and receive current full payment. Agencies will have until approximately the end of October to make their determination.

RECOMMENDATION: Information Only

ATTACHMENT: None

C/M

Item No. 13
SUBJECT: CONSIDERATION OF RESOLUTION FOR ENERGY EFFICIENCY MONTH

SOURCE: ADMINISTRATIVE SERVICES/CITY CLERK DIVISION

COMMENT: United Way of Tulare County has requested that the City Council approve a resolution declaring September 2009 as Energy Efficiency Month in the City of Porterville. The purpose of the resolution is to encourage city residents to reduce their energy consumption by replacing old appliances and light bulbs with energy efficient models and by reducing electricity use at peak times.

RECOMMENDATION: That the Council approve the resolution declaring September 2009 as Energy Efficiency Month in the City of Porterville.

Attachment: Letter of Request
Draft Resolution

Item No. 14
June 29, 2009

Dear City of Porterville Council Members,

Please accept this letter as a request to declare September 2009 as Energy Efficiency Month. The reasons to make such a resolution to increase awareness of energy efficiency are many, including:

- California is particularly vulnerable to the impacts of climate change
- Increased temperatures threaten to greatly reduce the Sierra snowpack, one of the State's primary sources of water
- Increased temperatures also threaten to further exacerbate California's air quality problems and adversely impact human health by increasing heat stress and related deaths, the incidence of infectious disease, and the risk of asthma, respiratory, and other health problems
- Rising sea levels threaten California's 1100 miles of coastal real estate and natural habitats
- The combined effects of an increase in temperatures and diminished water supply and quality threaten to alter micro-climates within the state, affect the abundance and distribution of pests and pathogens, and result in variations in crop quality and yield
- Many of the technologies that reduce greenhouse gas emissions also generate operating cost savings to consumers who spend a portion of the savings across a variety of sectors of the economy; this spending creates jobs and an overall benefit to the statewide economy.

The resolution is in part to encourage residents of Tulare County to reduce their energy consumption by replacing old appliances and light bulbs with energy efficient models and by reducing electricity use at peak times from 12pm to 7pm. Residents may also access more information about Flex Your Power, visit www.flexyourpower.org.

I thank you for your consideration in this matter,

Sincerely,

Brandi Clark
Enc.

United Way of Tulare County, 1601 E. Prosperity Ave., Tulare, CA 93274
Phone(559)685-1766 / Fax(559)685-9541 / FIRST CALL 1-800-283-9323
www.unitedwaytc.org
RESOLUTION NO. ____________

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF PORTERVILLE DECLARING SEPTEMBER 2009 AS ENERGY EFFICIENCY MONTH IN THE CITY OF PORTERVILLE

WHEREAS, California may be particularly vulnerable to the impacts of climate change; and

WHEREAS, increased temperatures may threaten to greatly reduce the Sierra snowpack, one of the State’s primary sources of water; and

WHEREAS, increase temperatures may also threaten to further exacerbate California’s air quality problems and adversely impact human health by increasing heat stress and related deaths, the incidence of infectious disease, and the risk of asthma, respiratory, and other health problems; and

WHEREAS, rising sea levels may threaten California’s 1,100 miles of valuable coastal real estate and natural habitats; and

WHEREAS, the combines effects of an increase in temperatures and diminished water supply and quality may threaten to alter micro-climates within the state, affect the abundance and distribution of pests and pathogens, and result in variations in crop quality and yield; and

WHEREAS, many of the technologies that reduce greenhouse gas emissions may also generate operating cost savings to consumers who spend a portion of the savings across a variety of sectors of the economy; this increased spending creates jobs and an overall benefit to the statewide economy.

NOW THEREFORE, be it resolved by the City Council of the City of Porterville that the month of September 2009 be declared as Energy Efficiency Month. During the month, residents of Porterville will be encouraged to reduce their energy consumption by replacing old appliances and light bulbs with energy efficient models and by reducing electricity use at peaks times from 12:00 p.m. to 7:00 p.m.

PASSED, APPROVED, AND ADOPTED this 18th day of August, 2009.

ATTEST:

John Lollis, City Clerk

By __________________________
Patrice Hildreth, Chief Deputy City Clerk

Pete V. McCracken, Mayor

ATTACHMENT
SUBJECT:  APPROVAL OF RESTATED HEALTH PLAN DOCUMENT

SOURCE:  ADMINISTRATIVE SERVICES DEPARTMENT

COMMENT:  At the request of Delta Health Systems, the third party administrator of the City’s self-funded health plan, staff has worked with Delta to clarify and reformat the City’s Health Plan Document in order to eliminate ambiguous language and reformat the document so as to provide greater accuracy and efficiency in claims administration. No changes to benefits have been made in the Plan. At this time, staff requests that the City Council, as Trustees of the Employee Benefit Trust, approve the Restated Plan Document. A copy of said document is attached hereto for Council’s review.

RECOMMENDATION:  That the City Council, as Trustees of the Employee Benefit Trust, approve the draft resolution approving the City’s Restated Health Plan Document dated August 1, 2009.

ATTACHMENTS:  Draft Resolution
              Restated Health Plan Document (Exhibit A)
RESOLUTION NO. ______-2009

A RESOLUTION OF THE CITY COUNCIL
OF THE CITY OF PORTERVILLE APPROVING THE RESTATED
HEALTH PLAN DOCUMENT DATED AUGUST 1, 2009

WHEREAS, the City of Porterville has a self-funded insurance plan which is funded through the Employee Benefit Trust.

WHEREAS, Delta Health Systems, the third-party administrator for the City's Health Plan Document, has requested that the Document be restated and reformatted in order to clarify ambiguity and to provide greater accuracy and efficiency in claims administration.

WHEREAS, City staff has worked with Delta Health Systems to finalize the Restated Health Plan Document dated August 1, 2009. The restatement includes only language clarification and reformatting and does not modify any benefits.

WHEREAS, as Trustees of the Employee Benefit Trust, the City Council must approve the proposed restatement prior to it becoming effective.

NOW, THEREFORE, BE IT RESOLVED that the Porterville City Council, as Trustees of the City of Porterville Employee Benefit Trust, does hereby approve the Restated Health Plan Document dated August 1, 2009, attached hereto as Exhibit A.

PASSED, APPROVED, AND ADOPTED this 18th day of August, 2009.

ATTEST:

John D. Lollis, City Clerk

By: Patrice Hildreth, Chief Deputy City Clerk

Pete V. McCracken, Mayor
CITY OF PORTERVILLE

PLAN DOCUMENT
OF THE
MEDICAL AND DENTAL BENEFITS

RESTATED: August 1, 2009

Contract Administrator:
Delta Health Systems
Stockton, California

The benefits described in this document are based on a July 1 - June 30 plan year and are part of the City of Porterville Employee Benefit Trust Fund (Plan Number 501).

Exhibit "A"
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</table>
IMPORTANT INFORMATION

WHO TO CONTACT FOR ADDITIONAL INFORMATION

A 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.

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 (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.
# DIRECTORY OF SERVICE PROVIDERS

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

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Sponsor / Plan Administrator</strong></td>
<td>City of Porterville</td>
</tr>
<tr>
<td>Interprets the Plan, answers eligibility questions and receives COBRA payments.</td>
<td>291 N. Main Street</td>
</tr>
<tr>
<td></td>
<td>Porterville, CA 93257</td>
</tr>
<tr>
<td><strong>Contract Administrator</strong></td>
<td>Delta Health Systems</td>
</tr>
<tr>
<td>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.</td>
<td>1234 West Oak Street / P. O. Box 80</td>
</tr>
<tr>
<td></td>
<td>Stockton, CA 95201-3080</td>
</tr>
<tr>
<td></td>
<td>Phone: (209) 948-8483 or (800) 291-0726</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.deltahealthsystems.com">www.deltahealthsystems.com</a></td>
</tr>
<tr>
<td><strong>Utilization Management</strong></td>
<td>Anthem Blue Cross</td>
</tr>
<tr>
<td>Administers the Utilization Management Program (e.g., pre-admission and review requirements).</td>
<td>Phone: (800) 274-7767</td>
</tr>
<tr>
<td><strong>Network – for Medical &amp; Dental Benefits</strong></td>
<td>Anthem Blue Cross</td>
</tr>
<tr>
<td>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.</td>
<td><a href="http://www.anthem.com">www.anthem.com</a></td>
</tr>
</tbody>
</table>
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.

Inpatient Admission - Except as noted, prior to any non-emergency admission to a Hospital or Skilled Nursing Facility (including an admission for mental health and substance abuse or acute rehabilitation), the Covered Person or someone acting on his 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 24 hours after admission or by the end of the first business day following admission. An emergency admission is one that involves the sudden onset of severe medical symptoms that: (1) could not have been reasonably anticipated, (2) require 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 is not 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 the Pregnancy confinement for the mother or newborn is expected to exceed these limits, pre-service review for such extended confinement is required.

Specified Outpatient Services & Supplies - Prior to receipt of the following services, the Covered Person or someone acting on his behalf must contact the Utilization Management Organization and receive authorization for:

- home health care,
- home infusion (IV) therapy, and
- potentially cosmetic/investigative services.

Transplant Procedures - The Utilization Management Organization must be contacted for authorization prior to the performance of any transplant procedure.

NOTE: 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.

CASE MANAGEMENT SERVICES

In situations where extensive or ongoing medical care will be needed, the Utilization Management Organization may, with the patient's and Plan Sponsor's consent, provide case management services. Such services may include contacts with the patient, his family, the primary treating Physician, other caregivers and care consultants, and the hospital staff as necessary.

The Utilization Management Organization will evaluate and summarize the patient's continuing medical needs, assess the quality of current treatments, coordinate alternative care when appropriate and approved by the Physician and Plan Sponsor, review the progress of alternative treatment after implementation, and make appropriate recommendations to the Plan Sponsor.

The Plan Sponsor expressly reserves the right to make modifications to Plan benefits on a case-by-case basis to assure that appropriate and cost-effective care can be obtained in accordance with these services.

NOTE: Case Management is a voluntary service. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.
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 his 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 his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of those rates.

The Plan Sponsor will automatically provide a Plan participant with information about how he 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.

SCHEDULE OF MEDICAL BENEFITS

<table>
<thead>
<tr>
<th>MAXIMUM LIFETIME BENEFIT</th>
<th>$2,000,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical benefits for each Covered Person will not exceed the Maximum Lifetime Benefit. The Maximum Lifetime Benefit applies to all periods a person is covered under the Plan. Lower limits may apply to all or certain periods of Plan coverage, or to certain conditions or types or levels of care. Such limits are also included in this summary.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CALENDAR YEAR DEDUCTIBLES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Deductible</td>
<td>$150</td>
</tr>
<tr>
<td>Family Maximum Deductible</td>
<td>$300</td>
</tr>
</tbody>
</table>

- **Individual Deductible**: The Individual Deductible is an amount of Eligible Expenses that a Covered Person must pay each year. The deductible usually applies before the Plan begins to provide benefits.

- **Family Maximum Deductible**: If $300 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 his 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, provided the deductible amount is satisfied during a period of 12 consecutive months.

- **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.

<table>
<thead>
<tr>
<th>INDIVIDUAL COINSURANCE MAXIMUM</th>
<th>$5,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Except as noted, where the Plan pays Eligible Medical Expenses at less than 100% (see list below), those percentages (i.e., &quot;coinsurances&quot;) will apply to the first $5,000 of such expenses allowed for a Covered Person in a Calendar Year. Thereafter, the Plan will pay 100% of the Eligible Medical Expenses allowed for that Covered Person during the rest of the Calendar Year.</td>
<td></td>
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</tbody>
</table>
### ELIGIBLE MEDICAL EXPENSES

<table>
<thead>
<tr>
<th></th>
<th>Covered Person Pays</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident-Related Expense, per accident</td>
<td>0%†</td>
<td>100% to $500†</td>
</tr>
</tbody>
</table>

The $500 benefit for accident-related expenses is available only for treatment received within 90 days following the accident. The "Accident-Related Expense" benefit is available only for the following types of expenses:

- Hospital room and board and other required Hospital services
- Physician services
- services of an RN, LVN or LPN
- diagnostic services (X-ray and lab)
- ambulance service to transport a patient to and from the nearest Hospital where treatment can be provided

The accident benefit is provided before any other benefits are provided for the above expenses. Once the accident benefit is exhausted or the 90-day period has expired, accident-related expenses will be covered in the same manner as a Sickness.

#### Chiropractic Care / Massage Therapy

<table>
<thead>
<tr>
<th></th>
<th>Covered Person Pays</th>
<th>Plan Pays</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>20%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Limited to a combined maximum of 20 visits per Calendar Year. Benefits for chiropractic related X-rays are limited to $100 per Calendar Year.

#### Home Health Care

<table>
<thead>
<tr>
<th></th>
<th>Covered Person Pays</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20%</td>
<td>80%</td>
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</tbody>
</table>

Limited to 60 visits per Calendar Year. Each visit of 4 hours or less by a home health care provider will count as 1 (one) visit.

#### Hospice Care

<table>
<thead>
<tr>
<th></th>
<th>Covered Person Pays</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Limited to $10,000 in benefits per Lifetime.

#### Hospital Services – Inpatient & Outpatient

<table>
<thead>
<tr>
<th></th>
<th>Covered Person Pays</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20%</td>
<td>80%</td>
</tr>
</tbody>
</table>

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 Usual, Customary and Reasonable charge for an Intensive Care Unit.

#### Mental Health Care

- **Inpatient Care** 20% 80%
- **Outpatient Visits** 50% 50%

Inpatient mental health care is limited to 30 days per Lifetime. Outpatient care is limited to 20 visits per Calendar Year.

#### Orthotics

<table>
<thead>
<tr>
<th></th>
<th>Covered Person Pays</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Replacement of orthopedic shoes and other supportive appliances are limited to once per 12-month period for Covered Persons age 19 and over and to once per 6-month period for Covered Persons under age 19.

#### Physician Services – Inpatient & Outpatient

<table>
<thead>
<tr>
<th></th>
<th>Covered Person Pays</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20%</td>
<td>80%</td>
</tr>
</tbody>
</table>

#### Preventive Care

"Preventive Care" covers one routine well-woman exam each year, including a Pap smear and routine mammograms in accordance with American Cancer Society guidelines.

I† Calendar Year Deductible does not apply.

---

**IMPORTANT:** CERTAIN SERVICES AND/OR SUPPLIES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE UTILIZATION MANAGEMENT PROGRAM SECTION. ALSO, BENEFITS MAY BE REDUCED OR DENIED FOR PREEXISTING CONDITIONS. SEE SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS FOR MORE INFORMATION.
ELIGIBLE MEDICAL EXPENSES

<table>
<thead>
<tr>
<th>Eligible Medical Expenses</th>
<th>Covered Person Pays</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility / Rehabilitation Center</td>
<td>20%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Eligible Expenses for daily care are limited to 50% of the Semi-Private Room Charge of the Hospital of prior confinement. Coverage is limited to 60 days per Calendar Year, and must follow an Inpatient surgery or at least five (5) consecutive days of Hospital confinement.

| All Other Eligible Medical Expenses                            | 20%                 | 80%       |

ABOUT THE SCHEDULE...

The percentages shown in the schedule reflect the amounts the Plan pays of Eligible Expenses after any required Deductible 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.

†† Calendar Year Deductible does not apply.

IMPORTANT: CERTAIN SERVICES AND/OR SUPPLIES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE UTILIZATION MANAGEMENT PROGRAM SECTION. ALSO, BENEFITS MAY BE REDUCED OR DENIED FOR PREEXISTING CONDITIONS. SEE SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS FOR MORE INFORMATION.
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 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.

Acupuncture – Acupuncture treatment for a Sickness or Accidental Injury, but only when such services are provided by a Doctor of Medicine (MD) or Doctor of Osteopathy (DO).

Ambulance - Ambulance or air ambulance service when used to transport a Covered Person to and/or from a Hospital where care and treatment of the Sickness or Accidental Injury can be given. Van transport will be covered only when the company is licensed to transport a patient to a medical appointment/facility and an ambulance would have otherwise been used and covered for that service.

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.

Chemotherapy & Radiation Therapy - Services and supplies related to the administration of chemical agents in the treatment or control of a Sickness.

Radium and radioactive isotope therapy when provided for treatment or control of a Sickness.

Chiropractic Care & Massage Therapy - 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. Expenses also include chiropractic X-rays and massage therapy when performed by a licensed physical therapist.

Contraceptives - Contraceptive supplies and related Physician or professional services necessary for their administration.

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

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE MEDICAL BENEFIT SUMMARY FOR THAT INFORMATION.
due to a long-term need for the equipment. Such equipment must be prescribed by a Physician.

"Durable medical equipment" includes items such as crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, iron lung, 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. Duplicate equipment and excess charges for deluxe equipment or devices are not covered.

**Home Health Care** – Non-custodial services and supplies that are furnished to a Covered Person in accordance with a written home health care plan. The home health care plan must be established by the Covered Person’s attending Physician and must be monitored by the Physician during the period of home health care. Also, the attending Physician must have prescribed home health care in lieu of an otherwise covered Hospital confinement.

Home health care services and/or supplies must be provided through a Home Health Care Agency or by other Covered Providers as specified in the written home health care plan. Covered home health care services and supplies include, but are not limited to, the following:

- part-time or intermittent nursing care provided by or under the supervision of a registered nurse or a physical, occupational or speech therapist;
- services of physical, occupational and speech therapists;
- part-time or intermittent services of home health aides; and
- medical supplies, drugs and medicines prescribed by a Physician and laboratory services, but only to the extent that such items would have been covered if the patient had been confined in a Hospital.

**Hospice Care** - Care of a Covered Person with a terminal prognosis (i.e., a life expectancy of six months or less as certified in writing by the attending Physician) who has been admitted to a formal program of Hospice care. Eligible Expenses include Hospice program charges for:

- care in a free-standing Hospice facility, Hospital-based Hospice, extended care Hospice, or nursing home Hospice;
- care received from an interdisciplinary team of Hospice professionals for Hospice and home care; and
- pre-bereavement counseling.

Eligible Hospice expenses will also include up to six (6) post bereavement counseling sessions for Covered Persons who are in the patient’s immediate family members. Such sessions must occur within twelve (12) months following the death of the patient.

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

**Infertility Testing** – Diagnostic procedures performed to rule out medical conditions in conjunction with infertility. Treatment of infertility is not covered.

**Infusion Therapy** – Professional services of an appropriate Covered Provider for the Intravenous or aerosol administration of prescription drugs or other prepared or compounded substances. Infusion therapy may be administered in a Covered Person’s home, Physician’s office or at a Covered Provider facility.

Infusion therapy supplies including injectable prescription drugs or other substances that are approved by the Food and Drug Administration, and durable medical equipment necessary for infusion therapy.

**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.

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

**Mental Health Care** - Inpatient and Outpatient treatment of mental health conditions. 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.

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

- learning and behavior disorders including attention deficit disorder, hyperkinetic syndrome, autism or mental retardation;
- hypnotherapy;
- marriage and family counseling;
- sex counseling or sex therapy; or
- 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, as listed herein, for a covered newborn who is sick or injured, including routine newborn circumcision.

See "Pregnancy Care" for well newborn expenses.

**Nursing Services, Private Duty** - Private-duty nursing services by a registered nurse (RN), licensed vocational nurse (LVN) or licensed practical nurse (LPN) when Medically Necessary, prescribed in writing by the attending Physician, and provided while a Covered Person is hospitalized.

**Occupational Therapy** - Professional services of a licensed occupational therapist, when rendered on an Outpatient basis and under the direction of a Physician.

**Orthotics** - Orthopedic (non-dental) braces, casts, splints, trusses, shoes and other orthotics that are prescribed by a Physician and that are required for support of a body part due to a congenital condition, or an Accidental Injury or Sickness. Eligible expenses also include replacement of orthopedic shoes and other supportive appliances. Shoe inserts purchased over-the-counter are not covered.

**Oxygen** - see "Durable Medical Equipment"

**Physical & Speech Therapy** – Physiotherapy or speech therapy provided by a Physician or by a physical or speech therapist under the supervision of a Physician and to restore or rehabilitate a Covered Person from a Sickness or Accidental Injury. See "Chiropractic & Massage Therapy" for massage services rendered by a physical therapist.

**Physician Services** - Medical and surgical treatment by a Physician (MD or DO), including office, home or Hospital visits, clinic care and consultations. See "Second (2nd) Surgical Opinion" below for requirements applicable to surgery opinion consultations.

**Pregnancy Care** - Pregnancy-related expenses of a covered Employee or covered Dependent spouse. Eligible Pregnancy-related 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; and
- well-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.

**IMPORTANT:** CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE MEDICAL BENEFIT SUMMARY FOR THAT INFORMATION.
NOTE: Pregnancy coverage will not include: (1) Lamaze and other charges for education related to pre-natal care and birthing procedures, (2) adoption expenses, (3) expenses of a surrogate mother who is not a Covered Person, or (4) pregnancy-related expenses of a Dependent daughter.

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

Prosthetics - Artificial limbs or eyes replacing natural limbs or eyes lost due to Sickness or Accidental Injury, internally implanted prosthetics such as pacemakers and hip and knee joint replacements and post-mastectomy breast prostheses as required by the Women's Health and Cancer Rights Act.

Prosthetics coverage does not include:

- dental prosthetics, except as expressly included under "Dental Care" in the Medical Limitations and Exclusions section; or
- repair or replacement of a prosthetic device except for replacement that is Medically Necessary due to a change in the Covered Person's physical condition.

Radiation Therapy – see “Chemotherapy & Radiation Therapy”

Rehabilitation Center - see "Skilled Nursing Facility or Rehabilitation Center"

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, but only to the extent that the therapy is for improvement of 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 or Rehabilitation Center - Inpatient care in Skilled Nursing Facility or Rehabilitation Center, but only when the admission to the facility or center is Medically Necessary and follows an Inpatient surgery or at least five (5) consecutive days of Hospital confinement.

Speech Therapy – see “Physical & Speech Therapy”

Sterilization Procedures - A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female). Reconstruction (reversal) of a prior elective sterilization procedure is not covered.

Transplant-Related Expenses (Human Tissue) - Eligible Expenses incurred by a Covered Person who is the recipient of a human organ or tissue transplant that is not experimental or investigational in nature (e.g., kidney, cornea, heart, lung, heart-lung, liver or pancreas). A Covered Person is encouraged to use a transplant “Center of Excellence” if possible. Expenses of a live organ donor are not covered.

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

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 the mother's life would be endangered if the Pregnancy were allowed to continue to term. Complications arising out of an abortion are covered as any other Sickness.

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

Alcoholism – Expenses related to treatment of alcoholism.

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

Chemical Dependency – Expenses related to treatment of narcotism, use of hallucinogenic drugs, or other similar substances.

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:

- procedures that are necessary for post-traumatic or post-oncology treatment;
- 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; and
- treatment necessary to correct a congenital abnormality (birth defect) of a covered individual.

Custodial & Maintenance Care - Care or confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training.

Any type of maintenance care which is not reasonably expected to improve the patient’s condition, except as may be included as part of a formal Hospice care program.

Dental & Oral Care - Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion, except for services of a Physician (including dental X-rays and general anesthesia if medically required) for:

- oral surgery for removal of tumors, cysts or impacted teeth (partially or totally covered by bone);
- treatment of temporomandibular joint dysfunction; or
- repair of sound natural teeth that are damaged in an Accidental Injury, and then limited to charges incurred within six (6) months from the date of the accident unless it is medically-indicated that treatment be delayed.

Please refer to the Dental Benefits Summary for additional information.

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 Services

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; or
- treatment of weak, strained, flat, unstable or unbalanced 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 Aids - Hearing aids or the fitting of hearing aids.

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.

Learning & Behavioral Disorders - Testing or treatment for learning disabilities or behavioral disorders including attention deficit disorder (ADD), attention deficit hyperactive disorder (ADHD), mental retardation, or autism.

Maintenance Care – see “Custodial & Maintenance Care”

Marriage & Family Counseling - Counseling for marital or family problems.

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

Not Medically Necessary / Not Physician Prescribed - Unless expressly included herein, any services or supplies that are:

- not Medically Necessary, and
- not incurred on the advice of a Physician.

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 discrepancies in the relationship of the jaws.

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.
MEDICAL LIMITATIONS AND EXCLUSIONS, continued

Preexisting Conditions - see section entitled Special Restrictions for Preexisting Conditions for information.

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. Excluded services and supplies include, but are not limited to: therapy or counseling, medications, implants, hormone therapy, surgery, and other medical or psychiatric treatment.

Smoking Cessation – Programs, prescriptions or over-the-counter medications.

Vaccinations – Immunizations or vaccinations other than tetanus or rabies vaccinations administered in connection with an Accidental Injury.

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. Please refer to the Vision Care Plan Document for additional information. This exclusion will not apply to: (1) services necessitated by a Sickness or Accidental Injury, (2) the initial purchase of glasses or contact lenses following cataract surgery, or (3) radial keratotomy or laser surgery to correct refractive error, but only when vision cannot be corrected with corrective lenses.

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

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

Weight Control - Services or supplies for obesity, weight reduction or dietary control, except when provided in a case of extreme Medical Necessity for morbid obesity. "Morbid obesity" means the Covered Person's body weight exceeds the medically-recommended weight by either 100 pounds or is twice the medically-recommended weight for a person of the same height, age and mobility as the Covered Person.

Wigs or Wig Maintenance - see "Hair Restoration"

- (See also General Exclusions section) -
SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS

Definition of a Preexisting Condition
For Plan purposes, a "preexisting condition" is an illness or injury for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months before an individual's enrollment date. A Pregnancy will not be considered a preexisting condition, regardless of the date of conception, diagnosis, or first treatment. Genetic information is not a preexisting condition in the absence of a diagnosis of a condition related to the genetic information.

For purposes of the Plan and the above paragraph, the following will apply:

- Medical advice, diagnosis, care or treatment must have been received from a health care provider or practitioner duly licensed to provide such care under state law and who is operating within the scope of practice authorized by applicable state law.
- An individual's "enrollment date" is his first day of Plan coverage or, if there is a pre-existing limitation for coverage, the first day of the period of limitation.

Special Waiting Periods for a Preexisting Condition
If there is a preexisting condition in the six (6) months before the individual's enrollment date, the chart below shows when coverage for that condition will start to be covered:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Employee is covered for that preexisting condition...</th>
<th>Dependent is covered for that preexisting condition...</th>
</tr>
</thead>
<tbody>
<tr>
<td>If there is no treatment for the preexisting condition during the first three months of coverage under this plan...</td>
<td>90 days [or 3 months?] from the date coverage under this plan began</td>
<td>90 days [or 3 months?] from the date coverage under this plan began</td>
</tr>
<tr>
<td>If there is treatment for the preexisting condition during the first three months of coverage under this plan...</td>
<td>180 days [or 6 months?] from the date coverage under this plan began</td>
<td>One (1) year from the date coverage under this plan began</td>
</tr>
</tbody>
</table>

Important: The preexisting condition waiting periods may be credited if an individual had other coverage. See the "Allowance for Prior Creditable Coverage" below.

Exceptions to the Preexisting Condition Limitations
The preexisting condition limitation will not apply to an Employee's adopted child or newborn who is enrolled in a timely manner when the child is first eligible (see Eligibility and Effective Dates section) — or to any such child enrolled in other creditable coverage within 30 days after birth, adoption or placement for adoption and with no subsequent "break in coverage" — see below. For these purposes, an "adopted child" is any person under the age of 18 as of the date of adoption or placement for adoption. "Placement for adoption" means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.

NOTE: These preexisting condition limitations are intended to comply with at least the minimum requirements of the Health Insurance Portability and Accountability Act of 1996 (H.R. 3103) and Final Regulations. If they are incomplete or in conflict with the law, the law will prevail.

Allowance for Prior Creditable Coverage
An individual (Employee or Dependent) who enrolls in this Plan has a right to demonstrate "creditable coverage" and reduce or eliminate the pre-existing condition limitations that would otherwise apply — but only if the individual has less than a 63-day break in coverage (i.e., not more than 62 days of non-coverage, not counting any days applied toward waiting period requirements). To demonstrate "creditable coverage" and any applicable waiting periods, an individual has the right to request certificate(s) of creditable coverage from prior/other health plan(s). This Plan will help any such individual in obtaining such certificate(s). An individual also has the right to demonstrate creditable coverage through the presentation of documentation or other means where a certificate of creditable coverage cannot be obtained from the other health plan(s).

Where coverage is determined to be "creditable coverage," the Plan enrollee will be credited with time covered under such prior plan(s) toward the time limits of this Plan's preexisting condition limitations. If, after creditable coverage has been taken into account, there will still be a preexisting condition limitation imposed on an individual,
the individual will be notified of that fact.

"Creditable coverage" includes coverage under a group health plan (including a governmental or church plan), individual health insurance coverage, Medicaid (other than coverage solely under § 1928 of the Social Security Act – the program for distribution of pediatric vaccines), Medicare, military-sponsored health care, a program of the Indian Health Services or of a tribal organization, a State health benefits risk pool, the Federal Employees Health Benefit Program, The State Children's Health Insurance Program, a public health plan as defined in the portability regulations (i.e., any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan), and a health benefit plan under the Peace Corps Act. A coverage can be "creditable coverage" even if such coverage remains in effect.

NOTE: See "Creditable Coverage Certificates" in the General Plan Information section for information on how to obtain such certificates from this Plan.
DENTAL BENEFIT SUMMARY

CHOICE OF PROVIDERS

The Plan Sponsor has contracted with an organization or "Network" of dental providers. When obtaining dental care, a Covered Person has a choice of using a dentist who is participating in that Network or using any other dentist of his choice (a Non-Network provider). A list or directory of Network providers will be given to Plan participants without charge.

Because Network providers have agreed to provide services to Covered Persons at negotiated rates, when a Covered Person uses a Network provider his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of the negotiated rates.

SCHEDULE OF DENTAL BENEFITS

<table>
<thead>
<tr>
<th>CALENDAR YEAR MAXIMUM BENEFIT</th>
<th>$2,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan benefits for each Covered Person will not exceed the maximum shown above.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CALENDAR YEAR DEDUCTIBLES</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Deductible</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td>Family Maximum Deductible</td>
<td>$75</td>
<td></td>
</tr>
</tbody>
</table>

Individual Deductible - The Individual 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.

Family Maximum Deductible - If $75 in eligible dental 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 his 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, provided the deductible amount is satisfied during a period of 12 consecutive months.

<table>
<thead>
<tr>
<th>ELIGIBLE DENTAL EXPENSES</th>
<th>Covered Person Pays</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive &amp; Basic Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The benefits you receive is based on the number of years you have been covered under this plan:</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td>• 1st day through the 1st Year</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>• 2nd Year</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>• 3rd Year +</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If a person has an interruption of coverage of 1 year or less, benefits will be reinstated at the same level it was prior to the interruption. If the interruption of coverage of more than 1 year, the benefit level will start over at 70%.

Note: Routine cleanings are limited to 2 per Calendar Year.

Major Services (Prosthetics) 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 major dental work is needed (i.e., where the proposed course of treatment will cost more than $250), 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.

NOTE: 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.
ELIGIBLE DENTAL EXPENSES

Eligible dental expenses are the Usual, Customary and Reasonable charges for the dental services and supplies that are listed below and that are: (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 he is licensed.

For benefit purposes, dental expenses will be deemed incurred on the date on which the service or supply which gives rise to the expense is rendered or obtained.

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 & BASIC SERVICES

Anesthesia - General anesthesia when administered in connection with oral surgery or when deemed necessary by the dental provider for other covered dental services. Separate charges for pre-medications, local anesthesia, nitrous oxide, analgesia or conscious sedation are not covered. Such services are often included in the cost of the procedure itself.

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

Crowns - Initial placement of a gold, porcelain or composite 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 is covered, but not more frequently than once in any 12-month period. See "Cosmetic Dentistry" in the list of Dental Limitations and Exclusions for restrictions on veneer or facing (i.e., "tooth-colored") restorations. Crowns placed for periodontal splinting are not covered.

Emergency Treatment

Endodontics - 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.

Flouride - Topical application of stannous or sodium fluoride.

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.

Palliative - Emergency treatment for the relief of dental pain.

Pathology - Laboratory services required for dental procedures.

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

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.

IMPORTANT: CERTAIN ELIGIBLE DENTAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE DENTAL SCHEDULE(S) OF BENEFITS FOR THAT INFORMATION.
MAJOR SERVICES

Prosthetics - Initial placement of a full or partial denture or bridge to replace one or more natural teeth that are extracted while the person is covered hereunder - provided the placement of the denture or bridge occurs within twelve (12) months of the date the teeth are extracted. Any allowance made for a prosthetic includes necessary adjustments within six (6) months of placement.

Addition of teeth to a full or partial denture or bridge to replace teeth extracted while the person is covered hereunder - provided the addition of teeth to the denture or bridge occurs within twelve (12) months of the date the teeth are extracted.

Replacement or alteration of an existing full or partial denture or bridge if required due to one of the following events, such event occurred on or after the Covered Person’s effective date of coverage, and the replacement or alteration is completed within six (6) months after the event:

- an Accidental injury requiring oral surgery; or
- oral surgery treatment involving the repositioning of muscle attachments or the removal of a tumor, cyst, torus or redundant issue.

Replacement of a full denture if required as a result of structural change within the mouth and if such replacement is made more than five (5) years after the prior installation - but not a replacement made less than two (2) years after the person’s effective date of coverage hereunder.

Temporary full dentures are not covered. Also, replacement of a denture is not covered if Plan benefits were paid for a prior replacement within the preceding 5-year period, unless:

- replacement is made necessary by the initial placement of an opposing full denture or the extraction of natural teeth; or
- the denture is a stayplate or a similar temporary partial denture and is being replaced by a permanent denture; or
- the denture, while in the oral cavity, has been damaged beyond repair as a result of an injury that occurred while the person was covered.

Repairs - Repair of dentures or bridgework.
DENTAL LIMITATIONS AND EXCLUSIONS

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

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

**Congenital Conditions** - Treatment of congenital (hereditary) conditions (e.g. congenitally missing teeth), unless expressly included.

**Cosmetic Dentistry** - Treatment rendered for cosmetic purposes. Excess charges for a veneer or facing (i.e., a "tooth-colored" exterior) on a crown or pontic or excess charges for a tooth-colored restoration on a tooth posterior to the second bicuspide. The maximum allowance will be the allowance for the least costly restoration that will provide a functional result.

**Customized Prosthetics** – Excess charges for precision or semi-precision attachments, overdentures, 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 are also excluded from coverage.

**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**

**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.

**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 to the extent to 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);
- dental hygienist, X-ray technician or other qualified technician who is under the supervision of a dentist; or
- Physician furnishing dental services for which he is 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; and
- 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.

**Orthodontia, Etc.** - Orthodontia procedures, appliances or restorations used to increase vertical dimension or to
Orthognathic Surgery - Surgery to correct discrepancies in the relationship of the jaws.

Personalization or Characterization of Dentures

Prior to Effective Date / After Termination Date - Courses of treatment that began prior to the person's effective date of coverage, including crowns, bridges or dentures that were ordered prior to the effective date. However, dental X-rays and dental cleanings will not be deemed to commence a dental procedure. Expenses incurred after termination of coverage are also not covered under this plan.

Sealants

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.

TMJ Treatment / Jaw Surgery - Procedures, restorations or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome.

- (See also General Exclusions section) -
GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

**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. 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 which the Plan determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research. Treatments, procedures, devices, or drugs shall be excluded under this Plan unless:

- approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law;
- reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses; and
- reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses.

"Reliable evidence" shall include anything determined to be such by the Plan, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the medical professional community in the United States, including the CMS Medicare Coverage Issues Manual.

**Forms Completion** - Charges made for the completion of claim forms or for providing supplemental information.

**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. 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.

**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.

**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. This exclusion does not apply to any benefit or coverage that is available through the Medical Assistance Act (Medicaid).
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 are also not covered under this plan.

Outside United States - Charges incurred outside of the United States unless incurred while a Covered Person is traveling on business or for pleasure and such services or supplies are legal and would be covered expenses inside the United States.

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).

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.

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 that arises from or is sustained in the course of any occupation or employment for compensation, profit or gain, including self-employment. This exclusion applies whether or not 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. If the Plan elects to provide benefits for any such condition, the Plan 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 of the following that provides health care benefits or services:

- any group cash or service benefit plan under which a person is entitled to receive benefits or service for or by reason of medical/dental care or treatment, whether any such plan is insured or uninsured;
- group, blanket or franchise insurance coverage, group hospital or medical service plans and other group prepayment coverage;
- any coverage under labor-management trustee plans, employee benefit organization plans;
- state no-fault auto plans;
- student accident plans; or
- Medicare, TRICARE 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 (an HMO, for example), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

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; and
- 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).

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.

Automobile Coverage - When medical benefits are available under vehicle insurance, This Plan will always be considered an excess (or secondary) coverage and will not reimburse vehicle plan deductibles. This applies without regard to an individual's election under PIP (personal injury protection) coverage with an auto carrier.

Medicare or TRICARE as an "Other Plan" - Medicare or TRICARE 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 benefits paid or payable and on Part B or Part D benefits paid or payable if the Claimant is enrolled for those Medicare benefits. 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.

"Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides for more than half the Calendar Year without regard to any temporary visitation.

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.
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, Plan Beneficiaries, and/or their dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") 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"). Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. By accepting benefits the Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) 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 Covered Person(s) 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 Covered Person(s) is entitled, regardless of how classified or characterized.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

The Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)’ and/or the Plan’s name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from:
- 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 coverage;

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 Covered Person(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supercedes 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 Covered Person(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 Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

**Excess Insurance** - If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as provided for under the Plan's Coordination of Benefits section. 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 coverage.

**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** - In the event that the Covered Person(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

**Obligations** - It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

- 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 Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person(s)' cooperation or adherence to these terms.

**Offset** - Failure by the Covered Person(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person(s) satisfies his or her obligation.
Minor Status - In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor’s parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor’s parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor’s parents or court-appointed guardian.

Language Interpretation - The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan’s subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability - In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.
ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements - Employees
To participate as an Employee in the Plan coverages that are described in this plan document, an individual must:

- be in full-time active employment for the Employer,
- performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Employer requires him to travel),
- enroll for coverage (as listed on the following page under When You Can Enroll and Effective Date of Coverage), and
- agree to pay any required contributions toward the cost of coverage.

An Employee will be deemed in "active employment" on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day. An Employee will also be deemed in "active employment" on any day on which he is absent from work during an approved FMLA leave or solely due to his 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 his first scheduled workday, he 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.

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 same sex domestic partner (or same-sex partner if either the employer or partner is over age 62) provided the partners have a "Declaration of Domestic Partnership" with the California Secretary of State;

- an unmarried child under age 19 who depends upon the Employee (or parent(s)) for support and resides with the Employee in a parent-child relationship. For these purposes a "child" will include:
  - a natural child;
  - a stepchild;
  - a child who is adopted by the Employee or placed with him 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; or
  - notwithstanding any residency or main support and care requirements, a child for whom Plan coverage is required due to a Medical Child Support Order (MCISO) 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 of ERISA (section 609(a)). A child whose coverage is subject to a court order need not be a Tax Code dependent of an Employee;

- an unmarried student age 19 or over but less than 25, if such child meets the above Dependent child eligibility requirements except for age, and: (1) is in full-time attendance at an accredited and state-licensed technical school or institution of higher education, or (2) is a full-time missionary. Full-time school attendance means 12 units or more, per semester. Full-time school attendance status will continue:
  - if cessation is due to a school vacation and attendance resumes on the date the school reconvenes, or
  - when a leave of absence is medically necessary; in this case, coverage will extend for up to one year.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.
**ELIGIBILITY AND EFFECTIVE DATES, continued**

**Non-Eligible Dependents**
An eligible Dependent does not include:

- a spouse following legal separation or a final decree of dissolution of marriage or divorce (including any children of the spouse who were eligible only because of the marriage);
- any person who is on active duty in a military service, to the extent permitted by law;
- any person who is enrolled as an Employee; or
- 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.

**When You Can Enroll and Effective Date of Coverage**
The following chart outlines when you can enroll for medical and dental, as well as your effective date of coverage (i.e., when your coverage begins):

<table>
<thead>
<tr>
<th>When You Can Enroll</th>
<th>Effective Date of Coverage for Employee</th>
<th>Effective Date of Coverage for Dependent(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>As a new hire</td>
<td>You are automatically enrolled in the plans on the first of the month following 30 days of active employment. You must complete and return your enrollment within 30 days of your hire date.</td>
<td>The same date as the employee if all benefit enrollment forms are completed and returned within 30 days of the employees hire date.</td>
</tr>
<tr>
<td>During the year, if you have a qualifying:</td>
<td>Not applicable. You are automatically enrolled for coverage.</td>
<td>Ninety (90) days from the date of the change in status or event that provides you with special enrollment rights if all benefit enrollment forms are completed and returned within 30 days of the change/event.</td>
</tr>
<tr>
<td>- change in status event, or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- event that provides you with special enrollment rights.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Newborn 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 become a Covered Person only if the child is enrolled within the limited 31-day benefit period – see "Entitlement Due to Acquiring New Dependent(s)" in the Special Enrollment Rights.

**NOTE:** During the limited 31-day benefit period, a newborn 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 such 31-day 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:

- he 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 him. "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 and the Employee requested Plan enrollment within thirty (30) days of termination of the other coverage. A loss of coverage event includes but is not limited to:
ELIGIBILITY AND EFFECTIVE DATES, continued

- 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 an individual incurs a claim that would meet or exceed a lifetime limit on all benefits. An individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until thirty (30) days after the earliest date that a claim is denied due to the operation of the lifetime limit;

- 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; or

- loss of eligibility when COBRA continuation coverage is exhausted.

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:

- 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 that begins after the date on which the Plan received the completed application; or

- 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 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.
ELIGIBILITY AND EFFECTIVE DATES, continued

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 30 days from the date such order is determined to be qualified (QMCSO). 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 a QMCSO 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.

Late Enrollment / Re-Enrollment
If an individual does not enroll when he is first eligible or if he allows coverage to lapse but later re-enrolls, then Plan coverage will be effective following a waiting period of ninety (90) days following the date application is made. Any such individual will be considered a “late enrollee” and will be subject to a longer preexisting condition period - see Special Restrictions for Preexisting Conditions section. NOTE: See “Special Enrollment Rights” for exceptions to this provision.

Reinstatement / Rehire
If an Employee is temporarily laid off or is granted a leave of absence and coverage terminates, then coverage will be reinstated on the first day of the month coinciding with or following the Employee’s return to active service in an eligible status, provide that: (1) the Employee returns immediately after cessation of either of the above events, and (2) contributions for his coverage are resumed.

If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer’s guidelines and the Family and Medical Leave Act (FMLA), and during the leave Employee discontinued paying his share of the cost of coverage, such Employee may have coverage reinstated as if there had been no lapse (for himself and any Dependents who were covered at the point contributions ceased). To avoid interruption of coverage during the leave, the Plan Sponsor will have the right to keep coverage in force at its own expense and can require that unpaid coverage contribution costs be repaid by the Employee at the end of the FMLA leave.

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 his 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, retiree 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 at midnight on the earliest of the following dates:

- the date of termination of the Plan or the Plan benefits as described herein;
- the date of termination of participation in the Plan (or these Plan benefits) by the Employee;
- 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);
- the day the Employee becomes an active member of the armed forces of any country; or
- the day the Employee leaves or is dismissed from the employment of the Employer or ceases to be eligible or 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.

See also "Termination for Fraud" at the end of the General Plan Information section.

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 at midnight on the earliest of the following dates:

- the date of termination of the Plan or these Plan benefits or discontinuance of Dependent coverage under the Plan;
- the date of termination of the coverage of the Employee;
- at midnight on the day the covered Dependent becomes an active member of the armed forces of any country;
- the last day the Dependent meets the eligibility requirements, 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; or
- 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 (QMCPO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has comparable replacement coverage that is in effect or will take effect immediately upon termination.

See also "Termination for Fraud" at the end of the General Plan Information section.

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 Mentally Retarded or Handicapped Dependent Children
If an already covered Dependent child is incapable of self-sustaining employment by reason of mental retardation or physical handicap, then such child's status as a "Dependent" will continue so long as:

- he remains in such condition, and otherwise conforms to the definition of "Dependent;"
- such condition commenced on or before the child attained age 19;
- 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;

The Employee must submit proof of the child's incapacity to the Plan or the Trust within thirty-one (31) days of the child's 19th birthday, and thereafter at reasonable intervals as required by the Plan or the Trust.

Extension of Coverage for Students on Medically Necessary Leave
To comply with California SB 1168, coverage for a Dependent child who is attending a postsecondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965) will be extended for up to one (1) year if the child takes a medically necessary leave of absence.

For these purposes "medically necessary leave of absence" means any change in enrollment of such child at the educational institution that:

- commences while the child is suffering from a serious illness or injury;
- is medically necessary; and
- causes such child to lose student status for purposes of continued eligibility (see student eligibility requirements in the Eligibility and Effective Dates section).

A Physician's written certification by the Dependent child's treating Physician must be provided. Such statement must certify that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.

The period of extended coverage begins on the first day of the medically necessary leave of absence and ends on the date that is one (1) year later or on the date coverage would otherwise terminate under the terms of this Plan document, whichever comes first.

A dependent child whose coverage is continued under the terms of this provision shall be entitled to the same benefits as if the child continued to be a student at the institution of higher education and was not on a medically necessary leave of absence.

Extensions of Coverage During Absence From Work
If an Employee fails to continue in active employment but is not terminated from employment (e.g., he is absent due to an approved leave, a temporary layoff, etc.), he may be permitted to continue health care coverages for himself and his Dependents though he 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 where the Family and Medical Leave Act (FMLA) may apply, any coverage which 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 employee 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; or
- the date of termination of this 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 he: (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

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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 for 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 him/her unable to perform the functions of his or her 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 his FMLA rights from the Plan Sponsor’s Human Resources or Personnel department. Any Plan provisions which 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 servicemember. A “covered servicemember” is a member of the Armed Forces (including the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is an outpatient, or is on the temporary disability retired list, for a “serious injury or illness” (an injury or illness incurred in line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform his or her duties).

**Extension of Coverage During U.S. Military Service**

Regardless of an Employee’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 his 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 his 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 following Employee’s cessation of active employment is the lesser of:

- 24 months; 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;
- 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 or preexisting condition exclusion 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 a covered Employee retires from active service from the Employer, then such Employee may continue these coverages for himself (and for his spouse if the spouse has been covered for at least the 30-day period prior to Employee’s retirement), subject to payment of the required contributions. Coverage can continue for either individual from the time of retirement and until age 65, except that dental benefits can be continued without regard to age.

The retiree will be required to contribute to the Plan at rates determined by the Plan Sponsor (i.e., 102% of the actuarially established contribution rate). 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.

NOTE: 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, except that HIPAA’s special enrollment rights will apply.

- (See COBRA Continuation Coverage) -
EXTENSION OF BENEFITS DURING TOTAL DISABILITY

If an Employee or Dependent is Totally Disabled on the date his coverage terminates, medical 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 other group benefits; or
- upon termination of the Plan.

For an Employee, "Total Disability" or "Totally Disabled" means he is prevented, solely because of a non-occupational injury or non-occupational illness, from engaging in his regular or customary occupation and is performing no work of any kind or compensation or profit. For a Dependent, it is disability that prevents the Dependent from engaging in substantially all the normal activities of a person in good health of like age and sex, provided such child is under the regular care and attendance of a Physician (MD or DO) who certifies as to the individual's disabilities.

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 his 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 setting. A determination on a Pre-Service Claim is not a guarantee of benefits from the Plan. Plan benefit payments are subject to review upon submission of a claim to the Plan 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 twelve (12) months of the date charges are incurred. Any exceptions to the submission of claims later than twelve (12) months are subject to approval of the Trustees, but in no event may claims be considered for payment later than fifteen (15) months from the date on which charges were incurred.

   A Post-Service Claim should be submitted to:

   Delta Health Systems
   P. O. Box 80
   Stockton, CA 95201-5918

   **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 his right to sue to recover benefits under the Plan or to enforce rights due under the Plan or any other causes of action that he 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 his 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 PROCEDURES, continued

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.

<table>
<thead>
<tr>
<th>&quot;PRE-SERVICE&quot; CLAIM ACTIVITY</th>
<th>TIME LIMIT OR ALLOWANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Claim - defined below</td>
<td></td>
</tr>
<tr>
<td>Claimant Makes Initial Incomplete Claim Request</td>
<td>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.</td>
</tr>
<tr>
<td>Plan Receives Completing Information</td>
<td>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.</td>
</tr>
<tr>
<td>Claimant Makes Initial Complete Claim Request</td>
<td>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.</td>
</tr>
<tr>
<td>Claimant Appeals</td>
<td>See “Appeal Procedures” subsection. An appeal for an urgent claim may be made orally or in writing.</td>
</tr>
<tr>
<td>Plan Responds to Appeal</td>
<td>Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), after receipt of Claimant's appeal.</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>&quot;PRE-SERVICE&quot; CLAIM ACTIVITY</th>
<th>TIME LIMIT OR ALLOWANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concurrent Care Claim - defined below</td>
<td></td>
</tr>
<tr>
<td>Plan Wants to Reduce or Terminate Already Approved Care</td>
<td>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.</td>
</tr>
</tbody>
</table>
Claimant Requests Extension for Urgent Care

<table>
<thead>
<tr>
<th>Action</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>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. Otherwise, the Plan's notification must be made in accordance with the time allowances for appeal of an urgent, pre-service or post-service claim, as appropriate.</td>
<td></td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Action</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claimant Makes Initial <strong>Incomplete</strong> Claim Request</td>
<td>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.</td>
</tr>
<tr>
<td>Plan Receives <strong>Completing</strong> Information</td>
<td>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 &quot;full notice&quot; below.</td>
</tr>
<tr>
<td>Claimant Makes Initial <strong>Complete</strong> Claim Request</td>
<td>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 &quot;full notice&quot; below.</td>
</tr>
<tr>
<td>Claimant Appeals</td>
<td>See &quot;Appeal Procedures&quot; subsection.</td>
</tr>
<tr>
<td>Plan Responds to Appeal</td>
<td>Within 30 days after receipt of appeal (or where Plan requires 2 mandatory levels of appeal, within 15 days for each appeal).</td>
</tr>
</tbody>
</table>

"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**

<table>
<thead>
<tr>
<th>Action</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claimant Makes Initial <strong>Incomplete</strong> Claim Request</td>
<td>Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request.</td>
</tr>
<tr>
<td>Plan Receives <strong>Completing</strong> Information</td>
<td>Within 30 days, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of &quot;full notice&quot; below.</td>
</tr>
<tr>
<td>Claimant Makes Initial <strong>Complete</strong> Claim Request</td>
<td>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 &quot;full notice&quot; below.</td>
</tr>
<tr>
<td>Claimant Appeals</td>
<td>See &quot;Appeals Procedures&quot; subsection.</td>
</tr>
<tr>
<td>Plan Responds to Appeal</td>
<td>Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).</td>
</tr>
</tbody>
</table>

"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 the 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;
- a description of any additional information needed to change the decision and an explanation of why it is needed; and
- 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 his claim, in writing, to a new decision-maker and he may submit new information (e.g., comments, documents and records) in support of his appeal. A Claimant may not take legal action on a denied claim until he has exhausted the Plan’s mandatory (i.e., non-voluntary) appeal procedures - see NOTE.

In response to his 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, he will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to his 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 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.
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.

**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.

**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; and
- 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.

**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 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.
DEFINITIONS, continued

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 his license; or
- in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association.

The following is a list of covered providers:

- Audiologist;
- Certified or Registered Nurse Midwife;
- Certified Registered Nurse Anesthetist (CRNA);
- Chiropractor (DC);
- Dentist (DDS or DMD);
- 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 Chiropractor (DPM, DSP, or DSC);
- Psychiatrist (MD);
- Registered Nurse (RN);
- Respiratory Therapist; and
- Speech Pathologist.

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 his 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 prosthethist-orthotists;
- portable X-ray companies;
- independent laboratories and lab technicians;
- diagnostic imaging facilities;
- blood banks;
- speech and hearing centers; and
- ambulance companies.

A Covered Provider does not include:

- a Covered Person treating himself 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
- 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 his services.
DEFINITIONS, continued

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.

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; and
- 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 accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals;
- complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;
- is primarily engaged in providing medical treatment to sick and injured persons as registered bed patients and maintains permanent facilities for five or more such patients;
- is operated under the supervision of a staff of Physicians;
- continuously provides 24-hour-a-day nursing service by registered nurses;
- maintains a daily medical record for each patient;
- maintains facilities for diagnosis of injury or disease;
- maintains permanent facilities for major surgical operations on its premises; and
- is not, other than incidentally: (1) a place of rest, for custodial care, for the aged, or for the care of senile persons, (2) a nursing home, (3) a hotel, or (4) a school or similar institution.

For treatment of mental health conditions, a "Hospital" will also include a facility that is appropriately licensed to provide such specialty care in the area in which it is located and that is operating within the scope of that license.

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-a-day basis without being issued passes to leave the premises. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.
DEFINITIONS, continued

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.

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 Pharmacopeia 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. The term "Physician" will not include the Covered Person himself, his 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.

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.
DEFINITIONS, continued

Rehabilitation Center - A facility that is designed to provide therapeutic and restorative services to sick or injured persons and that:

- carries out its stated purpose under all relevant state and local laws; or
- is accredited for its stated purpose by either the JCAHO or the Commission on Accreditation for Rehabilitation Facilities; or
- is approved for its stated purpose by Medicare.

Semi-Private Room Charge - The standard charge by a facility for a semi-private room and board accommodation (2 or more beds), or the average of such charges where the facility has more than one established level of such charges, or the actual charge by the facility for a single bed room and board accommodation 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; and
- 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, 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.

NOTES: If, during a single surgical session, two (2) or more procedures are performed in different operative fields and through different incisions, UCR will be the largest amount designated for any one of such procedures plus one-half of the UCR amount designated for each of the other procedures, not to exceed the amount actually charged.
**GENERAL PLAN INFORMATION**

<table>
<thead>
<tr>
<th>Name of Plan</th>
<th>City of Porterville Employee Benefit Trust</th>
</tr>
</thead>
</table>
| Plan Sponsor / Plan Administrator | City of Porterville  
291 N. Main Street  
Porterville, CA  93257  
(209) 782-7466 |
| Participating Employer(s) | City of Porterville |
| Plan Sponsor ID Number (EIN) | 94-6000398 |
| Plan Year | July 1 through June 30 |
| Plan Year | 501 |
| Named Fiduciary  
See also definition of "Fiduciary" | City of Porterville  
291 N. Main Street  
Porterville, CA  93257  
(209) 782-7466 |
| Trustees | The City Council of the City of Porterville (or as reflected under the Amendment and Restatement of Agreement and Declaration of Trust) |
| Agent for Service of Legal Process  
Legal process may be served upon the Plan Administrator or a Fiduciary | City of Porterville  
291 N. Main Street  
Porterville, CA  93257  
(209) 782-7466 |
| Type of Plan | This is an employee welfare benefit plan providing group |
| Plan Benefits Described Herein | Self-Funded Medical and Dental Benefits |
| Type of Administration | Contract Administration – see "Administrative Provisions" for additional information |
| Contract Administrator | Delta Health Systems  
1234 W. Oak Street  
Stockton, CA  95201  
(209) 948-8483 or (800) 291-0726 |
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 or ERISA; 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 he 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 directors, 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.

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 he 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 Plan 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.

Funding
Plan benefits described herein are paid through a trust arrangement.
GENERAL PLAN INFORMATION, continued

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).

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 Benefit Document and 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.

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 his 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; or
- a claim for benefits is not filed within the time limits of the Plan.

Material Modification
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 modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage and generally would include any Plan modification or change that: (1) eliminates or reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations, (2) increases premiums, deductibles, coinsurance, copays, or other amounts to be paid by a Plan participant or beneficiary, or (3) establishes new conditions or requirements (i.e., preauthorization requirements) to obtaining services or benefits under the Plan.

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, his eligibility, benefits or both, will be adjusted to reflect his 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.

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 his (and his 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; including conditions arising out of acts of domestic violence);
- claims experience;
- receipt of health care;
- medical history;
- evidence of insurability;
- disability; or
- genetic information.

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.

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 his 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 therefor 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 his Dependents.

Rights Against the Plan Sponsor or Employer
GENERAL PLAN INFORMATION, continued

Except for those rights expressly granted under ERISA §502, 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.

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; or
- an individual has submitted a claim that, in good faith judgment and investigation, he knew or should have known, contained false or fraudulent elements under state or federal law.

Type of Plan
This Plan is not a plan of insurance. This Plan is a self-funded nonfederal governmental group health plan that, for the most part, is exempt from the requirements of the Employee Retirement Income Security Act (ERISA). However, governmental plans are not automatically exempted from the following amendments to ERISA: The Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns and Mothers Health Protection Act (NMHPA), and the Womens 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.

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 his 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 coverage 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 he was a nonresident alien who received no earned income from the Employee 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 his 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 his or her 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); or
- 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.

Non-COBRA 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 him 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, he 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.

NOTE: See the “Effect of the Trade Act” provision for information regarding a second 60-day election period allowance.
COBRA CONTINUATION COVERAGE, continued

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 his 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 his 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 his 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-ill or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

See the "Effect of the Trade Act" provision for additional cost of coverage information.
COBRA CONTINUATION COVERAGE, continued

**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 loss of coverage due to 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 himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare; or
- for any other Qualifying Event, the maximum coverage period ends 36 months after the loss of coverage due to 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 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.

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 his or her 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 himself.

**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 loss of coverage due to 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 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 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 his or her 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.

Effect of the Trade Act - In response to Public Law 107-210, referred to as the Trade Act of 2002 ("TAA"), the Plan is deemed to be "Qualified Health Insurance" pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals - The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation ("PBGC"), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement or federal income tax filings. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period - Definitions:

- Non-electing TAA-Eligible Individual – A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.
- TAA-Eligible Individual – An eligible TAA recipient and an eligible alternative TAA recipient.
- TAA-Related Election Period – with respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.
- TAA-Related Loss of Coverage – means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Nonelecting TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made no later than six (6) months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to the such individual's TAA-Related Election Period.

HIPAA Creditable Coverage Credit
With respect to any TAA-Eligible Individual who elects COBRA continuation of coverage as a Nonelecting TAA Individual, the period beginning on the date the TAA-Related Loss of Coverage, and ending on the first day of the TAA-Related Election Period shall be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to the Plan's preexisting condition exclusion provision.

Applicable Cost of Coverage Payments
Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.
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.

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 July 1, 2008.

City of Porterville

By: ________________________________

Title: ______________________________

WITNESS:

By: ________________________________

Title: ______________________________

City of Porterville Medical and Dental Benefits / page 61
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: City of Porterville

Signed (authorized representative of Plan Sponsor)  Date

• • • • • • •

YOU SHOULD ALSO BE AWARE OF THE FOLLOWING REQUIREMENTS THAT MAY APPLY TO YOUR PLAN...

• It is important that the Summary Plan Description be reviewed and signed in a timely manner to assure that booklets can be prepared, printed and distributed to employees to assure compliance with ERISA requirements.

Within 30 days of a request, the administrator of any employee benefit plan must furnish to the Secretary of the Dept. of Labor, any documents relating to the Plan, including but not limited to, the latest Summary Plan Description (the booklet) and any summaries of Plan changes not contained in the Summary Plan Description, the bargaining agreement, trust agreement, contract or other instrument(s) under which the Plan is established or operated.

• 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 must be furnished a summary of the change not later than 60 days after the adoption of the change. This does not apply if you provide summaries of modifications or changes at regular intervals of not more than 90 days. "Material modifications" are those that would be construed by the average Plan participant as being "important" reductions in coverage. Such reductions are outlined by the Department of Labor in Section 2520.104b-3(d)(3) of the regulations.

• Except for fully insured or unfunded plans covering fewer than 100 participants at the beginning of a plan year, employee welfare benefit plans must file annual reports with the IRS on IRS/DOL/PBGC Form 5500.

The 5500 form must be filed by the last day of the seventh month following the end of the Plan Year. An extension of up to 2.5 months may be granted for the filing of such forms.

NOTE: The Secretary of Labor may assess a civil penalty against a Plan Administrator for failure or refusal to file an annual report.

If required, a Summary Annual Report (generally prepared in conjunction with the 5500 filing) must be given to Plan participants within two months after the deadline (including extensions granted by the IRS) for filing the Form 5500.

If you have any questions or concerns about these accounting requirements, talk to your broker/consultant, claims (contract) administrator, or accounting professional.

THIS DOCUMENT WAS NOT PREPARED OR REVIEWED BY AN ATTORNEY AND IS NOT INTENDED AS LEGAL ADVICE.
SUBJECT: AMENDMENT TO WORKERS’ COMPENSATION COVERAGE

SOURCE: ADMINISTRATIVE SERVICES DEPARTMENT

COMMENT: From time to time, volunteers perform work for the City in a variety of different capacities. In fact, this summer the City has utilized the services of volunteers quite extensively, both through organizations such as CSET and the SEE Program, among others, as well as through sole individuals donating their time to assist with various projects. Staff is very supportive of the use of volunteers and believes the City has greatly benefitted from their services.

It has come to staff’s attention that a need for workers’ compensation coverage to protect volunteers while working for the City exists. While most volunteers who are hired through organizations such as CSET or the SEE Program are covered through those organizations’ workers’ compensation programs, sole individuals donating their time who are not affiliated with any organization are currently not protected.

Since the Central San Joaquin Valley Risk Management Authority already provides workers’ compensation coverage for all City employees, including Reserve Firefighters and Reserve Police Officers, extending the City’s coverage to now include volunteers could be offered at no additional premium. It is staff’s belief that exposure in this regard would also be very limited, and thus recommends that the City Council approve amending the City’s workers’ compensation coverage to include non-safety volunteers.

RECOMMENDATION: That the City Council approve the draft resolution amending the City’s workers’ compensation coverage to include non-safety volunteers working for the City.

ATTACHMENT: Draft resolution

Item No. 16
RESOLUTION NO. __________________

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF PORTERVILLE
PROVIDING WORKERS' COMPENSATION COVERAGE FOR CITY' NON-
SAFETY VOLUNTEERS

WHEREAS, the City Council of Porterville desires to provide workers’ compensation
coverage for City’s non-safety volunteers pursuant to the provision of Section 3363.5 of
the Labor Code; and

WHEREAS, the City Council finds its best interests will be served by utilizing volunteers
in the provision of certain city services; and

WHEREAS, said volunteers should be eligible for workers’ compensation coverage
while on duty;

NOW, THEREFORE, BE IT RESOLVED, the City Council of Porterville hereby finds
and determines:

1. That the public interest is best served by providing workers’ compensation
   coverage to non-safety volunteers.

2. That the volunteers described above shall be deemed to be employees for
   the purposes of Division 4 of the California Labor Code while the
   person(s) actually performs volunteers services, provided that the rights of
   volunteers shall be limited to those benefits set forth in the Labor Code.

PASSED, APPROVED, AND ADOPTED this 18th day of August, 2009

Pete V. McCracken, Mayor

ATTEST:
John Lollis, City Clerk

By __________________________
Patrice Hildreth, Chief Deputy City Clerk
SUBJECT: SECOND READING – ORDINANCE 1757 – PERTAINING TO NOISE

SOURCE: ADMINISTRATIVE SERVICES/CITY CLERK DIVISION

COMMENT: Ordinance No. 1757, An Ordinance of the City Council of the City of Porterville Adding to the Municipal Code Chapter 18, Article V Pertaining to Noise, was given first reading on August 4, 2009, and has been printed.

RECOMMENDATION: That the Council give Second Reading to Ordinance No. 1757, waive further reading, and adopt said Ordinance.

Attachment: Ordinance No. 1757

Item No. 17
ORDINANCE NO. 1757

AN ORDINANCE OF THE CITY COUNCIL OF THE CITY OF PORTERVILLE
ADDING TO THE MUNICIPAL CODE CHAPTER 18, ARTICLE V
PERTAINING TO NOISE

WHEREAS: In 1987, the City Council adopted the Noise Element of the General Plan which included a draft noise ordinance proposed for adoption; and

WHEREAS: The City Council directed Staff to draft an item for review to determine a need for a Noise Ordinance; and

WHEREAS: Draft Ordinance section addition CHAPTER 18, Article V regulates excessive noise that may be detrimental to public health, safety and welfare; and

WHEREAS: the City Council has duly considered staff recommendations to add to the current Municipal Code CHAPTER 18, ARTICLE V to regulate noise that may be detrimental to public health, safety and welfare; and

WHEREAS: An increasing number of issues pertaining to noise have risen and enforcement has been problematic due to the lack of enforceable standards;

NOW, THEREFORE, BE IT ORDAINED: That the City Council of the City of Porterville does hereby add Porterville Municipal Code Chapter 18, Article V as follows:

Section 1. Porterville Municipal Code Appendix A, Zoning, Section 2618 H is amended to read as follows:

2618: PERFORMANCE STANDARDS:

"H. Noise: No use may generate noise that is in violation of the City's Noise Standards contained in Chapter 18 Article V of the Porterville Municipal Code or other standards as may be adopted by the City Council."

Section 2. Porterville Municipal Code Section 3-15 is amended to read as follows:

"3-15: NONCOMMERCIAL USE; REGULATIONS GENERALLY:

Use of sound trucks or any other vehicle in the city with sound amplifying equipment in operation shall be subject to the following regulations:

A. The only sounds permitted are music.

B. Operations of sound equipment shall be permitted during the hours of nine o'clock (9:00) A.M. to eight o'clock (8:00) P.M.
C. Sound amplifying equipment shall not be operated unless the vehicle or sound truck upon which such equipment is mounted is operated at a speed of at least ten (10) miles per hour except when such vehicle is stopped or impeded by traffic. Where the vehicle is stopped, the sound amplifying equipment shall not be operated for longer than one minute at each such stop.

D. Sound shall not be issued within one hundred (100) yards of hospitals, schools, churches or courthouses.

E. The music amplified shall not be profane, lewd, indecent or slanderous.

F. The volume of sound shall be controlled so that it will not be audible for a distance in excess of fifty feet (50') from the vehicle or sound truck and so that such volume is not unreasonable, loud, raucous, jarring, disturbing or a nuisance to persons within the area of audibility."

Section 3. Porterville Municipal Code Chapter 18, Article V is added as follows:

**NOISE ORDINANCE**

**Chapter 18 Article V**

**Sections:**

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<td>Definitions.</td>
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<td>Noise Standards-General Provisions.</td>
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<td>Permit for relief.</td>
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<td>18-91</td>
<td>Violations.</td>
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18-80 Purpose.

A. The City Council declares and finds that excessive noise levels are detrimental to the public health, safety and welfare and contrary to the public interest as follows:

1. By interfering with sleep, communication, relaxation and the full use of one’s property; and

2. By contributing to hearing impairment and a wide range of adverse physiological and psychological stress conditions; and

3. By adversely affecting the value of real property.

B. It is the intent of this chapter to protect persons from excessive levels of noise within or near a residence, school, church, hospital or public library and to warn persons of the hazards of excessive noise in places of public entertainment.

18-81 Definitions.

The following words, phrases and terms as used in this chapter shall have the following meanings:

A. “Ambient noise level” means the composite of noise from all sources excluding the alleged offensive noise. In this context it represents the normal or existing level of environmental noise at a given location for a specific time of the day or night.

B. “A-weighted sound level” means the sound level in decibels as measured with a sound level meter using the “A” weighted network (scale) at slow meter response. The unit of measurement is referred to herein as dBA.

C. “Construction” means construction, enlargement, alteration, conversion or movement of any building, structures or land together with any scientific surveys associated therewith.

D. “Cumulative period” means an additive period of time composed of individual time segments, which may be continuous or interrupted.

E. “Decibel” means a unit for measuring the amplitude of a sound, equal to 20 times the logarithm to the base ten of the ratio of the pressure of the sound measured to the reference pressure, which is 20 micropascals (20 micronewtons per square meter).

F. “Emergency work” means the use of any machinery, equipment, vehicle, manpower or other activity in a short-term effort to protect, or restore safe conditions in the community, or work by private or public utilities when restoring utility service.
G. "Fixed noise source" means a device, machine or combination thereof which creates sounds while fixed or stationary, including but not limited to residential, agricultural, industrial and commercial machinery and equipment, pumps, fans, compressors, air conditioners and refrigeration equipment.

H. "Hospital" means any building or portion thereof used for the accommodation and medical care of sick, injured or infirm persons including rest homes and nursing homes.

I. "Impulsive noise" means a noise of short duration, usually less than one second, with an abrupt onset and rapid decay.

J. "Intruding noise level" means the sound level created, caused, maintained or originating from an alleged offensive source, measured in decibels, at a specified location while the alleged offensive source is in operation.

K. "L_{eq}" means the equivalent sound level. The sound level containing the same total energy as a time varying signal over a given sample period. For purposes of this ordinance, the L_{eq} is measured over a one-hour sample period.

L. "Mobile noise source" means any source other than a fixed noise source.

M. "Noise disturbance" means any sound which violates the quantitative standards set forth in this chapter.

N. "Residential property" means a parcel of real property which is developed and used either in whole or in part for residential purposes.

O. "School" means public or private institutions conducting regular academic instruction at preschool, kindergarten, elementary, secondary or collegiate levels.

P. "Pure tone noise" means any noise which is distinctly audible as a single pitch (frequency) or set of pitches. For the purposes of this ordinance, a pure tone shall exist if the one-third octave band sound pressure level in the band with the tone exceeds the arithmetic average of the sound pressure levels of the two contiguous one-third octave bands by 5dB for center frequencies of 500 Hz and above and by 8 dB for center frequencies between 160 and 400 Hz and by 15 dB for center frequencies less than or equal to 125 Hz.

Q. "Sounding amplifying equipment" means any machine or device for the amplification of the human voice, music, or any other sound. Sound amplifying equipment shall not include standard automobile radios or tape players when heard only by the occupants of the vehicle in which the automobile radio is installed. Sound amplifying equipment as used in this chapter shall not include warning devices in authorized emergency vehicles, or horns or other warning devices in any vehicle, which are used only for traffic safety purposes."
R. "Sound level meter" means an instrument meeting American National Standard Institute (ANSI) Standard S1.4-1971 for Type 1 or Type 2 sound level meters or an instrument and the associated recording and analyzing equipment, which will provide equivalent data.

S. "Sound truck" means any motor vehicle, or any other vehicle regardless of motive power, whether in motion or stationary, having mounted thereon any sound amplifying equipment.

18-82 Noise Standards- General Provisions

A. The standards which shall be considered in determining whether a violation of Section 18-83 or 18-84 exists shall include but not be limited to the following:

1. The volume of the noises
2. The intensity of the noises
3. Whether the nature of the noise is usual or unusual
4. Whether the origin of the noise is natural or unnatural
5. The volume and intensity of the background noise, if any
6. The proximity of the noise to residential sleeping facilities
7. The nature and zoning of the area within which the noise emanates
8. The density of inhabitation of the area within which the noise emanates
9. The time of day or night the noise occurs
10. The duration of the noise
11. Whether the noise is recurrent, intermittent, or constant
12. Whether the noise is produced by a commercial or noncommercial activity

B. It is unlawful for any person to make, continue, allow, or cause to be made or emanate any excessively, unnecessarily, unnaturally, or unusually loud noise or sound from any radio, compact disk player, stereo, television or other mechanical, electrical, or electronic sound amplification device or instrument which annoys, disturbs, injures, or endangers the comfort, repose, quiet, health, peace, or safety of other persons in the city; such acts are hereby being declared a public nuisance. In interpreting and applying this section, the following shall apply:
1. Emanating noise or sound shall be defined for these purposes as it is described in Section 18-83 A and/or 18-84 A.

2. Prima facie evidence exists when such noise or sound annoys, disturbs, injures, or endangers the comfort, repose, quiet, health, peace, business, or safety of other persons and is shown by proof of non-compliance with subsection (A) of this section, or by a complaint by a person or persons regarding such noise or sound. A complainant must have standing to file a complaint.

3. The distance from the source of such noise or sound shall be measured from the actual source itself, or where the source is located on private property not adjacent to residential property, in which case the distance shall be measured from the property line.

4. Alternative prima facie evidence that such noise or sound is excessively, unnecessarily, unnaturally, or unusually loud is shown by a sound level exceeding the ambient sound level by more than five decibels measured at the property line, or in the case of common wall construction such as condominiums, apartments, or business facilities, measured within the adjoining occupied units.

5. Nothing in this section prohibits or declares unlawful or a nuisance:
   a. The operation of warning or amplification devices by emergency, fire, or law enforcement vehicles or personnel;
   b. Lawful use of vehicle horns or backup warning devices;
   c. Private or public warning equipment or systems;
   d. The conduct of previously authorized and otherwise lawful public activity such as parades, speeches, lectures, ceremonies, entertainment, sports, music, or recreation events;
   e. The usual and customary operations of bells, gongs, buzzers, or similar mechanical, electrical or electronic sound amplification devices to mark time or call to attendance for an otherwise lawful use or purpose, except within public rights of way pursuant to Section 20-6 of the Municipal code.

6. Sound Amplification Devices (Refer to Advertising and Signs Code, Section 3-15): The use of sound trucks or any other vehicle in the city with sound amplifying equipment in operation shall comply with the provisions of Section 3-15 of the Porterville Municipal Code.
C. Public Park/City Facilities

1. Sound or noise produced by amplification equipment used at all city parks and other city facilities shall not exceed seventy (75) dBA when measured at a distance of one-hundred (100) feet from the sound source or the closest residential property line, whichever is closest to the noise source.

2. It should be the event sponsor’s responsibility to insure that sound levels are below the specified noise level standard. The sponsor shall provide a sound level meter to accomplish this task.

3. Failure of the event sponsor to enforce the sound limits may result in any or all of the following:
   a. The forced curtailment of activities as ordered by the police department
   b. Citation issued by the police department under the City’s nuisance abatement ordinance
   c. Forfeiture of deposits placed with City by the sponsor for use of the facility

D. Any noise measurement made pursuant to the provisions of this chapter shall be made with a sound level meter using the “A” weighted network (scale) at slow meter response. Fast meter response shall be used for impulsive type sounds. Calibration of the measurement equipment utilizing an acoustical calibrator certified by its manufacturer to be in compliance with National Institute of Standards and Technology (NIST) reference calibration levels shall be performed immediately prior to recording noise level data.

E. Exterior noise levels shall be measured from the nearest residential, school, hospital, church or public library property line to the noise source. Where practical, the noise testing microphone shall be positioned three to five feet above the ground and away from reflective surfaces.

F. Interior noise levels shall be measured within the affected dwelling unit, at points at least four feet from the wall, ceiling or floor nearest the noise source, with windows in the normal seasonal configuration. Reported interior noise levels shall be determined by taking the arithmetic average of the readings taken at the various microphone locations.
18-83 Exterior Noise Standards

A. It is unlawful for any person at any location within the incorporated areas of the City to create any noise, or to allow the creation of any noise, on property owned, leased, occupied or otherwise controlled by such person which causes the exterior noise level when measured at any affected residence, school, hospital, church or public library to exceed the noise level standards as set forth in the following table:

<table>
<thead>
<tr>
<th>Category</th>
<th>Daytime</th>
<th>Nighttime</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7 a.m. to</td>
<td>10 p.m. to</td>
</tr>
<tr>
<td></td>
<td>10 p.m.</td>
<td>7 a.m.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Hourly L_{eq}</th>
<th>Maximum Sound Level (L_{MAX})</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>70</td>
<td>65</td>
</tr>
</tbody>
</table>

B. In the event the measured ambient noise level without the alleged offensive source in operation exceeds the applicable noise level standard in either category above, the applicable standard or standards shall be adjusted so as to equal the ambient noise level.

C. Each of the noise level standards specified above shall be reduced by five dB for pure tone noises, noises consisting primarily of speech or music, or for recurring impulsive noises.

D. If the intruding noise source is continuous and cannot reasonably be discontinued or stopped for a time period whereby the ambient noise level without the source can be measured, the noise level measured while the source is in operation shall be compared directly to the noise level standards.

18-84 Residential Interior Noise Standards

A. It is unlawful for any person at any location within the incorporated areas of the City, to operate or cause to be operated within a dwelling unit or on property occupied by a non-residential use, any source of sound or to allow the creation of any noise which causes the noise level when measured inside another dwelling unit to exceed the noise level standards as set forth in the following table:
### Interior Noise Level Standards, dBA

<table>
<thead>
<tr>
<th>Category</th>
<th>Daytime</th>
<th>Nighttime</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7 a.m. to 10 p.m.</td>
<td>10 p.m. to 7 a.m.</td>
</tr>
<tr>
<td>Maximum Sound Level ($L_{\text{MAX}}$)</td>
<td>55</td>
<td>45</td>
</tr>
</tbody>
</table>

B. The noise level standards specified above shall be reduced by five dB for pure tone noises, noises consisting primarily of speech or music, or for recurring impulsive noises.

C. If the intruding noise source is continuous and cannot reasonably be discontinued or stopped for a time period whereby the ambient noise level without the source can be measured, the noise level measured while the source is in operation shall be compared directly to the noise level standards.

18-85 Noise Source Exemptions.

The following activities shall be exempted from the provisions of this chapter.

A. Noises from safety signals, warning devices, and emergency pressure relief valves.

B. Noises resulting from any authorized emergency vehicle, when responding to an emergency call or acting in time of emergency.

C. Noises resulting from emergency work, including repair of public utilities.

D. Activities conducted in public parks, public playgrounds and public or private school grounds, including but not limited to school athletic and school entertainment events, except as otherwise noted in this ordinance.

E. Any mechanical device, apparatus or equipment used, related to, or connected with emergency activities or emergency work.

F. Noise sources associated with construction, whether private or public, within 500 feet of the uses mentioned in Section 18-83, paragraph A, provided such activities do not take place before 6:00 a.m. or after 9:00 p.m. on any day except Saturday or Sunday, or before 7:00 a.m. or after 5:00 p.m. on Saturday or Sunday.

G. Noise sources associated with the maintenance of residential property provided such activities take place between the hours of 6:00 a.m. and 9:00 p.m. on any day except Saturday or Sunday, or between the hours of 7:00 a.m. and 9:00 p.m. on Saturday or Sunday.
H. Noise sources associated with a lawful commercial or industrial property caused by mechanical devices or equipment, including air conditioning or refrigeration systems, installed prior to the effective date of this chapter; that this exemption shall expire 12 months after the effective date of this chapter.

I. Noise sources associated with the collection of waste or garbage.

J. Noise sources associated with seasonal agricultural packing operations provided that noise levels produced by such operations do not exceed the exterior noise level standards set forth in Section 18-82 when measured as provided in Section 18-83 for a cumulative period of more than 90 days out of the year.

K. Any activity to the extent regulation thereof has been preempted by state or federal law.

18-86 Residential Air Conditioning and Refrigeration Systems.

Notwithstanding the provisions of Section 18-82 where the intruding noise source when measured as provided in Section 18-83 is an existing residential air conditioning or refrigeration system or associated equipment, the exterior noise level shall not exceed fifty-five (55) dBA. For residential air conditioning or refrigeration systems or associated equipment installed after the effective date of this chapter, the exterior noise level when measured as provided in Section 18-83 shall not exceed fifty (50) dBA.

18-87 Waste and Garbage Collection Equipment.

Notwithstanding the provisions of Section 18-82, the collection of waste or garbage from residential property by persons authorized to engage in such activity, and who are operating truck-mounted loading or compacting equipment, shall not take place before 6:00 a.m. or after 7:00 p.m. The noise level created by such activities when measured at a distance of fifty (50) feet in an open area shall not exceed the following standards:

A. Eighty-five (85) dBA for equipment in use, purchased or leased prior to the effective date of this chapter;

B. Eighty (80) dBA for new equipment purchased or leased after the effective date of this chapter.

18-88 Electrical Substations.

Notwithstanding the provisions of Section 18-82, noise sources associated with the operation of electrical substations shall not exceed fifty (50) dBA when measured as provided in Section 18-83.

18-89 Warning signs in places of public entertainment.
It is unlawful for any person to operate or permit the operation or playing of any loudspeaker, musical instrument, motorized racing vehicle, or other source of sound for public entertainment within a building or structure wherein the noise level exceeds ninety-five (95) dBA as determined by using the slow response of a sound level meter at any point normally occupied by a customer, without a conspicuous and legible sign stating: “WARNING! SOUND LEVELS WITHIN MAY CAUSE HEARING IMPAIRMENT.”

18-90 Permit for relief

Applications for a permit relief from the noise level designated in this chapter on the basis of undue hardship and special events may be made to the City Manager or his duly authorized representative for recommendation to the City Council. Any permit granted by the City Council under this section shall contain all conditions upon which the permit has been granted and shall specify a reasonable time that the permit shall be effective. The City Council may grant the relief as applied for if the Council finds:

A. That additional time is necessary for the applicant to alter or modify his/her activity or operation to comply with this chapter; or
B. The activity, operation, or noise source will be of temporary duration. The noise source cannot be done in a manner that would comply with this chapter; and
C. That no other reasonable alternative is available to the applicant; and
D. The City Council may prescribe any conditions or requirements deemed necessary to minimize adverse effects upon the community or surrounding neighborhood.

18-91 Violations.

Penalty.
Each violation of the provisions of this chapter shall be deemed a misdemeanor punishable by imprisonment in the county jail not exceeding six months, or by fine not exceeding one thousand dollars ($1000), or both. Upon recommendation of the prosecuting attorney, the Court may reduce the charged offense from misdemeanor to an infraction, punishable under Chapter 1-9 of this Code.

Prosecution.
Violations of this chapter shall be prosecuted in the same manner as other misdemeanor violations of the City’s Code; provided, however, that in the event of violation, a written notice of intention to prosecute will be given to the alleged violator not less than five calendar days prior to the issuance of a misdemeanor complaint. No complaint shall be issued in the event the cause of violation is removed, the condition abated or fully corrected within the five-day period. In the event the alleged violator cannot be located in order to serve the notice of intention to prosecute, the notice as required in this section shall be deemed to be given upon mailing the notice by registered or certified mail to the alleged violator at his/her last known address or at the place where the violation occurred, in which event the five-day period shall commence at the date of the day following the mailing of the notice.
Section 2:

This Ordinance shall be in full force and effect thirty (30) days from and after its publication and passage.

PASSED, APPROVED, AND ADOPTED this 18th day of August, 2009.

______________________________
Pete V. McCracken, Mayor

ATTEST:

John Lollis, City Clerk

By____________________________
Patrice Hildreth, Chief Deputy City Clerk
CITY COUNCIL AGENDA: August 18, 2009

SUBJECT: TRANSIT SYSTEM OVERVIEW FOR FISCAL YEAR 2008/09

SOURCE: Administration (Transit)

COMMENT: Fiscal Year 2008/09 ended with quite a milestone for Fixed Route. We served 555,511 passengers (12.8% increase), and for the first time, we have surpassed 500,000 in ridership. Another positive outcome was the system's ability to maintain a 20.4% blended farebox ratio - also a “first” since the City transitioned into the Federal transit program. The following is a summary of the last four fiscal years showing total ridership, total operating costs, total farebox, and the resulting farebox ratio. The ratio is determined by dividing total farebox received from Fixed Route and Demand Response by the total operating costs associated with both systems.

<table>
<thead>
<tr>
<th>Fiscal Yr.</th>
<th>Ridership (F. Route)</th>
<th>Total Operating Costs</th>
<th>Total Farebox</th>
<th>Blended Farebox Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005/06</td>
<td>451,046</td>
<td>$1,654,343</td>
<td>$289,774</td>
<td>17.5%</td>
</tr>
<tr>
<td>2006/07</td>
<td>449,538</td>
<td>$1,528,612</td>
<td>$293,700</td>
<td>19.2%</td>
</tr>
<tr>
<td>2007/08</td>
<td>492,699</td>
<td>$1,634,580</td>
<td>$311,877</td>
<td>19.1%</td>
</tr>
<tr>
<td>2008/09</td>
<td>555,511</td>
<td>$1,725,786</td>
<td>$352,014</td>
<td>20.4%</td>
</tr>
</tbody>
</table>

Demand-Response ridership during these four years began at 58,611 in FY 05/06, decreasing each year thereafter considerably – 27,477, 22,682, and 21,958, respectively. The decreases were the result of the City’s effort to scale back the more expensive Demand-Response system and encourage riders to utilize fixed route.

As the Council will notice from the above table, FY 2005/06 and 2006/07 failed to see the required 20% farebox ratio. Since the City was a new urbanized area, leniency is generally granted during the first two years to allow an entity ample time to transition from a rural (10%) designation into an urbanized designation (20%). Realizing that we were not going to be able to meet the 20% farebox ratio in 2007/08, staff requested that the Tulare County Association of Governments (TCAG) grant the City a reduction in farebox ratio from 20% to 15% for an additional two years. The reduction was approved by TCAG April 21, 2008, for Fiscal Years 2007/08 and 2008/09.

DD

Appropriated/Funded

CM

Item No. 18
Fixed Route has been able to maintain the 20% + farebox ratio each year since its transition into the Federal program; however, the problem arises from the burden that the Demand Response system places upon the formula. Demand-Response only serves one to three people on a given trip, compared to a maximum of 28 individuals per trip on Fixed Route. The average operating cost per passenger on Demand Response is $25.87 compared to $2.08 on Fixed Route.

With the constant reminder that FY 2008/09 was our second and final year with the reduced farebox ratio, staff and Sierra Management analyzed every possible situation that could be adjusted to reduce operating costs. Monthly meetings were held with the Shop Superintendent to work together to maintain vehicle maintenance costs, dispatchers worked very closely with passengers to encourage multiple riders per trip on Demand-Response to increase efficiency wherever possible, and Sierra Management looked within its own operation scaling back to save the City money toward its operating costs. Every avenue that was a possibility was reviewed and changes have been made.

The current fiscal year will be monitored extremely closely to determine if the blended farebox ratio can be maintained at 20%. In an unprecedented effort on the part of a transit contractor, Sierra Management has voluntarily reduced its contract to the City by $100,000 for FY 2009/10, which they were able to do through their own efforts to conserve and scale back. It was their way of helping the City share the pain of increasing costs and making every effort to stay within the required farebox ratio.

If after all the efficiency changes and alterations to the transit contract, we are still unable to maintain the 20% farebox ratio, the only other alternative will be to review fares. The current Fixed Route fare is $1 per ride, with free transfers. Demand Response is $1.50 per ride for Seniors, Disabled, and Medicare Card holders, and $3.00 for General Ridership. The $1.50 fare has been constant since January 1, 2003. With the reduced transit funding and financial pressure being placed on transit operations throughout the nation, Tulare County transit agencies are no exception. The City of Visalia recently adopted a fare increase for both Demand Response and Fixed Route. Their new Fixed Route general fare is $1.25 and Demand Response is $2.25 for Seniors, Disabled and Medicare Care holders. With Visalia being the only other city in the county under the same Federal program as Porterville with the required 20% farebox ratio, they are the comparable city with which we compare. The City of Tulare, even though it still remains a rural designation, is struggling to maintain its system without having to increase rates or scale back routes.
Given the economic conditions, raising fares will be the last possible alternative we will consider. However, with all the efforts to date to curtail operating costs, that may be our only other option if we determine our efforts are not sufficient to obtain the required results. Staff is hopeful, but cautious, considering the studies and analysis completed during our current Short Range Transit Plan indicating we would be unable to maintain the required farebox ratio without raising fares.

Staff will be monitoring the system closely and will keep you advised on at least a quarterly basis. We are pleased we had such positive results to report for FY 2008/09, and will continue to strive for increased ridership and system efficiency and compliance.

RECOMMENDATION: None – information only.
CITY COUNCIL AGENDA: AUGUST 18, 2009

SCHEDULED MATTER

SUBJECT: REQUEST FOR A TEMPORARY STRUCTURE PERMIT FOR THE STORAGE AND CONSIGNMENT OF EQUIPMENT (952 West North Grand Avenue)

SOURCE: COMMUNITY DEVELOPMENT DEPARTMENT - PLANNING DIVISION

COMMENT: The applicant is requesting a temporary structure permit to allow for the storage and consignment of vehicles and equipment. The site is located on the northeast corner of Highway 65 and North Grand Avenue (952 W. North Grand Avenue).

HISTORY: Annexed in 1978 (Annexation No. 261), the site located at 952 W. North Grand has been used as a storage lot for decades. Since being brought into the City limits, the site has been through a number of Project Review Committee (PRC) meetings for various proposals including a proposed veterinary clinic in September 1997, a proposed auto sales lot with temporary office in November 2001, and an indoor gun range, restaurant, gas island and carwash in April 2004. Due to challenges with the site and the extent of the proposals, none of the projects have been constructed. Two main constraints on the site have included the non-conforming status of the storage of material, and the future construction of a freeway interchange that will eliminate the majority of the project site when constructed in the next 10 or so years.

Since the property has existed as a legal non-conforming use for storage of construction materials and equipment, the effect of the proposed change focuses on whether the consignment of vehicles for sale should be permitted as a temporary use.

Staff has processed this request based on a past action of the Council to consider a temporary remote control vehicle track on a site on Henderson Avenue just east of the abandoned San Joaquin Valley Railroad right-of-way. On October 19, 2004, the City Council adopted Ordinance 1659, allowing for a temporary remote control vehicle track in a manner similar to this proposed use and in the same manner as temporary structures. Section 7-3.3 of the Porterville Municipal Code empowers the City Council to conditionally approve temporary structures and provides the City Council the discretion to determine the type and location of the structure, period of time the structure will be allowed, and other conditions deemed pertinent by the City Council.

PROJECT DESCRIPTION:

The applicant is requesting a temporary structure permit to continue the legal nonconforming use for the storage of equipment with the addition of allowing consignment of equipment for sale on the property. Unlike some of the earlier submittals that proposed using a portion of the site, the applicant has made significant efforts in cleaning up the entire blighted site and is proposing to reduce the level of nonconformity by doing minor improvements to the site. The applicant proposes to store and consign

DD: APPROPRIATED/FUNDED N/A CM ITEM NO 19
items such as farming supplies, tractors, and vehicles and has already paved the area with decomposed granite (DG). Although decomposed granite is more effective in mitigating dust and providing all weather access to the site, the applicant is proposing to utilize his water truck to dampen the DG as needed to control dust. Staff and the applicant have discussed a 5-year timeframe for allowing the temporary use before making it permanent and installing full on-site and off-site improvements. Staff indicated this would be communicated to the City Council for consideration although the Council can, if approved, change the term of the temporary use. While the applicant has made a specific proposal, there are a number of options available to the City Council which are as follows:

OPTIONS:

1. Approve the request as proposed per the submitted plan and conditions contained in the attached resolution.

2. Deny the applicant’s request and require the full extent of improvements be made prior to allowing any degree of use other than storage.

3. Approve the request with conditions to apply oil or other dust retardant to the customer parking and vehicular travel areas.

4. Approve the request and require the applicant to pave the travel ways per Sections 2206 and 2211 of the Zoning Ordinance.

While there are certainly implications with respect to precedence, staff has identified some benefits of this proposal. The proposal cleans up a blighted gateway into the City along Highway 65. Due to the economic distress our community and country face the desire to operate the site in a safe and efficient manner is a positive. As stated, earlier proposals mostly proposed scraping the materials off of one portion of the site to another and did not really address the underlying blight problem. The Caltrans Project Study Report calls for most of the property to be impacted by the proposed interchange improvements which is a component of the Measure R improvement program. Staff is seeking direction from Council on whether the City would like to facilitate the temporary use. In the event the Council wishes to approve the proposed temporary use, Staff has provided a draft resolution.

RECOMMENDATIONS: Provide direction to Staff

ATTACHMENTS: Draft Resolution with Site Plan
RESOLUTION NO.

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF PORTERVILLE APPROVING A TEMPORARY STRUCTURE PERMIT TO ALLOW FOR THE STORAGE AND CONSIGNMENT OF EQUIPMENT LOCATED AT 952 WEST NORTH GRAND AVENUE.

WHEREAS: The applicant has filed a request for a Temporary Structure Permit to operate an equipment storage and consignment business at 952 West North Grand Avenue; and

WHEREAS: Section 7-3.3 of the Porterville Municipal Code authorizes the City Council to, upon written application to the City Council, issue a permit enabling an applicant in time of stress or emergency or in conjunction with development of residential, commercial, or industrial projects, to erect, construct, maintain and utilize a temporary structure within the City of Porterville; and

WHEREAS: The applicant has worked with City Staff to address potential safety and other pertinent issues; and

WHEREAS: The City Council of the City of Porterville, at its regularly scheduled meeting of August 18, 2009 conducted a public meeting to consider approving a temporary structure permit to allow for the storage and consignment of equipment located at 952 West North Grand Avenue.

NOW, THEREFORE, BE IT RESOLVED: That the City Council of the City of Porterville does hereby grant a Temporary Use Permit to allow for the storage and consignment of equipment located at the Northeast corner of Highway 65 and North Grand Avenue (952 W. North Grand) with the following conditions:

a. The term of this temporary structure permit shall expire on August 18, 2014 unless otherwise extended or revoked.

b. The applicant shall pave the outdoor storage area and travel areas with decomposed granite or similar material to the satisfaction of the Zoning Administrator.

c. Install a vehicle barrier such as railroad ties acceptable to the City Engineer between the public parking area and the storage/display area.

d. The hours of operation shall be Monday- Saturday 8:00 a.m. to 4:00 p.m.

e. That outdoor storage area and travel ways shall be watered daily to mitigate dust.

f. That any other conditions set forth by Council shall be in compliance.
g. In the event the applicant fails to satisfy all conditions set forth by the City Council in the permit, the right to construct, maintain and utilize the temporary structure may be terminated immediately by action of the City Council; and, in addition thereto, a violation of the conditions of said permit is hereby declared to be unlawful.

h. Nothing herein shall permit an applicant to make use of any structure or area in violation of any zoning law, ordinance or regulation of the city.

i. Comply with plans included herein as Exhibit A.

Pete V. McCracken, Mayor

ATTEST:

John Lollis, City Manager

BY

Patrice Hildreth, Chief Deputy City Clerk
CENTRAL VALLEY CONSIGNMENT + STORAGE

STEVE PENN
(559) 284-5940

DESIGNATED AREAS OF OPERATION

☐  EQUIPMENT

///  Parking

...  Fence

\  gates

☒  STORAGE

DUST CONTROL

AREA COMPLETELY COVERED WITH GRANIT

ANY AND ALL AREAS IN USE WILL BE WATERED DAILY AS NEEDED

HOURS OF OPERATION: MONDAY - FRIDAY 8:00 TO 4:00 SAT 8:00 TO 12:00

EXHIBIT A
SUBJECT: CONSIDERATION OF SAMPLE SURVEY IN THE POTENTIAL FORMATION OF A MOSQUITO ABATEMENT DISTRICT IN SOUTHEASTERN TULARE COUNTY

SOURCE: City Manager

COMMENT: At its adjourned study session on Tuesday, June 23, 2009, the City Council acted to support the initiation of a property owner survey concerning the formation of a mosquito abatement district in Southeastern Tulare County, as well as financial support for the survey process. As a condition of its action of support, the Council directed that it be allowed to review and approve the survey before its production and distribution.

The LAFCO Study Committee, who is coordinating the district formation consideration efforts, has not yet authorized the drafting of a sample survey for the Council's review. However, a survey that was recently used in Lake County has been provided by the Committee for the Council's review and prospective comment. It continues to be understood that the City Council will have the opportunity to review the draft survey specific to Southeastern Tulare County prior to its production and distribution.

RECOMMENDATION: That the City Council consider the Lake County survey for prospective comments in the creation of the Southeastern Tulare County survey.

ATTACHMENT: Official Survey: Lake County Vector Control District
Mosquito Control in Lake County
The Lake County Mosquito and Vector Control District is an independently funded public agency separate from any City or the County and is the sole provider of mosquito control services for your property. The District’s function is to prevent the diseases transmitted by mosquitoes and other vectors and to reduce nuisance levels of mosquitoes, gnats, flies and other pests. (A “vector” is an organism capable of transmitting disease to humans and domestic animals).

Why Did You Receive This Survey?
The District has historically been funded by a small portion of local property taxes, and receives no other annual revenues. For the last 10 years, a significant portion of the District’s property tax share has been transferred by the State to other agencies. Cost increases and the cost of controlling West Nile Virus have further stressed the District’s limited budget.

As a result of these budget issues, the District is interested in gathering the opinions of local property owners regarding a proposal to expand and improve the District’s mosquito and disease control services, as well as input on a proposed annual assessment to pay for those services. The proposed assessment would fund full, year-round services that control mosquitoes, ticks, flies, gnats and other vectors, and the diseases they transmit. Also, much needed upgrades to the District’s obsolete laboratory would be funded.

How Mosquitoes Are Controlled
Mosquitoes are successfully controlled by focusing on finding the sources of mosquito breeding (usually stagnant, standing water) and eliminating immature mosquitoes (larvae) before they emerge as adult mosquitoes and begin to bite people and animals. By regularly testing for the presence of disease in mosquitoes, these diseases can be detected early and additional control measures can be taken to protect public health.

Proposed Services
An annual assessment would enable the District to provide improved mosquito and disease control services, and expanded monitoring of other vectors and pests. Following are some of the proposed new and enhanced services:
- Faster response to resident requests concerning mosquitoes, insects, rodents, and other vectors.
- Treat sources with environmentally safe products wherever mosquito larvae and/or pupae are found.
- Improve mosquito sh program which provides free mosquito-eating sh for backyard ponds and other water features to property owners.
- Improve testing for mosquito- and vector-borne diseases.
- Upgrade existing lab facility to analyze Lake County’s unique insects and vectors more safely and quickly.
- Surveillance and testing of ticks and rodents and the diseases they carry.
- Conduct environmentally safe adult mosquito control when necessary to protect public health.
- Provide more community education and outreach programs.
More About the Proposed Measure
A local funding measure would enable the District to expand and improve its mosquito, vector and disease control services. If a local funding measure is approved, the District would have sufficient resources to control mosquitoes and other vectors year round. In addition, the District would regularly test for, and respond to, existing and newly emerging diseases that are carried by mosquitoes and other vectors.

Flies, Ticks, and Other Vectors
The District monitors the presence of flies, gnats, ticks, and other vectors, as well as the diseases they carry. The District provides information to residents and businesses regarding how to make environmental modifications to eliminate the habitat for these and other vectors, as well as information on how people can protect themselves, their families, and their pets from these pests. The District also provides free identification of insects and other vectors and free mosquito fish for use in pools, fountains and water features.

How Does the District Test for Diseases?
In order to test for vector-borne viruses such as Encephalitis and West Nile Virus, the District uses disease surveillance approaches such as mosquito and insect traps. These traps require significant effort to operate because they must be set in the evening in locations throughout the District and must be emptied the following morning. Insects collected are counted, identified and sent to a laboratory for disease testing. If diseases are discovered, the District implements a response plan that could include focused abatement efforts in the area, public education and notification, and other services as warranted.

Will This Affect the Environment?
Mosquito abatement and disease control services involve the use of environmentally friendly methods to eliminate the sources of mosquitoes and other disease carrying insects. This approach starts with identifying and eliminating breeding grounds in standing, stagnant water such as those found in backyards and old tires. For sources in ponds anduntended swimming pools, the District uses mosquito fish and other natural resources to target and eliminate mosquito larvae.

How Are Diseases Prevented By Mosquito and Vector Control Services?
First, by reducing mosquito and insect populations through monitoring and treatment activities, the transmission of vector-borne diseases is minimized. Second, through the regular testing of mosquitoes and other insects for the presence of disease, emerging disease threats can be discovered and the proper steps can be taken to protect the public health.
1. Property owners in your area may be asked to vote by mail on a local ballot measure. Following is a summary of the proposal:

   In order to:
   - Provide improved, year-round control of mosquitoes and other vectors and the diseases they carry;
   - Provide monitoring and response to public health issues such as West Nile Virus, encephalitis, Lyme disease, hantavirus, plague, and emerging diseases; and
   - Rehabilitate and upgrade laboratory / operational facilities to improve mosquito and vector-borne diseases research and testing,

   would you support an annual assessment for your property(s)* in the amount of ______ ?

<table>
<thead>
<tr>
<th>Definitely YES</th>
<th>Probably YES</th>
<th>Probably NO</th>
<th>Definitely NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

   *Assessment amount listed is the proposed total combined annual amount for all properties you own.

2. This measure will improve the control of mosquitoes and the diseases they carry

3. This measure will provide a stable funding source for local disease control services

4. This measure will reduce mosquito populations using environmentally safe methods

5. This measure will reduce response time for service requests

6. This measure will increase the use of mosquito-traps to measure mosquito populations in local areas and implement surveillance-based control programs

7. This measure will protect the public health by controlling insects, rodents and other disease-carrying vectors in Lake County

8. The District will educate residents about how to protect themselves from diseases carried by mosquitoes and other vectors

9. This measure will help to prevent future outbreaks of West Nile Virus and other diseases

10. This measure will help control gnats, flies, ticks, and other pests

11. 100% of the proceeds from the measure would be used for mosquito and vector control services

12. This measure will rehabilitate the outdated laboratory facility so the District can test for diseases more safely and quickly

13. We should be spending our tax dollars on more pressing issues, like improving law enforcement and road maintenance

Please write any reasons why you support or oppose this measure:
SCHEDULED MATTER

SUBJECT: COUNCILMEMBER REQUESTED AGENDA ITEM – MURRY PARK POOL SLIDE INSTALLATION

SOURCE: COMMUNITY DEVELOPMENT DEPARTMENT

COMMENT: At the request of Council member Pedro Martinez, staff has researched the possibility of funding the installation of the slide at the Murry Park pool which has been delayed several years due to reallocation of funds to other projects. Staff has been able to identify funds within the Community Development Block Grant program that could be utilized for this project, including the additional Entitlement allocation for 09/10. Notification of these additional funds was received too late to be included in the 09/10 Action Plan. If the City Council directs, an amendment to the 09/10 Action Plan can be initiated and brought back to Council for action the first meeting in October after the public notification period has expired.

The Parks and Leisure Services Commission discussed this issue at the August 6, 2009 meeting and voted to recommend the installation of the slide at Murry Park swimming pool.

RECOMMENDATION: Provide appropriate direction to staff
COUNCIL AGENDA: August 18, 2009

SUBJECT: COUNCILMEMBER REQUESTED AGENDA ITEM – The Porterville Recorder Agenda Publication

SOURCE: City Manager

COMMENT: At its meeting on June 2, 2009, Councilman Pedro “Pete” Martinez stated that he was interested in staff investigating the expense in having the City Council’s Agenda Legal Description Sheet published in The Porterville Recorder prior to City Council meetings. Staff has communicated with The Recorder, and has been given an annual quote of $14,328 for a half-page notice space that would be printed each Saturday (highest circulation) before scheduled Council meetings.

RECOMMENDATION: None

ATTACHMENT: None

Item No. 22
COUNCIL AGENDA: August 18, 2009

SUBJECT: COUNCILMEMBER REQUESTED AGENDA ITEM – Subjects for Discussion with Local Legislators in Sacramento

SOURCE: City Manager

COMMENT: At its meeting on August 4, 2009, Councilman Pedro “Pete” Martinez stated that he is planning to soon travel to Sacramento for the purposes of meeting with local area legislators. The Councilman indicated that he will be personally delivering a letter from himself as a member of the City Council concerning his personal opinions of the proposed legislation Senate Bill 54. In addition, the Councilman has invited the Council to authorize him to speak with the legislators on other issues as so commissioned by the Council (i.e., water, gangs, air quality, etc).

RECOMMENDATION: That the City Council consider potential issues for discussion, and authorize Councilman Martinez to speak on the behalf of the Council.

ATTACHMENT: None
SUBJECT: COUNCILMEMBER REQUESTED AGENDA ITEM – Letter of Opposition to State Senate Bill 802 (Leno)

SOURCE: Administration

COMMENT: At the appeal of the California League of Cities, Councilman Hamilton has requested that the City Council consider approving a letter of opposition to Senate Bill (SB) 802, which is legislation intended to limit retention proceeds to no more than a five percent (5%) rate. Currently, local agencies commonly utilize ten percent (10%) retention rates. The League has taken a position of opposition to this legislation due to no obvious reason to limit retention proceeds to the five percent rate, however, there are instances where five percent retention would be insufficient, particularly for smaller agencies.

RECOMMENDATION: None

ATTACHMENT: State Senate Bill 802 (Leno)
Draft Letter of Opposition
An act to amend Section 10261 of, and to add Section 7201 to, the Public Contract Code, relating to public contracts.

LEGISLATIVE COUNSEL'S DIGEST

SB 802, as introduced, Leno. Public contracts: retention proceeds.

(1) Existing law authorizes the Department of General Services, or any other department with authority to enter into contracts, to contract with suppliers for goods and services. Existing law provides that in a contract between the original contractor and a subcontractor, and in a contract between a subcontractor and any subcontractor thereunder, the percentage of retention proceeds withheld cannot exceed the percentage specified in the contract between the public entity and the original contractor.

This bill would instead prohibit retention proceeds to exceed 5% of the payment, as specified, for all contracts entered into on or after January 1, 2010, between a public entity, as defined, and an original contractor, between an original contractor and a subcontractor, and between all subcontractors thereunder.

(2) Existing law contains various provisions relating to contracts for the performance of public works of improvement, including provisions for the disbursing and withholding of retention proceeds. Existing law requires the Department of General Services to withhold not less than 5% of the contract price until final completion and acceptance of the project.

This bill would require the Department of General Services to withhold not more than 5% of the contract price until final completion and acceptance of the project.

The people of the State of California do enact as follows:

1 SECTION 1. Section 7201 is added to the Public Contract Code, to read:
2 7201. (a) (1) This section shall apply with respect to all contracts entered into on or after January 1, 2010, between a public entity and an original contractor, between an original contractor and a subcontractor, and between all subcontractors thereunder, relating to the construction of any public work of improvement.
3 (2) Under no circumstances shall any provision of this section be construed to limit the ability of any public entity to withhold 150 percent of the value of any disputed amount of work from the final payment, as provided for in subdivision (c) of Section 7107.
4 In the event of a good faith dispute, nothing in this section shall be construed to require a public entity to pay for work that is not approved or accepted in accordance with the proper plans or specifications.
5 (3) For purposes of this section, "public entity" means the state, including every state agency, office, department, division, bureau, board, or commission, the California State University, the University of California, a city, county, city and county, including chartered cities and chartered counties, district, special district, public authority, political subdivision, public corporation, or nonprofit transit corporation wholly owned by a public agency and formed to carry out the purposes of the public agency.
6 (b) (1) The retention proceeds withheld from any payment by a public entity from the original contractor, by the original contractor from any subcontractor, and by a subcontractor from any subcontractor thereunder shall not exceed 5 percent of the payment. In no event shall the total retention proceeds withheld exceed 5 percent of the contract price. In a contract between the original contractor and a subcontractor, and in a contract between a subcontractor and any subcontractor thereunder, the percentage of the retention proceeds withheld shall not exceed the percentage specified in the contract between the public entity and the original contractor.
(2) This subdivision shall not apply if the contractor provides written notice to the subcontractor, prior to or at the time that the bid is requested, that a bond may be required and the subcontractor subsequently is unable or refuses to furnish to the contractor a performance or payment bond issued by an admitted surety insurer.  

(c) A party identified in subdivision (a) shall not require any other party to waive any provision of this section.

SEC. 2. Section 10261 of the Public Contract Code is amended to read:

10261. Payments upon contracts shall be made as the department prescribes upon estimates made and approved by the department, but progress payments shall not be made in excess of 95 percent of the percentage of actual work completed plus a like percentage of the value of material delivered on the ground or stored subject to or under the control of the state, and unused, except as otherwise provided in this section. The department shall withhold not-less *more* than 5 percent of the contract price until final completion and acceptance of the project. However, at any time after 95 percent of the work has been completed, the department may reduce the funds withheld to an amount not less than 125 percent of the estimated value of the work yet to be completed, as determined by the department, if the reduction has been approved, in writing, by the surety on the performance bond and by the surety on the payment bond. The Controller shall draw his or her warrants upon estimates so made and approved by the department and the Treasurer shall pay them. The funds may be released by electronic transfer if that procedure is requested by the contractor, in writing, and if the public entity has, in place at the time of the request, the mechanism for the transfer.
August 13, 2009

Senator Mark Leno
State Capitol Building, Room 4061
Sacramento, CA 95814

Re: Notice of Opposition: SB 802 (Leno) – Public Contracts: Retention Proceeds

Dear Senator Leno:

On behalf of the City of Porterville, we wish to inform you of our adamant opposition to your Senate Bill (SB) 802 because it will limit a local agency’s ability to set retention rates to no more than 5% in public contracts.

Cities use retention in public contracts because it helps assure that work is done in compliance with the contract document and serves as a financial incentive for contractors to complete a project. In addition, should a contractor fail to perform or not complete the project, the retention funds can be used to cover the cost of project completion. For many local agencies, it also common practice to reduce the retention rate midway through a project to reward efficient project completion. Either way, local control over retention rates should be retained as a tool to ensure project completion is on-time and within budget.

SB 802 will limit the ability of public agencies to protect themselves by capping the level of retention proceeds and significantly raising the financial risks on construction projects. Because of this, the City of Porterville is officially opposing this bill.

Sincerely,

______________________________
Pete V. McCracken, Mayor

______________________________
Brian E. Ward
Vice Mayor

______________________________
Cameron J. Hamilton
Council Member

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Pedro R. Martinez
Council Member

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Felipe A. Martinez
Council Member

cc: Assembly Member Connie Conway
Senator Roy Ashburn
Governor Arnold Schwarzenegger, via fax #445-4633
Assembly Republican Caucus, via fax: #319-3902
League of California Cities, via fax: #916-658-8240