Dr. Christopher Harvey, Mayor
Emily Hill, Mayor Pro Tem, Place 1
Anne Weir, Place 2
Maria Amezcua, Place 3
Sonia Wallace, Place 4
Aaron Moreno, Place 5
Deja Hill, Place 6

City Council Regular Meeting

Wednesday, August 07, 2024 at 7:00 PM

Manor City Hall, Council Chambers, 105 E. Eggleston St.

AGENDA

This meeting will be live-streamed on Manor's YouTube Channel
You can access the meeting at https://www.youtube.com/@cityofmanorsocial/streams

CALL TO ORDER AND ANNOUNCE A QUORUM IS PRESENT

INVOCATION

PLEDGE OF ALLEGIANCE

EVENTS/ANNOUNCEMENTS

A. **Back to School Haircut Event, Sunday, August 11, 2024, at The Lab Barbershop, 201 E. Parsons St., Manor, Texas.**
Submitted by: Yalondra Valderrama Santana, Heritage & Tourism Manager

PUBLIC COMMENTS

Non-Agenda Item Public Comments (white card): Comments will be taken from the audience on non-agenda related topics for a length of time, not to exceed three (3) minutes per person.

Agenda Item Public Comments (yellow card): Comments will be taken from the audience on non-agenda and agenda items combined for a length of time, not to exceed five (5) minutes total per person on all items, except for Public Hearings. Comments on Public Hearing items must be made when the item comes before the Council and, not to exceed two (2) minutes per person. ***No Action or Discussion May be Taken by the City Council during Public Comments on Non-Agenda Items.***

To address the City Council, please complete the white or yellow card and present it to the City Secretary, or designee prior to the meeting.

CONSENT AGENDA

All of the following items on the Consent Agenda are considered to be self-explanatory by the Council and will be enacted with one motion. There will be no separate discussion of these items unless requested by the Mayor or a Council Member; in which event, the item will be removed from the consent agenda and considered separately.

1. **Consideration, discussion, and possible action to approve the City Council Minutes of July 31, 2024, City Council Workshop.**
   Submitted by: Lluvia T. Almaraz, City Secretary

2. **Consideration, discussion, and possible action on accepting the 2024 Third Quarter City Council Committee Reports.**
   Submitted by: Scott Moore, City Manager

   - **Park Committee**
   - **Economic Development Committee**
   - **Community Collaborative Committee**
   - **HealthCare Committee**
   - **Public Safety Committee**

3. **Consideration, discussion, and possible action on a Joint Agreement with Travis County for the November 5, 2024, General Election; and Authorize the Mayor to execute the agreement.**
   Submitted by: Lluvia T. Almaraz, City Secretary

4. **Consideration, discussion, and possible action on a Resolution ordering the November 5, 2024, General Election to elect a Mayor and three (3) Council Members of the City Council (Place Nos. 1, 3, and 5); and Authorize the Mayor to execute the Notice of General Election.**
   Submitted by: Lluvia T. Almaraz, City Secretary

5. **Consideration, discussion, and possible action on a Resolution authorizing the acquisition of an accessible voting system in compliance with state and federal laws through a service agreement with Travis County.**
   Submitted by: Lluvia T. Almaraz, City Secretary

6. **Consideration, discussion, and possible action on the insurance policies for dental, life, vision, and short-term disability for FY 2024-2025 between the City of Manor and Renaissance Life and Health Insurance Company of America.**
   Submitted by: Tracey Vasquez, HR Director

7. **Consideration, discussion, and possible action on the insurance policies for health benefits for FY 2024-2025 between the City of Manor and United Healthcare Insurance Company.**
   Submitted by: Tracey Vasquez, HR Director

REGULAR AGENDA

8. **Consideration, discussion, and possible action on approval of contractor and construction contract for the overlay of Lexington Street from Murray to US290.**
Submitted by: Matt Woodard, Public Works Director

9. **Consideration, discussion, and possible action on the City of Manor's Request for Proposals Solid Waste & Recycling Services RFP# 2024-07 and the submitted proposals.**
Submitted by: Scott Jones, Economic Development Director

10. **Consideration, discussion, and possible action on a Resolution establishing a city sponsorship program; approving the policy and agreement; approving the application process; approving the amount of funding allocated for events and providing for related matters.**
Submitted by: Yalondra M. Valderrama Santana, Heritage & Tourism Manager

11. **Consideration, discussion, and possible action on a Website Services Agreement with CivicPlus.**
Submitted by: Scott Moore, City Manager

12. **Second and Final Reading: Consideration, discussion, and possible action on an Ordinance rezoning the Monarch Ranch Subdivision, being 134.53 acres, more or less, and located at the southwest corner of the intersection at Gregg Lane and FM 973, Manor, TX from Planned Unit Development (PUD) to Planned Unit Development (PUD).**
Applicant: SEC Planning
Owner: Blackburn Group LLC
Submitted by: Scott Dunlop, Development Services Director

13. **Consideration, discussion, and possible action on the Third Amendment to the Development Agreement Establishing Development Standards for Monarch Ranch.**
Submitted by: Scott Dunlop, Development Services Director

14. **Second and Final Reading: Consideration, discussion, and possible action on an Ordinance rezoning one (1) lot on 0.31 acres, more or less, and being located near the intersection of Gregg Manor Road and West Eggleston Street, Manor, TX from (C-1) Light Commercial to Multi-Family 25 (MF-2).**
Applicant: MWSW LLP
Owner: DD&B Construction Inc.
Submitted by: Scott Dunlop, Development Services Director

15. **Consideration, discussion, and possible action on authorizing a letter of support to the Central Texas Regional Mobility Authority for U.S. 290 Highway Improvements.**
Submitted by: Scott Moore, City Manager

EXECUTIVE SESSION

The City Council will now Convene into executive session pursuant to the provisions of Chapter 551 Texas Government Code, in accordance with the authority contained in:

- Sections 551.071 and 551.072, Texas Government Code, and Section 1.05, Texas Disciplinary Rules of Professional Conduct to consult with legal counsel and to deliberate the purchase of real property;

- Sections 551.071 Texas Government Code, and Section 1.05, Texas Disciplinary Rules of Professional Conduct to consult with legal counsel regarding Shadowglen PUD;

- Section 551.071 Texas Government Code and Section 1.05, Texas Disciplinary Rules of Professional Conduct to consult with legal counsel regarding the Hibbs Lane Parcel;and

- Section 551.071 Texas Government Code and Section 1.05, Texas Disciplinary Rules of Professional Conduct to consult with legal counsel regarding the Vaughn 347 acre tract

OPEN SESSION

The City Council will now reconvene into Open Session pursuant to the provisions of Chapter 551 Texas Government Code and take action, if any, on item(s) discussed during Closed Executive Session.

ADJOURNMENT

In addition to any executive session already listed above, the City Council reserves the right to adjourn into executive session at any time during the course of this meeting to discuss any of the matters listed above, as authorized by Texas Government Code Section §551.071 (Consultation with Attorney), §551.072 (Deliberations regarding Real Property), §551.073 (Deliberations regarding Gifts and Donations), §551.074 (Personnel Matters), §551.076 (Deliberations regarding Security Devices) and §551.087 (Deliberations regarding Economic Development Negotiations).

CONFLICT OF INTEREST

In accordance with Section 12.04 (Conflict of Interest) of the City Charter, "No elected or appointed officer or employee of the city shall participate in the deliberation or decision on any issue, subject or matter before the council or any board or commission, if the officer or employee has a personal financial or property interest, direct or indirect, in the issue, subject or matter that is different from that of the public at large. An interest arising from job duties, compensation or benefits payable by the city shall not constitute a personal financial interest."

Further, in accordance with Chapter 171, Texas Local Government Code (Chapter 171), no City Council member and no City officer may vote or participate in discussion of a matter involving a business entity or real property in which the City Council member or City officer has a substantial interest (as defined by Chapter 171) and action on the matter will have a special economic effect on the business entity or real property that is distinguishable from the effect on the general public. An affidavit disclosing the conflict of interest must be filled out and filed with the City Secretary before the matter is discussed.

POSTING CERTIFICATION

I, the undersigned authority do hereby certify that this Notice of Meeting was posted on the bulletin board, at the City Hall of the City of Manor, Texas, a place convenient and readily accessible to the general public at all times and said Notice was posted on the following date and time: Friday, August 2, 2024, by 5:00 PM and remained so posted continuously for at least 72 hours preceding the scheduled time of said meeting.

/s/ Lluvia T. Almaraz, TRMC
City Secretary for the City of Manor, Texas

NOTICE OF ASSISTANCE AT PUBLIC MEETINGS:

The City of Manor is committed to compliance with the Americans with Disabilities Act. Manor City Hall and the Council Chambers are wheelchair accessible and accessible parking spaces are available. Requests for accommodations or interpretive services must be made 10 days prior to this meeting. Please contact the City Secretary at 512.215.8285 or e-mail lalmaraz@manortx.gov

BACK TO SCHOOL HAIRCUT

AUG 11 | 10AM-4PM

The Lab Barbershop,
201 E Parsons St. Manor TX

- FREE HAIRCUTS FOR SCHOOL AGE KIDS
  1ST COME 1ST SERVE
- BOUNCY HOUSE & FUN GAMES
- FREE FOOD & DRINKS

THE LAB EST 2020

MANOR EST. TEXAS 1872

For more information contact J'Rod Franks @ (512) 709-6744

AGENDA ITEM NO. _____

AGENDA ITEM SUMMARY FORM

PROPOSED MEETING DATE: August 7, 2024
PREPARED BY: Lluvia T. Almaraz, City Secretary
DEPARTMENT: Administration

AGENDA ITEM DESCRIPTION:
Consideration, discussion, and possible action to approve the City Council Minutes of July 31, 2024, City Council Workshop.

BACKGROUND/SUMMARY:

LEGAL REVIEW: Not Applicable
FISCAL IMPACT: No
PRESENTATION: No
ATTACHMENTS: Yes

- July 31, 2024, City Council Workshop Minutes

STAFF RECOMMENDATION:
The city staff recommends that the City Council approve the City Council Meeting minutes as presented.

PLANNING & ZONING COMMISSION: **Recommend Approval** **Disapproval** **None**

CITY COUNCIL
WORKSHOP SESSION MINUTES
JULY 31, 2024

PRESENT:

Dr. Christopher Harvey, Mayor

COUNCIL MEMBERS:

Emily Hill, Mayor Pro Tem, Place 1
Anne Weir, Place 2
Maria Amezcua, Place 3 (arrived at 7:33 p.m.)
Sonia Wallace, Place 4
Aaron Moreno, Place 5
Deja Hill, Place 6

CITY STAFF:

Scott Moore, City Manager
Lluvia T. Almaraz, City Secretary
Ryan Phipps, Chief of Police
Tracey Vasquez, HR Director
Scott Jones, Economic Development Director
Belen Peña, Finance Director
Phil Green, IT Director

WORKSHOP SESSION – 7:00 P.M.

With a quorum of the Council Members present, the workshop session of the Manor City Council was called to order by Mayor Harvey at 7:03 p.m. on Wednesday, July 31, 2024, in the Manor City Hall, 105 E. Eggleston St., Manor, Texas.

A. Discussion of the Proposed FY24-25 Annual Budget

Scott Moore, City Manager, and Belen Peña, Finance Director, discussed the attached PowerPoint presentation.

The topic of Discussion:

- Proposed Budget

Draft Minutes

- Debt Service Obligations
- Annual Debt
- Ad Valorem Rate/Revenue Comparisons
- Sales Tax Collection
- Hot Tax Collection
- Findings/Observation Notes
- Tax Rate

There was no action taken.

ADJOURNMENT

The Manor City Council Workshop Session Adjourned at 8:20 p.m. on Wednesday, July 31, 2024.

The Manor City Council approved these minutes on August 7, 2024.

APPROVED:

_____
Dr. Christopher Harvey
Mayor

ATTEST:

_____
Lluvia T. Almaraz, TRMC
City Secretary

Draft Minutes

PROPOSED BUDGET

FISCAL YEAR 2024-2025

PREPARED BY: FINANCE DEPARTMENT

WORKSHOP 7/31/2024

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FY 2024-2025 Proposed Annual Budget

10 -GENERAL FUND FINANCIAL SUMMARY						Proposed	Annual BUDGET FY 2024-25
				50.00 % OF YEAR COMPLETE			
REVENUE SUMMARY	FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	REQUESTED 2024-25 BUDGET
ADMINISTRATION							
TAXES	10,665,656	12,574,806	13,927,200	12,225,431	87.78	1,701,769	**15,643,100**
MISCELLANEOUS	3,268,638	(121,657)	31,810	38,359	120.59	(6,549)	**36,900**
PERMITS/LICENSES	3,975	420	6,290	60	0.95	6,230	**6,300**
OTHER	157,345	1,731,667	1,242,646	882,606	71.03	360,040	**1,485,000**
TOTAL ADMINISTRATION	14,095,614	14,185,236	15,207,946	13,146,456	86.44	2,061,490	**17,171,300**
STREET							
MISCELLANEOUS	105,018	586,479	187,474	8,752	4.67	178,722	**174,000**
SANITATION CHARGES	1,470,042	1,663,397	1,120,000	885,773	79.09	234,227	**1,775,000**
TOTAL STREET	1,575,059	2,249,876	1,307,474	894,525	68.42	412,949	**1,949,000**
DEVELOPMENT SERVICES							
MISCELLANEOUS	51,078	53,299	54,310	20,182	37.16	34,128	**42,000**
PERMITS/LICENSES	3,550,779	2,476,132	2,374,211	1,928,130	81.21	446,081	**2,303,100**
TOTAL DEVELOPMENT SERVICES	3,601,857	2,529,430	2,428,521	1,948,313	80.23	480,208	**2,345,100**
PARKS/RECREATIONS							
MISCELLANEOUS	40,000	40,000	0	0	0.00	0	**-**
TOTAL PARKS/RECREATION	40,000	40,000	0	0	0.00	0	**-**
COURT							
MISCELLANEOUS	2,294	2,236	1,400	1,860	132.86	(460)	**2,000**
COURT FEES	523,039	529,897	419,037	466,603	111.35	(47,566)	**531,200**
TOTAL COURT	525,333	532,133	420,437	468,463	111.42	(48,026)	**533,200**

FY 2024-2025 Proposed Annual Budget

POLICE							
MISCELLANEOUS	66,004	97,331	42,513	44,193	103.95	(1,680)	**35,000**
POLICE CHARGES/FEES	74,953	62,377	76,138	163,732	215.05	(87,594)	**72,000**
TOTAL POLICE	140,956	159,707	118,651	207,925	175.24	(89,274)	**107,000**
ECONOMIC DEV. SERVICES							
TAXES	1,132	0	0	0	0.00	0	-
TOTAL ECONOMIC DEV. SERVICES	1,132	0	0	0	0.00	0	-
COMMUNITY DEV. SERV.							
PERMITS/LICENSES	0	0	0	0	0.00	0	**8,000**
TOTAL COMM. DEV. SERVICES	0	0	0	0	0.00	0	**8,000**
NON-DEPARTMENTAL							
TRANSFERS	0	0	315,105	0	0.00	315,105	-
TOTAL NON-DEPARTMENTAL	0	0	315,105	0	0.00	315,105	-
TOTAL REVENUES	**19,979,952**	**19,696,382**	**19,798,134**	**16,665,682**	**84**	**3,132,452**	**22,113,600**

FY2024-2025 PROPOSED ANNUAL BUDGET

10 -GENERAL FUND
REVENUES

50.00 % OF YEAR COMPLETE

ADMINISTRATION REVENUES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	Proposed Annual Budget FY 2024-25 REQUESTED 2024-25 BUDGET
TAXES								
10-4100-40-40000	AD VALOREM TAXES - CURRENT	7,254,552	8,787,133	10,271,817	10,217,836	99.47	53,981	**11,682,073**
10-4100-40-40010	AD VALOREM TAXES - PRIOR	81,418	13,158	35,000	12,245	34.99	22,755	**25,000**
10-4100-40-40015	RENDITION PAYMENTS	-	-	-	-	-	-	**0**
10-4100-40-40016	VEHICLE DEALER INVENTORY	13,291	7,188	7,188	-	-	7,188	**2,000**
10-4100-40-40020	AD VALOREM TAXES P&I	73,682	31,374	50,000	33,760	67.52	16,240	**50,000**
10-4100-40-40025	SALES TAX COMPTROLLER	2,381,579	2,808,340	2,561,190	1,458,947	56.96	1,102,243	**2,900,000**
10-4100-40-40040	FRANCHISE TAX-ELECTRIC	354,850	409,658	430,000	262,309	61.00	167,691	**430,000**
10-4100-40-40043	FRANCHISE TAX-CABLE TE	134,899	100,060	96,000	45	0.05	95,955	**96,000**
10-4100-40-40044	FRANCHISE PEG TAX - CABLE TV	26,644	13,689	13,700	35,731	260.81	(22,031)	**13,700**
10-4100-40-40045	FRANCHISE TAX-GAS/PROP	40,544	59,684	60,000	15,130	25.22	44,870	**60,000**
10-4100-40-40047	FRANCHISE TAX-TELEPHONE	17,192	67,311	60,000	54,128	90.21	5,872	**60,000**
10-4100-40-40050	FRANCHISE TAX-SOLID WASTE	265,003	245,414	318,000	129,137	40.61	188,863	**300,000**
10-4100-40-40051	SIGN KIOSK FEES	3,285	3,750	4,000	2,695	67.38	1,305	**4,000**
10-4100-40-40060	MIXED BEVERAGE TAXES	15,469	26,638	18,000	2,021	11.23	15,979	**18,000**
10-4100-40-40061	OPEN RECORD FEES	3,250	1,410	2,305	1,445	62.71	860	**2,327**
TOTAL TAXES		10,665,656	12,574,806	13,927,200	12,225,431	87.78	1,701,769	**15,643,100**
MISCELLANEOUS								
10-4100-42-42070	CITY MERCH	2,750	2,084	2,000	199	9.95	1,801	**2,000**
10-4100-42-42099	MISCELLANEOUS	3,265,888	(135,081)	20,000	33,570	167.85	(13,570)	**25,000**
10-4100-42-42100	GRANTS	-	-	-	-	-	-	**0**
10-4100-42-42200	VERIZON LEASE AGREEMENT	-	11,340	9,810	4,590	46.79	5,220	**9,900**
10-4100-42-42500	DONATIONS	-	-	-	-	-	-	**0**
10-4100-42-48100	UNCLAIMED PROPERTY	-	-	-	-	-	-	**0**
TOTAL MISCELLANEOUS		3,268,638	(121,657)	31,810	38,359	120.59	(6,549)	**36,900**

PERMITS/LICENSES								
10-4100-45-42010	PERMITS-PET	100	30	440	-	-	440	**450**
10-4100-45-42020	HEALTH PERMITS	-	-	-	-	-	-	**0**
10-4100-45-42040	PERMITS- CITY MISC	-	40	150	-	-	150	**150**
10-4100-45-42050	LICENSES- ALCHOLIC BEV	3,875	350	5,700	60	1.05	5,640	**5,700**
TOTAL PERMITS/LICENSES		3,975	420	6,290	60	0.95	6,230	**6,300**
OTHER								
10-4100-48-42050	NOTARY FEES	322	162	129	-	-	129	**130**
10-4100-48-48000	INTEREST INCOME	157,023	1,731,505	1,242,517	882,606	71.03	359,911	**1,484,870**
TOTAL OTHER		157,345	1,731,667	1,242,646	882,606	71.03	360,040	**1,485,000**
TOTAL ADMINISTRATION REVENUES		**14,095,614**	**14,185,236**	**15,207,946**	**13,146,456**	**86.44**	**2,061,490**	**17,171,300**

STREET REVENUES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
MISCELLANEOUS								
10-4225-42-42098	CAP METRO BCT	84,500	84,500	169,000	-	-	169,000	**169,000**
10-4225-42-42099	MISCELLANEOUS	20,518	501,979	18,474	8,752	47.37	9,722	**5,000**
TOTAL MISCELLANEOUS		105,018	586,479	187,474	8,752	4.67	178,722	**174,000**
SANITATION CHARGES								
10-4225-44-44010	SOLID WASTE REVENUE	1,445,928	1,637,789	1,100,000	871,604	79.24	228,396	**1,750,000**
10-4225-44-44025	LATE FEES TRASH	24,113	25,608	20,000	14,169	70.85	5,831	**25,000**
TOTAL SANITATION CHARGES		1,470,042	1,663,397	1,120,000	885,773	79.09	234,227	**1,775,000**
TOTAL STREET REVENUES		**1,575,059**	**2,249,876**	**1,307,474**	**894,525**	**68.42**	**412,949**	**1,949,000**

FY2024-2025 PROPOSED ANNUAL BUDGET

DEVELOPMENT SERVICES REVENUES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
MISCELLANEOUS								
10-4300-42-42090	TECHNOLOGY FEES	40,530.00	31,939	34,000	16,020	47.12	17,980	**34,000**
10-4300-42-42091	ONLINE PAYMENT FEE	5,028.00	5,260	4,310	2,964	68.77	1,346	**5,000**
10-4300-42-42092	FILMING PROJECT FEES	100.00	-		-	-	-	**0**
10-4300-42-42099	MISCELLANEOUS	5,000.00	15,000	15,000	1,198	7.99	13,802	**2,000**
10-4300-42-42100	RETURN CHECK FEE	420.00	1,100	1,000	-	-	1,000	**1,000**
TOTAL MISCELLANEOUS		51,078	53,299	54,310	20,182	37.16	34,128	**42,000**
PERMITS/LICENSES								
10-4300-45-42040	PERMITS-CITY MISC.	-	-	-	-	-	-	**0**
10-4300-45-44095	SIGN PERMITS	1,686	3,423	3,083	1,802	58.44	1,281	**3,000**
10-4300-45-44096	SITE PLAN	28,061	31,384	26,936	28,661	106.40	(1,725)	**30,000**
10-4300-45-44097	NOTIFICATIONS	7,975	11,285	7,525	4,730	62.86	2,795	**8,000**
10-4300-45-45000	DEVELOPER FUNDINGS	-	-	-	-	-	-	**0**
10-4300-45-45050	PLAT AND PLAN FEES	171,739	95,195	160,000	82,195	51.37	77,805	**125,000**
10-4300-45-45075	BLDG. PLAN REVIEW	-	-	100	-	-	100	**0**
10-4300-45-45076	SUBDIVISION TEST & INSP	542,181	552,681	565,000	525,795	93.06	39,205	**475,000**
10-4300-45-45077	ZONING	8,130	15,088	9,217	3,356	36.41	5,861	**9,000**
10-4300-45-45100	BUILDING PERMITS	1,985,122	1,102,307	1,000,000	922,505	92.25	77,495	**1,000,000**
10-4300-45-45101	R.O.W. PEMITS	1,800	1,500	2,250	637	28.29	1,613	**1,500**
10-4300-45-45102	GAMING MACHINES	-	-	-	1,600	-	(1,600)	**1,600**
10-4300-45-45200	BUILDINGS INSPECTION FEES	799,085	663,269	600,000	356,850	59.48	243,150	**600,000**
10-4300-45-45500	PROFESSIONAL DEPOSIT FEES	-	-	100	-	-	100	**0**
10-4300-45-45501	W/WW FEASIBILITY STUDY	5,000	-	-	-	-	-	**50,000**
TOTAL PERMITS/LICENSES		3,550,779	2,476,132	2,374,211	1,928,130	81.21	446,081	**2,303,100**
TOTAL DEVELOPMENT SERVICES REVENUES		**3,601,857**	**2,529,430**	**2,428,521**	**1,948,313**	**80.23**	**480,208**	**2,345,100**

FY2024-2025 PROPOSED ANNUAL BUDGET

PARKS/RECREATION		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
MISCELLANEOUS								
10-4400-42-42101	PARK LAND MAINT PMNTS	40,000	40,000	-	-	-	-	**0**
TOTAL MISCELLANEOUS		40,000	40,000	-	-	-	-	**0**
TOTAL PARKS REVENUES		**40,000**	**40,000**	**-**	**-**	**-**	**-**	**0**

COURT REVENUES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
10-4500-42-42090	ONLINE PAYMENT FEES	2,294	2,236	1,400	1,860	132.86	(460)	**2,000**
TOTAL MISCELLANEOUS		2,294	2,236	1,400	1,860	132.86	(460)	**2,000**
COURT FEES								
10-4500-46-46100	COURT TECHNOLOGY FEE	6,842	7,142	12,000	6,912	57.60	5,088	**12,000**
10-4500-46-46200	COURT BUILDING SECURITY	7,815	8,292	8,600	8,259	96.03	341	**9,000**
10-4500-46-46300	COURT COSTS EARNED	501,178	506,584	393,028	443,178	112.76	(50,150)	**500,000**
10-4500-46-46301	JUVENILLE CASE MGR FUND	7,063	7,724	5,303	8,092	152.60	(2,789)	**10,000**
10-4500-46-46302	JURY FUND	141	155	106	162	152.59	(56)	**200**
TOTAL COURT FEES		523,039	529,897	419,037	466,603	111.35	(47,566)	**531,200**
TOTAL COURT REVENUES		**525,333**	**532,133**	**420,437**	**468,463**	**111.42**	**(48,026)**	**533,200**

POLICE REVENUES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
MISCELLANEOUS								
10-4600-42-41015	GRANT PROCEEDS - POLIC	1,064	5,380	22,513	-	-	22,513	**5,000**
10-4600-42-42099	MISCELLANEOUS	64,940	91,951	20,000	44,193	220.97	(24,193)	**30,000**
TOTAL MISCELLANEOUS		66,004	97,331	42,513	44,193	103.95	(1,680)	**35,000**

POLICE CHARGES/FEES								
10-4600-47-47000	ASSET SEIZURES	-	-	1,250	-	-	1,250	**0**
10-4600-47-47009	ALARM PERMIT	7,780	5,985	7,000	3,410	48.71	3,590	**5,000**
10-4600-47-47010	POLICE REPORTS	6	-	-	-	-	-	**0**
10-4600-47-47011	FINGER PRINTING	350	165	190	10	5.26	180	**190**
10-4600-47-47110	MOTOR VEHICLE DISB	14,958	16,888	12,288	8,155	66.37	4,133	**15,810**
10-4600-47-47200	WARRANT AND FTA FEES	31	62	2,410	112	4.66	2,298	**8,000**
10-4600-47-47310	IMPOUNDS	24,420	25,725	23,000	33,165	144.20	(10,165)	**23,000**
10-4600-47-47325	AUCTIONS	-	-	-	99,563	-	(99,563)	**5,000**
10-4600-47-47400	POLICE CAR RENTAL INCO	27,407	13,551	30,000	19,316	64.39	10,684	**15,000**
TOTAL POLICE CHARGES/FEES		74,953	62,377	76,138	163,732	215.05	(87,594)	**72,000**
TOTAL POLICE REVENUES		**140,956**	**159,707**	**118,651**	**207,925**	**175.24**	**(89,274)**	**107,000**

ECONOMIC DEV. SERVICES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2020-21 CURR. BUDGET	YTD ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
TAXES								
10-4800-40-40040	EVENT FEES	1,132	-	-	-	-	-	**0**
TOTAL ECONOMIC DEV. SERVICES		1,132	-	-	-	-	-	**-**
TOTAL ECONOMIC DEV. SVCS REVENUE		**1,132**	**-**	**-**	**-**	**-**	**-**	**0**

COMMUNITY DEV. SERVICES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
PERMITS/LICENSES								
10-4811-45-42040	VENDORS FEES	-		-	-	-	-	**8,000**
TOTAL PERMITS/LICENSES		-		-	-	-	-	**8,000**
TOTAL COMMUNITY DEV. SVCS REVENUE		**-**	**-**	**-**	**-**	**-**	**-**	**8,000**

FY2024-2025 PROPOSED ANNUAL BUDGET

NON-DEPARTMENTAL		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
TRANSFERS								
10-4999-49-50005	TRANSFERS IN	-	-	315,105	-	-	315,105	**0**
10-4999-49-50010	TRANSFERS FROM CPF	-	-	-	-	-	-	**0**
10-4999-49-59000	TRANSFERS FROM UF	-	-	-	-	-	-	**0**
TOTAL TRANSFERS		-	-	315,105	-	-	315,105	**0**
TOTAL NON-DEPARTMENTAL REVENUES		**-**	**-**	**315,105**	**-**	**-**	**315,105**	**0**
TOTAL REVENUES		**19,979,952**	**19,696,382**	**19,798,134**	**16,665,682**	**84.18**	**3,132,452**	**22,113,600**

FY 2024-2025 Proposed Annual Budget

10 -GENERAL FUND FINANCIAL SUMMARY						Proposed	Annual BUDGET FY 2024-25
				50.00 % OF YEAR COMPLETE			
EXPENDITURE SUMMARY	FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	REQUESTED 2024-25 BUDGET
COUNCIL							
PERSONNEL	0	0	0	0	0.0	0	**260,938**
OPERATING	0	0	360,000	0	0.0	360,000	**353,000**
TOTAL COUNCIL	0	0	360,000	0	0.0	360,000	**613,938**
ADMINISTRATION							
PERSONNEL	298,109	389,016	498,583	287,518	57.7	211,065	**571,529**
OPERATING	253,534	636,457	437,799	141,834	32.4	295,965	**118,500**
REPAIRS & MAINTENANCE	29,394	44,322	38,600	2,165	5.6	36,435	**38,600**
CONTRACTED SERVICES	647,448	1,421,326	1,052,300	709,613	67.4	342,687	**1,044,264**
TOTAL ADMINISTRATION	1,228,485	2,491,121	2,027,282	1,141,131	56.3	886,151	**1,772,893**
FINANCE							
PERSONNEL	530,095	589,774	761,499	204,887	26.9	556,612	**917,165**
OPERATING	239,647	276,799	237,680	118,130	49.7	119,550	**154,190**
REPAIRS & MAINTENANCE	1,060	11,371	3,000	6,934	231.1	(3,934)	**5,000**
CONTRACTED SERVICES	60,220	46,278	63,200	5,476	8.7	57,724	**69,300**
DEBT PAYMENTS	0	5,052	20,000	12,097	60.5	7,903	**25,000**
TOTAL FINANCE	831,022	929,272	1,085,379	347,524	32.0	737,855	**1,170,655**
STREET							
PERSONNEL	376,747	469,062	675,637	294,559	43.6	381,078	**728,873**
OPERATING	248,156	272,988	248,670	165,942	66.7	82,728	**261,200**
REPAIRS & MAINTENANCE	241,471	153,677	190,000	31,262	16.5	158,738	**192,000**
CONTRACTED SERVICES	2,351,517	2,345,380	2,782,800	1,807,786	65.0	975,014	**2,805,000**
DEBT PAYMENTS	86,169	711,029	235,302	204,614	87.0	30,688	**85,000**
CAPITAL OUTLAY < $5K	5,353	230,244	10,000	1,362	13.6	8,638	**10,000**
CAPITAL OUTLAY > $5K	34,150	7,362	10,000	0	0.0	10,000	**170,000**
TOTAL STREET	3,343,562	4,189,741	4,152,409	2,505,525	60.3	1,646,884	**4,252,073**

FY 2024-2025 Proposed Annual Budget

DEVELOPMENT SERVICES							
PERSONNEL	468,677	642,965	948,227	383,431	40.4	564,796	**965,702**
OPERATING	169,618	163,611	219,915	42,875	19.5	177,040	**204,100**
REPAIRS & MAINTENANCE	1,216	12,562	4,400	632	14.4	3,768	**4,000**
CONTRACTED SERVICES	355,283	544,221	310,000	160,949	51.9	149,051	**440,000**
DEBT PAYMENTS	6,458	11,676	28,500	25,304	88.8	3,196	**28,500**
TOTAL DEVELOPMENT SERVICES	1,001,252	1,375,035	1,511,042	613,191	40.6	897,851	**1,642,302**
PARKS							
PERSONNEL	322,340	474,016	606,628	290,887	48.0	315,741	**630,953**
OPERATING	38,408	39,926	54,650	28,794	52.7	25,856	**85,000**
REPAIRS & MAINTENANCE	467,959	150,413	341,000	21,363	6.3	319,637	**344,000**
CONTRACTED SERVICES	1,518	15,457	12,000	0	0.0	12,000	**86,000**
DEBT PAYMENTS	32,371	6,458	54,518	6,458	11.8	48,060	**75,300**
GRANT EXPENDITURES	0	0	10,000	0	0.0	10,000	**10,000**
CAPITAL OUTLAY < $5K	716	5,774	8,250	1,135	13.8	7,115	**8,200**
CAPITAL OUTLAY > $5K	209,951	13,393	25,000	0	0.0	25,000	**50,000**
TOTAL PARKS	1,073,263	705,436	1,112,046	348,636	132.5	763,410	**1,289,453**
COURT							
PERSONNEL	223,998	250,224	351,113	105,712	30.1	245,401	**317,335**
OPERATING	41,256	24,743	52,245	25,741	49.3	26,504	**63,000**
CONTRACTED SERVICES	189,505	197,352	181,198	84,071	46.4	97,127	**209,500**
CAPITAL OUTLAY < $5K	0	0	1,620	0	0.0	1,620	**-**
CAPITAL OUTLAY > $5K	0	7,890	13,307	0	0.0	13,307	**-**
TOTAL COURT	454,758	480,209	599,483	215,524	36.0	383,959	**589,835**
POLICE							
PERSONNEL	3,354,040	3,735,317	4,963,923	2,216,425	44.7	2,747,498	**5,599,762**
OPERATING	436,095	569,353	709,878	221,782	31.2	488,096	**731,300**
REPAIRS & MAINTENANCE	191,292	129,424	111,500	76,328	68.5	35,172	**211,500**
CONTRACTED SERVICES	284,674	324,980	393,349	370,771	94.3	22,578	**456,000**
DEBT PAYMENTS	410,105	622,995	565,500	159,410	28.2	406,090	**565,500**
CAPITAL OUTLAY < $5K	865	1,052	1,000	250	25.0	750	**1,000**
CAPITAL OUTLAY > $5K	48,583	265,509	323,659	335,298	103.6	(11,639)	**459,000**
TOTAL POLICE	4,725,654	5,648,628	7,068,809	3,380,263	47.8	3,688,546	**8,024,062**

FY 2024-2025 Proposed Annual Budget

INFORMATION TECHNOLOGY (I.T.)							
PERSONNEL	174,122	251,597	310,448	156,630	50.5	153,818	**325,858**
OPERATING	221,183	221,145	251,600	130,460	51.9	121,140	**298,400**
REPAIRS & MAINTENANCE	4,514	6,611	5,000	4,408	88.2	592	**15,000**
CONTRACTED SERVICES	217,781	279,299	274,371	149,479	54.5	124,892	**439,000**
DEBT PAYMENTS	0	0		2,868	0.0	(2,868)	
CAPITAL OUTLAY < $5K	72,394	51,019	45,000	4,483	10.0	40,517	**50,000**
CAPITAL OUTLAY > $5K	16,794	30,205	109,884	74,063	67.4	35,821	**115,000**
TOTAL I.T	706,788	839,874	996,303	522,392	52.4	473,911	**1,243,258**
ECONOMIC DEV. SVCS							
PERSONNEL	175,499	155,381	174,112	74,337	42.7	99,775	**166,446**
OPERATING	134,022	26,849	86,300	29,919	34.7	56,381	**130,500**
CONTRACT SERVICES	11,175	28,100	406,000	60,286	14.8	345,715	**375,000**
TOTAL ECONOMIC DEV SVCS	320,696	210,330	666,412	164,542	24.7	501,870	**671,946**
HUMAN RESOURCES							
PERSONNEL	124,619	176,157	230,871	105,388	45.6	125,483	**232,905**
OPERATING	21,756	59,762	65,600	19,981	30.5	45,619	**63,100**
CONTRACTED SERVICES	0	1,770	5,000	2,508	50.2	2,493	**5,000**
TOTAL HUMAN RESOURCES	146,375	237,689	301,471	127,876	42.4	173,595	**301,005**
COMMUNITY DEV. SVCS							
PERSONNEL	814	93,630	120,649	18,241	15.1	102,408	**101,857**
OPERATING	0	121,730	156,850	167,144	106.6	(10,294)	**440,323**
TOTAL COMMUNITY DEV	814	215,360	277,499	185,385	66.8	92,114	**542,180**
TOTAL EXPENDITURES	**13,832,671**	**17,322,697**	**19,798,135**	**9,551,989**	**48.25**	**10,246,146**	**22,113,600**
REVENUES OVER/(UNDER) EXPENDITURES	**6,147,282**	**2,373,685**	**(1)**	**7,113,693**		**(7,113,694)**	**0**

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FY2024-2025 PROPOSED ANNUAL BUDGET

10 -GENERAL FUND
DEPARTMENTAL EXPENDITURES

Proposed Annual Budget FY 2024-25

50.00 % OF YEAR COMPLETE

COUNCIL EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
PERSONNEL								
10-5175-50-50010	SALARIES	-	-	-	-	-	-	**222,000**
10-5175-50-50200	EMPLOYER PAID TAXES	-	-	-	-	-	-	**16,983**
10-5175-50-50255	WORKERS' COMPENSATION	-	-	-	-	-	-	**955**
10-5175-50-50521	COUNCIL EDUCATION	-	-	-	-	-	-	**21,000**
TOTAL PERSONNEL		-	-	-	-	-	-	**260,938**
OPERATING								
10-5175-51-51018	COMMUNITY PROGRAMS	-	-	-	-	-	-	**300,000**
10-5175-51-51160	ELECTION EXPENSES	-	-	-	-	-	-	**20,000**
10-5175-51-51480	MEETING EXPENSES	-	-	-	-	-	-	**7,500**
10-5175-51-51746	SUPPLIES-OFFICE	-	-	-	-	-	-	**500**
10-5175-51-51790	COUNCIL TRAVEL	-	-	-	-	-	-	**25,000**
TOTAL OPERATING		-	-	-	-	-	-	**353,000**
TOTAL COUNCIL EXPENSES		**-**	**-**	**-**	**-**	**-**	**-**	**613,938**

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FY2024-2025 PROPOSED ANNUAL BUDGET

50.00 % OF YEAR COMPLETE

ADMINISTRATION EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
PERSONNEL								
10-5100-50-50010	SALARIES	209,421	287,563	352,040	220,186	62.55	131,854	**438,435**
10-5100-50-50050	OVERTIME	589	-	708	-	-	708	**1,092**
10-5100-50-50075	LONGEVITY	1,000	700	1,000	800	80.00	200	**1,200**
10-5100-50-50200	EMPLOYER PAID TAXES	15,560	22,406	27,319	13,637	49.92	13,682	**33,716**
10-5100-50-50255	WORKERS' COMPENSATION	156	168	170	1,067	627.43	(897)	**1,807**
10-5100-50-50325	HEALTH INSURANCE	24,481	31,040	45,185	17,269	38.22	27,916	**41,396**
10-5100-50-50335	HEALTH ASSISTANCE	-	-	260	4,500	1,730.77	(4,240)	**4,500**
10-5100-50-50410	EMPLOYER RETIREMENT CO	18,234	24,693	30,155	13,281	44.04	16,874	**34,883**
10-5100-50-50520	EMPLOYEE EDUCATION	2,703	4,588	5,360	1,898	35.42	3,462	**7,000**
10-5100-50-50521	COUNCIL EDUCATION	21,866	10,659	22,886	9,066	39.61	13,820	**0**
10-5100-50-50650	VEHICLE ALLOWANCE	4,098	7,200	13,000	5,815	44.73	7,185	**7,500**
10-5100-50-50700	REIMBURSABLE UNEMPLOYM	-	-	500	-	-	500	**0**
TOTAL PERSONNEL		298,109	389,016	498,583	287,518	57.67	211,065	**571,529**
OPERATING								
10-5100-51-51010	ADVER/NOTIFICATION/PUBLIC HEA	22,429	9,933	14,500	5,104	35.20	9,396	**14,500**
10-5100-51-51011	PRE-EMPLO SCREENING	67	1	50	1	2.00	49	**50**
10-5100-51-51012	ADMIN RENT	5,517	5,510	3,800	3,000	78.95	800	**6,000**
10-5100-51-51018	COMMUNITY PROGRAMS	-	94,396	300,000	15,092	5.03	284,908	**0**
10-5100-51-51043	CITY EVENTS	15,595	10,907	15,000	1,087	7.25	13,913	**0**
10-5100-51-51044	AUTHORIZE.NET FEES	151	330	210	120	57.14	90	**210**
10-5100-51-51160	ELECTION EXPENSES	47,690	20,792	7,000	24,618	351.68	(17,618)	**0**
10-5100-51-51335	INSURANCE-PROPERTY, CA	990	1,106	1,110	1,191	107.30	(81)	**8,000**
10-5100-51-51339	INSURANCE-SPECIAL EVENTS	-	424	180	-	-	180	**180**
10-5100-51-51480	MEETING EXPENSES	8,491	6,578	7,500	3,223	42.98	4,277	**3,000**
10-5100-51-51485	MISCELLANEOUS	79,783	437,528	45,000	68,566	152.37	(23,566)	**45,000**
10-5100-51-51602	PENALTIES & INTEREST	-	-	150	70	46.69	80	**150**
10-5100-51-51603	PERIODICALS AND PUBLIC	422	81	200	1,670	834.75	(1,470)	**200**
10-5100-51-51625	POSTAGE/DELIVERY	652	622	500	186	37.10	315	**500**
10-5100-51-51634	EDC BEAUTIFICATION	10,500	-	-	-	-	-	**0**
10-5100-51-51635	PROFESSIONAL & MEMBERS	15,395	18,214	9,500	2,736	28.80	6,764	**9,500**
10-5100-51-51746	SUPPLIES-OFFICE	10,607	4,180	7,562	2,945	38.94	4,617	**7,562**

10-5100-51-51747	COVID 19 SUPPLIES	8,670	1,420	-	-	-	-	**0**
10-5100-51-51780	STAFF TRAVEL	6,999	6,366	2,100	2,612	124.37	(512)	**5,000**
10-5100-51-51790	COUNCIL TRAVEL	-	-	5,000	-	-	5,000	**0**
10-5100-51-51813	UTILITIES-ELECTRIC BLU	12,007	11,947	11,522	5,543	48.11	5,979	**11,522**
10-5100-51-51817	UTILITIES-NATURAL GAS	1,273	1,420	1,415	993	70.16	422	**1,626**
10-5100-51-52110	OFFICE EQUIPMENT LEASE	6,296	4,705	5,500	3,078	55.97	2,422	**5,500**
TOTAL OPERATING		253,534	636,457	437,799	141,834	32.40	295,965	**118,500**
REPAIRS & MAINTENANCE								
10-5100-52-52010	BUILDING REPAIRS & MAINT	25,714	40,622	35,000	95	0.27	34,905	**35,000**
10-5100-52-52012	CLEANING & MAINTENANCE	3,680	3,700	3,600	2,070	57.51	1,530	**3,600**
TOTAL REPAIRS & MAINTENANCE		29,394	44,322	38,600	2,165	5.61	36,435	**38,600**
CONTRACTED SERVICES								
10-5100-54-51165	ENG/PLAN LEGAL SERVICES	158,589	373,766	180,000	128,891	71.61	51,109	**180,000**
10-5100-54-51440	LEGAL FEES	66,203	168,782	65,000	29,344	45.14	35,656	**65,000**
10-5100-54-51441	JUSTFOIA	4,303	3,625	5,000	8,171	163.42	(3,171)	**9,835**
10-5100-54-51442	MEETING/AGENDA MANAGEMENT	5,767	3,800	3,800	-	-	3,800	**3,800**
10-5100-54-51443	LASERFISCHE/CDI	-		80,000	84,997	106.25	(4,997)	**67,629**
10-5100-54-51502	SALES TAX REBATE GREENV	207,002	272,889	360,000	-	-	360,000	**360,000**
10-5100-54-51503	AD VALOREM REBATE GREENV	79,026	79,444	153,000	-	-	153,000	**153,000**
10-5100-54-51504	MUNICODE	2,248	11,392	15,000	-	-	15,000	**15,000**
10-5100-54-51520	R.O.W. PURCHASE	67,127	342,470	100,000	409,094	409.09	(309,094)	**100,000**
10-5100-54-51590	DOCUMENT STORAGE/DESTRUCTI	3,842	976	4,500	874	19.43	3,626	**4,000**
10-5100-54-51760	TAXING DISTRICT FEES	47,330	57,521	56,000	37,838	67.57	18,162	**56,000**
10-5100-54-51998	NEEDS ASSESMENT	3,012	90,661	10,000	3,904	39.04	6,096	**10,000**
10-5100-54-51999	GRANT WRITER SERVICE	3,000	16,000	20,000	6,500	32.50	13,500	**20,000**
TOTAL CONTRACTED SERVICES		647,448	1,421,326	1,052,300	709,613	67.43	342,687	**1,044,264**
TOTAL ADMINISTRATION EXPENDITURES		**1,228,485**	**2,491,121**	**2,027,282**	**1,141,131**	**56.29**	**886,151**	**1,772,893**

FY2024-2025 PROPOSED ANNUAL BUDGET

FINANCE EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
PERSONNEL								
10-5150-50-50010	SALARIES	413,800	451,273	562,544	155,959	27.72	406,585	**698,081**
10-5150-50-50050	OVERTIME	1,180	1,492	8,000	668	8.35	7,332	**4,413**
10-5150-50-50075	LONGEVITY	4,100	4,300	5,000	2,500	50.00	2,500	**3,800**
10-5150-50-50200	EMPLOYER PAID TAXES	30,806	33,929	43,726	9,733	22.26	33,993	**54,031**
10-5150-50-50255	WORKERS' COMPENSATION	430	486	600	1,205	200.84	(605)	**13,399**
10-5150-50-50325	HEALTH INSURANCE	43,474	57,953	84,111	21,683	25.78	62,428	**83,473**
10-5150-50-50410	EMPLOYER RETIREMENT CO	35,533	38,930	47,018	13,089	27.84	33,929	**54,967**
10-5150-50-50520	EMPLOYEE EDUCATION	773	1,411	5,000	50	1.00	4,950	**5,000**
10-5150-50-50650	VEHICLE ALLOWANCE	-	-	5,500	-	-	5,500	**0**
TOTAL PERSONNEL		530,095	589,774	761,499	204,887	26.91	556,612	**917,165**
OPERATING								
10-5150-51-51010	ADVER/POSTING/PUBLIC HEARING	2,665	326	4,500	40	0.90	4,460	**4,500**
10-5150-51-51011	PRE-EMPLOYMENT SCREEN	3	-	100	1	1.00	99	**100**
10-5150-51-51042	CREDIT CARD MERCHANT SVCS	150,256	178,952	150,000	75,198	50.13	74,802	**75,000**
10-5150-51-51080	CASH SHORT & OVER	(692)	206	500	-	-	500	**100**
10-5150-51-51335	INSURANCE-PROPERTY, CA	2,563	2,875	3,305	1,306	39.52	1,999	**3,300**
10-5150-51-51338	INSURANCE LIABILITY	83	80	110	534	485.73	(424)	**1,000**
10-5150-51-51480	MEETING EXPENSES	287	562	500	-	-	500	**500**
10-5150-51-51485	MISCELLANEOUS	492	705	1,250	229	18.35	1,021	**1,250**
10-5150-51-51602	PENALTIES & INTEREST	-	-	600	-	-	600	**600**
10-5150-51-51603	PERIODICALS AND PUBLIC	-	681	100	704	703.50	(604)	**1,000**
10-5150-51-51625	POSTAGE/DELIVERY	68,023	81,492	60,000	34,842	58.07	25,158	**50,000**
10-5150-51-51635	PROFESSIONAL & MEMBERS	-	179	240	-	-	240	**240**
10-5150-51-51746	SUPPLIES-OFFICE	4,429	2,825	3,500	1,026	29.31	2,474	**3,500**
10-5150-51-51780	TRAVEL	1,279	876	5,000	494	9.89	4,506	**5,000**
10-5150-51-52110	OFFICE EQUIPMENT LEASE	5,405	3,814	3,475	2,098	60.38	1,377	**3,600**
10-5150-51-52340	VEHICLE FUEL & OIL	4,854	3,226	4,500	1,657	36.83	2,843	**4,500**
TOTAL OPERATING		239,647	276,799	237,680	118,130	49.70	119,550	**154,190**

REPAIRS & MAINTENANCE								
10-5150-52-52320	VEHICLE REPAIRS & MAINT	1,060	11,371	3,000	6,934	231.12	(3,934)	**5,000**
TOTAL REPAIRS & MAINTENANCE		1,060	11,371	3,000	6,934	231.12	(3,934)	**5,000**
CONTRACTED SERVICES								
10-5150-54-51000	ACCOUNTING & AUDITING	43,469	43,752	55,000	-	-	55,000	**55,000**
10-5150-54-51315	PAYROLL SERVICE	9,930	-	-	4,794	-	(4,794)	**6,000**
10-5150-54-51440	LEGAL FEES	5,700	885	6,500	-	-	6,500	**6,500**
10-5150-54-51590	DOCUMENT STORAGE	1,121	1,641	1,700	682	40.14	1,018	**1,800**
TOTAL CONTRACTED SERVICES		60,220	46,278	63,200	5,476	8.66	57,724	**69,300**
DEBT PAYMENTS								
10-5150-55-52310	VEHICLE LEASE EXPENSE	-	5,052	20,000	12,097	60.49	7,903	**25,000**
TOTAL DEBT PAYMENTS		-	5,052	20,000	12,097	60.49	7,903	**25,000**
TOTAL FINANCE EXPENDITURES		**831,022**	**929,272**	**1,085,379**	**347,524**	**32.02**	**737,855**	**1,170,655**

FY2024-2025 PROPOSED ANNUAL BUDGET

STREET EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
PERSONNEL								
10-5225-50-50010	SALARIES	256,034	323,941	474,066	208,199	43.92	265,867	**515,510**
10-5225-50-50050	OVERTIME	12,803	16,046	14,222	3,529	24.82	10,693	**14,552**
10-5225-50-50075	LONGEVITY	4,700	5,100	5,700	1,100	19.30	4,600	**6,700**
10-5225-50-50200	EMPLOYER PAID TAXES	20,452	25,752	37,790	15,950	42.21	21,840	**41,062**
10-5225-50-50255	WORKERS' COMPENSATION	12,992	14,431	14,000	10,624	75.88	3,376	**30,649**
10-5225-50-50325	HEALTH INSURANCE	43,479	53,113	84,111	36,760	43.70	47,351	**75,126**
10-5225-50-50410	EMPLOYER RETIREMENT CO	23,199	28,822	40,248	17,473	43.41	22,775	**41,774**
10-5225-50-50520	EMPLOYEE EDUCATION	3,087	1,856	3,500	924	26.40	2,576	**3,500**
10-5225-50-50700	REIMB UNEMPLOYMENT	-	-	2,000	-	-	2,000	**0**
TOTAL PERSONNEL		376,747	469,062	675,637	294,559	43.60	381,078	**728,873**
OPERATING								
10-5225-51-51011	PRE-EMPLOYMENT SCREENING	-	1	200	2	1.00	198	**200**
10-5225-51-51335	INSURANCE-PROPERTY, CA	4,760	10,710	4,800	5,249	109.34	(449)	**10,000**
10-5225-51-51338	INSURANCE LIABILITY	1,901	1,672	1,910	1,298	67.96	612	**2,500**
10-5225-51-51610	LICENSES	213	300	-	97	-	(97)	**200**
10-5225-51-51620	PHYSICALS/DRUG TESTING	63	101	200	-	-	200	**200**
10-5225-51-51740	SUPPLIES-MATERIALS	60,823	69,231	45,000	42,714	94.92	2,286	**45,000**
10-5225-51-51741	SUPPLIES-CHEMICALS	-	-	4,000	271	6.77	3,729	**4,000**
10-5225-51-51746	SUPPLIES OFFICE	19	-	500	-	-	500	**500**
10-5225-51-51780	TRAVEL	-	-	100	30	30.07	70	**500**
10-5225-51-51800	UNIFORMS & ACCESSORIES	3,415	3,646	6,960	1,739	24.99	5,221	**8,100**
10-5225-51-51813	UTILITIES-ELECTRIC BLU	114,335	139,784	120,000	84,976	70.81	35,024	**120,000**
10-5225-51-51815	UTILITIES-ELECTRIC TX	14,473	14,641	20,000	10,336	51.68	9,664	**20,000**
10-5225-51-52340	FUEL & OIL	31,391	25,621	25,000	14,825	59.30	10,175	**30,000**
10-5225-51-52440	EQUIPMENT RENTAL	-	330	5,000	555	11.11	4,445	**5,000**
10-5225-51-54020	STREET SIGNS	16,764	6,951	15,000	3,850	25.67	11,150	**15,000**
TOTAL OPERATING		248,156	272,988	248,670	165,942	66.73	82,728	**261,200**

REPAIRS & MAINTENANCE								
10-5225-52-52010	BUILDING REPAIRS & MAINT	12,115	1,010	10,000	-	-	10,000	**10,000**
10-5225-52-52320	VEH REPAIRS & MAINTENANCE	20,841	18,052	20,000	6,056	30.28	13,944	**20,000**
10-5225-52-52430	MACHINERY EQUIP-REPAIR	11,351	12,196	10,000	7,004	70.04	2,996	**12,000**
10-5225-52-54010	STREET REPAIRS & MAINT	197,163	122,418	150,000	18,202	12.13	131,798	**150,000**
TOTAL REPAIRS & MAINTENANCE		241,471	153,677	190,000	31,262	16.45	158,738	**192,000**
CONTRACTED SERVICES								
10-5225-54-51165	ENGINEERING/PLANNING S	84,552	168,791	169,000	950,696	562.54	(781,696)	**125,000**
10-5225-54-51166	STREET CONTRACTED REPAIRS	823,932	420,381	800,000	6,810	0.85	793,190	**800,000**
10-5225-54-51167	DRAINAGE STUDY	21,746	31,895	213,800	3,218	1.50	210,583	**200,000**
10-5225-54-54100	TRASH COLLECTION FEES	1,421,286	1,724,313	1,600,000	847,063	52.94	752,937	**1,680,000**
TOTAL CONTRACTED SERVICES		2,351,517	2,345,380	2,782,800	1,807,786	64.96	975,014	**2,805,000**
DEBT PAYMENTS								
10-5225-55-52310	VEHICLE LEASE EXPENSE	45,115	159,001	119,899	193,300	161.22	(73,401)	**65,000**
10-5225-55-52410	MACHINERY EQUIPMENT LE	41,054	552,028	115,403	11,314	9.80	104,089	**20,000**
TOTAL DEBT PAYMENTS		86,169	711,029	235,302	204,614	86.96	30,688	**85,000**
CAPITAL OUTLAY < $5K								
10-5225-57-52400	MACHINERY EQUIPMENT-PU	-	227,545	5,000	-	-	5,000	**5,000**
10-5225-57-52450	TOOLS	5,353	2,699	5,000	1,362	27.24	3,638	**5,000**
TOTAL CAPITAL OUTLAY < $5K		5,353	230,244	10,000	1,362	13.62	8,638	**10,000**
CAPITAL OUTLAY > $5K								
10-5225-58-52400	MACHINERY EQUIPMENT-PU	34,150	7,362	10,000	-	-	10,000	**170,000**
TOTAL CAPITAL OUTLAY > $5K		34,150	7,362	10,000	-	-	10,000	**170,000**
TOTAL STREET EXPENDITURES		**3,343,562**	**4,189,741**	**4,152,409**	**2,505,525**	**60.34**	**1,646,884**	**4,252,073**

FY2024-2025 PROPOSED ANNUAL BUDGET

DEVELOPMENT SERVICES EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
PERSONNEL								
10-5300-50-50010	SALARIES	370,194	499,182	720,835	291,716	40.47	429,119	**746,129**
10-5300-50-50050	OVERTIME	211	249	3,253	47	1.46	3,206	**5,468**
10-5300-50-50075	LONGEVITY	2,300	3,100	4,100	2,500	60.98	1,600	**4,700**
10-5300-50-50200	EMPLOYER PAID TAXES	27,013	36,875	55,706	21,307	38.25	34,399	**57,857**
10-5300-50-50255	WORKERS' COMPENSATION	443	500	500	3,573	714.62	(3,073)	**4,617**
10-5300-50-50325	HEALTH INSURANCE	35,075	57,528	93,456	37,479	40.10	55,977	**83,473**
10-5300-50-50410	EMPLOYER RETIREMENT CO	31,531	42,085	59,777	24,328	40.70	35,449	**58,859**
10-5300-50-50520	EMPLOYEE EDUCATION	1,910	3,445	4,600	2,481	53.93	2,119	**4,600**
10-5300-50-50650	VEHICLE ALLOWANCE	-	-	5,500	-	-	5,500	**0**
10-5300-50-50700	REIMB UNEMPLOYMENT	-	-	500	-	-	500	**0**
TOTAL PERSONNEL		468,677	642,965	948,227	383,431	40.44	564,796	**965,702**
OPERATING								
10-5300-51-51011	PRE-EMPLOYMENT SCREENING	63	5	100	-	-	100	**100**
10-5300-51-51042	CREDIT CARD MERCHANT	68,237	56,259	66,500	22,288	33.52	44,212	**66,500**
10-5300-51-51330	BLDG INSPECTION FEES	52,240	50,630	75,000	4,830	6.44	70,170	**75,000**
10-5300-51-51331	SUB DIV & INSP. FEES	6,744	-	10,000	-	-	10,000	**10,000**
10-5300-51-51332	OVERPAYMENT/REFUNDS	15,984	7,618	10,500	-	-	10,500	**0**
10-5300-51-51335	INSURANCE-PROPERTY, CA	1,248	1,407	1,248	776	62.15	472	**1,500**
10-5300-51-51338	INSURANCE LIABILITY	689	619	690	1,031	149.48	(341)	**1,500**
10-5300-51-51485	MISCELLANEOUS	5,069	16,607	16,282	91	0.56	16,191	**5,000**
10-5300-51-51603	POSTING & NOTIFICATION	5,184	12,997	9,000	1,466	16.28	7,534	**15,000**
10-5300-51-51610	PERMITS & LICENSES	-	-	120	55	45.83	65	**0**
10-5300-51-51611	TRAVIS CO RECORDATION FEES	-	1,000	2,500	2,000	80.00	500	**2,500**
10-5300-51-51625	POSTAGE/DELIVERY	1,049	2,460	1,475	113	7.66	1,362	**1,500**
10-5300-51-51635	PROF/MEMBERSHIP DUES	940	1,973	2,000	804	40.20	1,196	**2,000**
10-5300-51-51746	SUPPLIES-OFFICE	2,557	6,034	3,000	3,237	107.91	(237)	**4,000**
10-5300-51-51780	TRAVEL	1,925	-	7,000	1,431	20.44	5,569	**7,000**
10-5300-51-51800	UNIFORMS & ACCESSORIES	184	73	2,000	765	38.25	1,235	**1,500**
10-5300-51-52110	OFFICE EQUIP LEASES	-	-	2,500	840	33.62	1,660	**1,000**
10-5300-51-52340	VEHICLE FUEL & OIL	7,505	5,929	10,000	3,148	31.48	6,852	**10,000**
TOTAL OPERATING		169,618	163,611	219,915	42,875	19.50	177,040	**204,100**

REPAIRS & MAINTENANCE								
10-5300-52-52320	VEHICLE REPAIRS & MAIN	1,216	12,562	4,400	632	14.35	3,768	**4,000**
TOTAL REPAIRS & MAINTENANCE		1,216	12,562	4,400	632	14.35	3,768	**4,000**
CONTRACTED SERVICES								
10-5300-54-51165	ENG/PLANNING SERVICES	285,348	328,778	200,000	151,455	75.73	48,545	**250,000**
10-5300-54-51166	FEE SCHEDULE STUDY	4,420	17,480	10,000	-	-	10,000	**0**
10-5300-54-51440	LEGAL FEES	65,515	62,963	50,000	9,494	18.99	40,506	**60,000**
10-5300-54-51450	COMPREHENSIVE PLANNING SVC	-	135,000	50,000	-	-	50,000	**130,000**
TOTAL CONTRACTED SERVICES		355,283	544,221	310,000	160,949	51.92	149,051	**440,000**
DEBT PAYMENTS								
10-5300-55-52310	VEHICLE LEASE EXPENSE	6,458	11,676	28,500	25,304	88.79	3,196	**28,500**
TOTAL DEBT PAYMENTS		6,458	11,676	28,500	25,304	88.79	3,196	**28,500**
TOTAL DEVELOPMENT SERVICES EXPENDITURES		**1,001,252**	**1,375,035**	**1,511,042**	**613,191**	**40.58**	**897,851**	**1,642,302**

FY2024-2025 PROPOSED ANNUAL BUDGET

PARKS EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
PERSONNEL								
10-5400-50-50010	SALARIES	229,515	328,592	427,452	207,974	48.65	219,478	**448,948**
10-5400-50-50050	OVERTIME	5,882	14,724	12,824	3,130	24.41	9,694	**13,140**
10-5400-50-50075	LONGEVITY	3,800	2,900	3,600	900	25.00	2,700	**4,900**
10-5400-50-50200	EMPLOYER PAID TAXES	17,834	26,351	33,956	16,121	47.48	17,835	**35,725**
10-5400-50-50255	WORKERS' COMPENSATION	6,492	7,215	7,220	3,945	54.63	3,275	**15,971**
10-5400-50-50325	HEALTH INSURANCE	38,444	65,069	84,111	41,444	49.27	42,667	**75,126**
10-5400-50-50410	EMPLOYER RETIREMENT CO	20,295	28,901	36,165	17,373	48.04	18,793	**36,343**
10-5400-50-50520	EMPLOYEE EDUCATION	77	264	800	-	-	800	**800**
10-5400-50-50700	REIMB UNEMPLOYMENT	-	-	500	-	-	500	**0**
TOTAL PERSONNEL		322,340	474,016	606,628	290,887	47.95	315,741	**630,953**
OPERATING								
10-5400-51-51011	PRE-EMPLOYMENT SCREENING	265	2	20	1	5.00	19	**20**
10-5400-51-51335	INSURANCE - PROPERTY, CA	48	-	-	3,143	-	(3,143)	**12,000**
10-5400-51-51338	INSURANCE-LIABILITY	-	-	-	316	-	(316)	**1,200**
10-5400-51-51485	MISCELLANEOUS	76	-	100	-	-	100	**100**
10-5400-51-51610	LICENSES	-	-	100	-	-	100	**100**
10-5400-51-51620	PHYSICALS/DRUG TESTING	-	1	200	-	-	200	**200**
10-5400-51-51635	PROFESSIONAL & MEMBERSHIP DU	-	-		-		-	**0**
10-5400-51-51640	DUES & SUBSCRIPTIONS	(35)	-	-	-	-	-	**0**
10-5400-51-51740	SUPPLIES-CHEMICAL & MATERIALS	23,769	15,447	30,000	10,723	35.74	19,277	**30,000**
10-5400-51-51780	TRAVEL	-	-	100	1,096	1,095.76	(996)	**100**
10-5400-51-51800	UNIFORMS & ACCESSORIES	2,577	3,867	7,830	3,142	40.12	4,688	**9,000**
10-5400-51-51813	UTILITIES-ELECTRIC BLU	1,142	1,184	1,200	624	51.99	576	**1,200**
10-5400-51-52340	FUEL & OIL	9,480	19,196	13,000	9,713	74.72	3,287	**19,580**
10-5400-51-52440	EQUIPMENT RENTAL	536	-	1,500	-	-	1,500	**1,500**
10-5400-51-54020	PARKS SIGNS	550	230	600	36	6.00	564	**10,000**
TOTAL OPERATING		38,408	39,926	54,650	28,794	52.69	25,856	**85,000**

REPAIRS & MAINTENANCE								
10-5400-52-52010	BUILDING REPAIRS & MAI	1,885	397	5,000	220	4.40	4,780	**5,000**
10-5400-52-52320	VEH REPAIRS & MAINTENA	2,784	5,388	6,000	2,560	42.66	3,440	**7,000**
10-5400-52-52430	MACHINERY EQUIP-REPAIR	9,588	13,202	10,000	7,477	74.77	2,523	**12,000**
10-5400-52-54015	PARK REPAIRS /MAINTENAN	374,557	109,865	300,000	4,606	1.54	295,394	**300,000**
10-5400-52-54016	CEMETARY REPAIRS/MAINTENANC	6,660	12,000	20,000	6,500	32.50	13,500	**20,000**
10-5400-52-54017	TIMMERMAN REPAIRS/MAINTENA	72,485	9,562	-	-	-	-	**0**
TOTAL REPAIRS & MAINTENANCE		467,959	150,413	341,000	21,363	6.26	319,637	**344,000**
CONTRACTED SERVICES								
10-5400-54-51165	ENGINEERING/PLANNING S	1,518	10,132	11,000	-	-	11,000	**81,000**
10-5400-54-51440	LEGAL FEES	-	5,325	1,000	-	-	1,000	**5,000**
TOTAL CONTRACTED SERVICES		1,518	15,457	12,000	-	-	12,000	**86,000**
DEBT PAYMENTS								
10-5400-55-52310	VEHICLE LEASE EXPENSE	32,371	6,458	45,000	6,458	14.35	38,542	**75,300**
10-5400-55-52410	MACHINERY EQUIPMENT LE	-	-	9,518	-	-	9,518	**0**
TOTAL DEBT PAYMENTS		32,371	6,458	54,518	6,458	11.85	48,060	**75,300**
GRANT EXPENDITURES								
10-5400-56-58000	GRANT EXPENDITURES	-	-	10,000	-	-	10,000	**10,000**
TOTAL GRANT EXPENDITURES		-	-	10,000	-	-	10,000	**10,000**
CAPITAL OUTLAY < $5K								
10-5400-57-52400	MACHINERY EQUIPMENT-PU	184	4,758	7,500	912	12.16	6,588	**7,500**
10-5400-57-52450	TOOLS	532	1,016	750	223	29.74	527	**700**
TOTAL CAPITAL OUTLAY < $5K		716	5,774	8,250	1,135	13.76	7,115	**8,200**
CAPITAL OUTLAY > $5K								
10-5400-58-52400	MACHINERY EQUIPMENT-PU	209,951	13,393	25,000	-	-	25,000	**50,000**
TOTAL CAPITAL OUTLAY > $5K		209,951	13,393	25,000	-	-	25,000	**50,000**
TOTAL PARKS EXPENDITURES		**1,073,263**	**705,436**	**1,112,046**	**348,636**	**31.35**	**763,410**	**1,289,453**

FY2024-2025 PROPOSED ANNUAL BUDGET

MUNICIPAL COURT EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
PERSONNEL								
10-5500-50-50010	SALARIES	144,164	157,225	241,407	62,415	25.85	178,992	**212,696**
10-5500-50-50050	OVERTIME	5,670	6,568	2,414	5,603	232.12	(3,189)	**1,501**
10-5500-50-50075	LONGEVITY	1,500	1,900	2,200	-	-	2,200	**600**
10-5500-50-50150	MUNICIPAL JUDGES SALAR	23,287	28,733	27,192	14,466	53.20	12,726	**27,874**
10-5500-50-50200	EMPLOYER PAID TAXES	12,877	14,676	18,821	6,167	32.77	12,654	**18,564**
10-5500-50-50255	WORKERS' COMPENSATION	342	389	389	198	50.82	191	**995**
10-5500-50-50325	HEALTH INSURANCE	22,644	25,689	37,383	11,291	30.20	26,092	**33,389**
10-5500-50-50410	EMPLOYER RETIREMENT CO	12,828	13,844	17,807	5,572	31.29	12,235	**16,717**
10-5500-50-50520	EMPLOYEE EDUCATION	685	1,200	3,000	-	-	3,000	**5,000**
10-5500-50-50700	REIMB UNEMPLOYMENT	-	-	500	-	-	500	**0**
TOTAL PERSONNEL		223,998	250,224	351,113	105,712	30.11	245,401	**317,335**
OPERATING								
10-5500-51-51011	PRE-EMPLOYMENT SCREENING	-	1	25	1	4.00	24	**25**
10-5500-51-51042	COURT TECHNOLOGY EXPEN	28,526	15,028	36,300	16,969	46.75	19,331	**40,000**
10-5500-51-51080	CASH SHORT (OVER)	-	-	100	-	-	100	**150**
10-5500-51-51485	MISCELLANEOUS	3,560	1,717	1,500	4,948	329.90	(3,448)	**3,000**
10-5500-51-51603	PERIODICALS & PUBLICAT	-	-	100	-	-	100	**100**
10-5500-51-51625	POSTAGE/DELIVERY	1,535	1,767	3,600	662	18.39	2,938	**3,600**
10-5500-51-51635	PROFESSIONAL & MEMBERS	165	165	320	165	51.56	155	**400**
10-5500-51-51746	SUPPLIES-OFFICE	3,379	2,282	4,500	1,010	22.45	3,490	**5,000**
10-5500-51-51780	TRAVEL	733	1,036	1,500	15	0.98	1,485	**5,000**
10-5500-51-52100	COURT SECURITY	1,001	401	1,900	-	-	1,900	**1,900**
10-5500-51-52110	OFFICE EQUIPMENT LEASE	2,356	2,346	2,400	1,970	82.09	430	**3,825**
TOTAL OPERATING		41,256	24,743	52,245	25,741	49.27	26,504	**63,000**

CONTRACTED SERVICES								
10-5500-54-51440	LEGAL FEES	31,581	28,438	37,000	8,400	22.70	28,600	**37,000**
10-5500-54-51595	COLLECTION FEES	32,788	38,414	32,000	11,846	37.02	20,154	**32,000**
10-5500-54-56010	STATE COURT COST	125,136	130,464	111,698	63,825	57.14	47,874	**140,000**
10-5500-54-56425	JURY EXPENSE	-	36	500	-	-	500	**500**
TOTAL CONTRACTED SERVICES		189,505	197,352	181,198	84,071	46.40	97,127	**209,500**
CAPITAL OUTLAY < $5K								
10-5500-57-56105	CAP OUTLAY-COURT SECUR	-	-	1,620	-	-	1,620	**0**
TOTAL CAPITAL OUTLAY < $5K		-	-	1,620	-	-	1,620	**0**
CAPITAL OUTLAY > $5K								
10-5500-58-56105	CAP OUTLAY-COURT SECUR	-	7,890	6,000	-	-	6,000	**0**
10-5500-58-56108	CAP OUTLAY-COURT TECH	-	-	7,307	-	-	7,307	**0**
TOTAL CAPITAL OUTLAY > $5K		-	7,890	13,307	-	-	13,307	**0**
TOTAL MUNICIPAL COURT EXPENSES		**454,758**	**480,209**	**599,483**	**215,524**	**35.95**	**383,959**	**589,835**

FY2024-2025 PROPOSED ANNUAL BUDGET

POLICE EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
PERSONNEL								
10-5600-50-50010	SALARIES	2,409,134	2,565,644	3,523,077	1,556,872	44.19	1,966,205	**3,997,994**
10-5600-50-50011	COVID 19 SALARIES	3,267	-		-	-	-	**0**
10-5600-50-50012	HB2073 PD PAY	8,784	1,830	-	-			**10,896**
10-5600-50-50050	OVERTIME	149,199	262,102	202,824	99,805	49.21	103,019	**231,852**
10-5600-50-50075	LONGEVITY PAY	24,316	21,840	18,100	17,656	97.55	444	**22,200**
10-5600-50-50200	EMPLOYER PAID TAXES	192,075	213,893	286,416	124,205	43.37	162,211	**325,282**
10-5600-50-50255	WORKERS' COMPENSATION	45,282	56,860	85,000	48,255	56.77	36,745	**175,713**
10-5600-50-50325	HEALTH INSURANCE	261,168	306,025	467,913	200,226	42.79	267,687	**434,061**
10-5600-50-50326	TEAM BUILDING	-	85	4,300	-	-	4,300	**0**
10-5600-50-50335	HEALTH ASSISTANCE	-	10,500	-	-	-	-	**0**
10-5600-50-50410	EMPLOYER RETIREMENT CO	219,583	236,844	305,793	142,122	46.48	163,671	**331,764**
10-5600-50-50520	EMPLOYEE EDUCATION	41,232	59,693	70,000	27,284	38.98	42,716	**70,000**
10-5600-50-50700	REIMB UNEMPLOYMENT	-	-	500	-	-	500	**0**
TOTAL PERSONNEL		3,354,040	3,735,317	4,963,923	2,216,425	44.65	2,747,498	**5,599,762**
OPERATING								
10-5600-51-51010	ADVER/RECRUITING	-	-	20,000	251	1.26	19,749	**20,000**
10-5600-51-51335	INSURANCE-PROPERTY, CA	12,640	23,303	23,303	20,684	88.76	2,619	**23,303**
10-5600-51-51338	INSURANCE LIABILITY	76,818	55,875	55,875	27,550	49.31	28,325	**56,197**
10-5600-51-51485	MISCELLANEOUS	6,296	105,917	10,000	5,467	54.67	4,533	**15,000**
10-5600-51-51603	PERIODICALS & PUBLICAT	324	161	500	140	28.02	360	**1,000**
10-5600-51-51610	PERMITS & LICENSING	452	773	500	378	75.54	122	**500**
10-5600-51-51620	PHYSICALS/DRUG TESTING	6,406	5,292	6,000	1,490	24.83	4,510	**5,000**
10-5600-51-51625	POSTAGE/DELIVERY	1,781	1,637	4,000	297	7.43	3,703	**4,000**
10-5600-51-51635	PROFESSIONAL & MEMBERS	1,714	980	5,500	465	8.45	5,035	**5,500**
10-5600-51-51746	SUPPLIES-OFFICE	12,191	15,071	15,000	7,056	47.04	7,944	**17,500**
10-5600-51-51748	SUPPLIES-POLICE SPECIAL	11,853	15,629	25,000	3,732	14.93	21,268	**30,000**
10-5600-51-51780	TRAVEL	24,419	25,160	45,000	16,285	36.19	28,715	**50,000**
10-5600-51-51781	COMMUNITY PROGRAMS	-	4,849	5,000	4,443	88.86	557	**10,000**
10-5600-51-51782	SOCIAL RESOURCE MISCELLANEOU	-	370	5,000	383	7.67	4,617	**5,000**

10-5600-51-51783	ANIMAL CONTROL MISCELLANEOU	-	19	15,000	38	0.25	14,962	**20,000**
10-5600-51-51784	K-9	-	-	80,000	26	0.03	79,974	**50,000**
10-5600-51-51785	CTRS	-	-	60,000	17	0.03	59,983	**60,000**
10-5600-51-51798	CRIME LAB	5,894	5,752	7,500	732	9.76	6,768	**13,800**
10-5600-51-51799	CID SPECIALTY EQUIPMENT	17,429	59,123	62,500	13,434	21.49	49,066	**45,500**
10-5600-51-51800	UNIFORMS & ACCESSORIES	53,735	49,521	50,000	26,448	52.90	23,552	**50,000**
10-5600-51-51801	SAFETY & ACCESSORIES	6,798	6,861	7,000	6,237	89.10	763	**10,000**
10-5600-51-51802	AMMO/RANGE	8,427	41,209	40,000	59	0.15	39,942	**40,000**
10-5600-51-51803	HONOR GUARD		100	4,000	213	5.32	3,787	**4,000**
10-5600-51-51804	CITIZEN POLICE ACADEMY	4,153	4,371	7,500	64	0.86	7,436	**7,500**
10-5600-51-51805	POLICE BANQUET	3,067	4,910	5,000	2,283	45.65	2,717	**7,500**
10-5600-51-51806	TRAFFIC SPECIALTY EQUP	5,931	10,558	25,000	4,989	19.96	20,011	**25,000**
10-5600-51-51813	UTILITIES-ELECTRIC BLU	9,358	9,114	12,000	4,666	38.89	7,334	**12,000**
10-5600-51-52110	OFFICE EQUIPMENT LEASE	7,645	8,640	16,500	4,335	26.27	12,165	**16,500**
10-5600-51-52340	FUEL & OIL	157,593	113,601	96,000	68,620	71.48	27,380	**125,000**
10-5600-51-57400	WRECKER SERVICE	1,170	558	1,200	1,001	83.42	199	**1,500**
TOTAL OPERATING		436,095	569,353	709,878	221,782	31.24	488,096	**731,300**
REPAIRS & MAINTENANCE								
10-5600-52-52010	BUILDING REPAIRS & MAI	26,462	8,959	17,500	3,760	21.48	13,740	**20,000**
10-5600-52-52012	CLEANING & MAINTENANCE	3,003	2,829	4,000	1,298	32.45	2,702	**4,000**
10-5600-52-52240	SOFTWARE ANNUAL FEES	-	-	-	-	-	-	**67,500**
10-5600-52-52320	VEHICLE REPAIRS & MAIN	92,715	98,176	75,000	62,866	83.82	12,134	**95,000**
10-5600-52-52321	VEHICLE DAMAGE	69,112	19,460	15,000	8,405	56.03	6,595	**25,000**
TOTAL REPAIRS & MAINTENANCE		191,292	129,424	111,500	76,328	68.46	35,172	**211,500**
CONTRACTED SERVICES								
10-5600-54-51440	LEGAL FEES	270	1,050	5,000	1,307	26.13	3,694	**5,000**
10-5600-54-51502	CONSULTING SERVICES	-	858	1,000	3,850	385.00	(2,850)	**1,000**
10-5600-54-51590	DESTRUCTION SERVICES	300	96	1,000	192	19.20	808	**1,000**
10-5600-54-57001	RRS EMERGENCY RADIO SYS	13,897	12,238	29,000	8,073	27.84	20,927	**38,000**
10-5600-54-57350	EMERGENCY DISPATCH SER	270,207	310,738	357,349	357,349	100.00	-	**411,000**
TOTAL CONTRACTED SERVICES		284,674	324,980	393,349	370,771	94.26	22,578	**456,000**

DEBT PAYMENTS								
10-5600-55-52310	VEHICLE LEASE EXPENSE	410,105	622,995	565,500	159,410	28.19	406,090	**565,500**
TOTAL DEBT PAYMENTS		410,105	622,995	565,500	159,410	28.19	406,090	**565,500**
CAPITAL OUTLAY < $5K								
10-5600-57-57100	ANIMAL CONTROL EQUIPMENT	476	-	-				
10-5600-57-57101	OFFICE EQUIP PURCHASE	389	1,052	1,000	250	25.00	750	**1,000**
TOTAL CAPITAL OUTLAY < $5K		865	1,052	1,000	250	25.00	750	**1,000**
CAPITAL OUTLAY > $5K								
10-5600-58-52101	PD CONSTRUCTION SITE	-	-	1,000	-	-	1,000	**1,000**
10-5600-58-52330	POLICE SPECIALTY EQUIP	20,390	244,938	227,189	170,298	74.96	56,891	**283,110**
10-5600-58-57300	POLICE COMMUNICATION E	26,063	367	86,000	165,000	191.86	(79,000)	**174,890**
10-5600-58-58000	GRANT EXPENDITURES	2,130	20,204	9,470	-	-	9,470	**0**
TOTAL CAPITAL OUTLAY > $5K		48,583	265,509	323,659	335,298	103.60	(11,639)	**459,000**
TOTAL POLICE EXPENDITURES		**4,725,654**	**5,648,628**	**7,068,809**	**3,380,263**	**47.82**	**3,688,546**	**8,024,062**

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FY2024-2025 PROPOSED ANNUAL BUDGET

IT EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
PERSONNEL								
10-5700-50-50010	SALARIES	135,128	192,604	229,987	119,787	52.08	110,200	**253,473**
10-5700-50-50050	OVERTIME	852	2,802	3,483	1,376	39.51	2,107	**1,220**
10-5700-50-50075	LONGEVITY PAY	900	400	700	200	28.57	500	**1,100**
10-5700-50-50200	EMPLOYER PAID TAXES	9,786	14,507	17,914	8,428	47.05	9,486	**19,568**
10-5700-50-50255	WORKERS' COMPENSATION	192	222	300	146	48.58	154	**1,049**
10-5700-50-50325	HEALTH INSURANCE	14,248	21,691	28,037	14,054	50.13	13,983	**25,042**
10-5700-50-50410	EMPLOYER RETIREMENT CO	11,601	16,344	19,527	9,945	50.93	9,582	**19,907**
10-5700-50-50520	EMPLOYEE EDUCATION	1,415	3,026	4,500	2,692	59.82	1,808	**4,500**
10-5700-50-50650	VEHICLE ALLOWANCE	-	-	5,500	-	-	5,500	**0**
10-5700-50-50700	REIMB UNEMPLOYMENT	-	-	500	-	-	500	**0**
TOTAL PERSONNEL		174,122	251,597	310,448	156,630	50.45	153,818	**325,858**
OPERATING								
10-5700-51-51485	MISCELLANEOUS	15	379	500	219	43.71	281	**500**
10-5700-51-51625	POSTAGE/DELIVERY	-	-	100	-	-	100	**100**
10-5700-51-51635	PROFESSIONAL/MEMBERSHIP	430	314	1,900	-	-	1,900	**3,800**
10-5700-51-51746	SUPPLIES-OFFICES	2,128	3,564	3,000	923	30.76	2,077	**6,000**
10-5700-51-51769	INTERNET SERVICE	92,599	96,629	110,000	18,165	16.51	91,835	**150,000**
10-5700-51-51770	TELEPHONE COMMUNICATION	7,405	9,749	5,100	28,981	568.26	(23,881)	**7,000**
10-5700-51-51775	WIRELESS COMMUNICATION	118,367	108,223	125,000	82,172	65.74	42,828	**125,000**
10-5700-51-51780	TRAVEL	240	2,287	6,000	-	-	6,000	**6,000**
TOTAL OPERATING		221,183	221,145	251,600	130,460	51.85	121,140	**298,400**
REPAIRS & MAINTENANCE								
10-5700-52-52000	COMPUTER R & M	232	16	-	-	-	-	**0**
10-5700-52-52011	BUILDING SECURITY	4,282	6,595	5,000	4,408	88.16	592	**15,000**
TOTAL REPAIRS & MAINTENANCE		4,514	6,611	5,000	4,408	88.16	592	**15,000**
CONTRACTED SERVICES								
10-5700-54-51440	LEGAL FEES	-	-	-	-	-	-	**5,000**
10-5700-54-51501	IT CONSULTING SERVICES	7,475	8,654	25,000	-	-	25,000	**29,629**
10-5700-54-52005	EMERGENCY NOTIFICATION	4,371	4,371	4,371	4,371	100.00	0	**4,371**
10-5700-54-52240	SOFTWARE ANNUAL FEES	205,935	266,274	245,000	145,108	59.23	99,892	**400,000**
TOTAL CONTRACTED SERVICES		217,781	279,299	274,371	149,479	54.48	124,892	**439,000**

DEBT PAYMENTS								
10-5700-57-52310	VEHICLE LEASE EXPENSE	-	-	-	2,868	-	(2,868)	**6,000**
TOTAL DEBT PAYMENTS		-	-	-	2,868	-	(2,868)	**6,000**
CAPITAL OUTLAY <$5K								
10-5700-57-52200	COMPUTER EQUIPMENT	72,394	51,019	45,000	4,483	9.96	40,517	**50,000**
TOTAL CAPITAL OUTLAY<$5K		72,394	51,019	45,000	4,483	9.96	40,517	**50,000**
CAPITAL OUTLAY >$5K								
10-5700-58-52200	COMPUTER EQUIPMENT	16,794	30,205	109,884	74,063	67.40	35,821	**115,000**
TOTAL CAPITAL OUTLAY>5K		16,794	30,205	109,884	74,063	67.40	35,821	**115,000**
TOTAL IT EXPENDITURES		**706,788**	**839,874**	**996,303**	**522,392**	**52.43**	**473,911**	**1,243,258**

FY2024-2025 PROPOSED ANNUAL BUDGET

ECONOMIC DEV. SVCS		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
PERSONNEL								
10-5800-50-50010	SALARIES	144,792	120,578	125,565	63,453	50.53	62,112	**131,861**
10-5800-50-50075	LONGEVITY PAY	300	-	200	200	100.00	-	**300**
10-5800-50-50200	EMPLOYER PAID TAXES	11,140	9,934	9,621	4,884	50.76	4,737	**10,110**
10-5800-50-50255	WORKERS' COMPENSATION	82	100	200	53	26.56	147	**542**
10-5800-50-50325	HEALTH INSURANCE	4,303	7,327	9,346	283	3.03	9,063	**8,347**
10-5800-50-50410	EMPLOYER RETIREMENT CO	12,354	10,812	10,695	5,234	48.94	5,461	**10,285**
10-5800-50-50520	EMPLOYEE EDUCATION	1,235	1,831	12,985	45	0.35	12,940	**5,000**
10-5800-50-50650	VEHICLE ALLOWANCE	1,292	4,800	5,500	185	3.36	5,315	**0**
TOTAL PERSONNEL		175,499	155,381	174,112	74,337	42.69	99,775	**166,446**
OPERATING								
10-5800-51-51001	SESQUICENTENIAL EXPENSE	73,215	-	-	-	-	-	
10-5800-51-51010	ADVERTISING	2,180	6,668	35,000	21,653	61.86	13,347	**35,000**
10-5800-51-51020	INCENTIVES	-	-	-	-	-	-	**47,500**
10-5800-51-51043	CITY EVENTS	44,531	-	-	-	-	-	**0**
10-5800-51-51480	MEETING EXPENSES	2,898	2,000	3,000	387	12.89	2,613	**5,000**
10-5800-51-51625	POSTAGE/DELIVERY	58	226	3,500	113	3.23	3,387	**1,500**
10-5800-51-51630	SUBSCRIPTIONS	1,967	8,085	5,800	2,544	43.86	3,256	**6,500**
10-5800-51-51635	PROFESSIONAL/MEMBERSHIP	1,774	5,385	25,000	3,686	14.74	21,314	**25,000**
10-5800-51-51746	SUPPLIES-OFFICES	2,381	2,086	3,000	415	13.83	2,585	**3,000**
10-5800-51-51780	TRAVEL	5,019	2,389	10,000	1,122	11.22	8,878	**5,000**
10-5800-51-51800	UNIFORMS & ACCESSORIES	-	10	1,000	-	-	1,000	**2,000**
TOTAL OPERATING		134,022	26,849	86,300	29,919	34.67	56,381	**130,500**
CONTRACTED SERVICES								
10-5800-54-51440	LEGAL FEES	-	-	50,000	-	-	50,000	**50,000**
10-5800-54-51501	CONSULTING SERVICES	11,175	28,100	356,000	60,286	16.93	295,715	**325,000**
TOTAL		11,175	28,100	406,000	60,286	14.85	345,715	**375,000**
TOTAL ECONOMIC DEV SVCS EXPENDITURES		**320,696**	**210,330**	**666,412**	**164,542**	**24.69**	**501,870**	**671,946**

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FY2024-2025 PROPOSED ANNUAL BUDGET

HUMAN RESOURCES		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
PERSONNEL								
10-5810-50-50010	SALARIES	84,065	129,446	160,166	81,059	50.61	79,107	**168,224**
10-5810-50-50050	OVERTIME	32	838	1,532	691	45.09	841	**1,610**
10-5810-50-50075	LONGEVITY PAY	-	1,300	1,500	1,000	66.67	500	**1,700**
10-5810-50-50200	EMPLOYER PAID TAXES	6,059	10,709	12,485	6,096	48.83	6,389	**13,122**
10-5810-50-50255	WORKERS' COMPENSATION	-	-	200	26	12.96	174	**703**
10-5810-50-50325	HEALTH INSURANCE	40	16,702	18,691	9,353	50.04	9,338	**16,695**
10-5810-50-50410	EMPLOYER RETIREMENT CO	7,053	11,668	13,297	7,163	53.87	6,134	**13,350**
10-5810-50-50411	HR REQUIRED EDUCATION	25,325	1,795	10,000	-	-	10,000	**10,000**
10-5810-50-50520	EMPLOYEE EDUCATION	2,046	3,699	7,500	-	-	7,500	**7,500**
10-5810-50-50650	VEHICLE ALLOWANCE	-	-	5,500	-	-	5,500	**0**
TOTAL PERSONNEL		124,619	176,157	230,871	105,388	45.65	125,483	**232,905**
OPERATING								
10-5810-51-51010	EMPLOYMENT ADVERTISING	-	-	2,500	438	17.50	2,063	**3,000**
10-5810-51-51011	PRE-EMPLOYMENT SCREENING	-	-	100	-	-	100	**100**
10-5810-51-51041	EMPLOYEE APPRECIATION	12,026	18,044	25,000	16,544	66.18	8,456	**30,000**
10-5810-51-51060	MARKETING MATERIALS	-	-	15,000	1,086	7.24	13,914	**10,000**
10-5810-51-51480	MEETING EXPENSES	100	132	1,500	28	1.85	1,472	**1,000**
10-5810-51-51485	MISCELLANEOUS	5,138	31,228	3,500	47	1.33	3,453	**3,500**
10-5810-51-51603	PERIODICALS & PUBLICATIONS	-	29	2,500	-	-	2,500	**2,000**
10-5810-51-51635	PROFESSIONAL/MEMBERSHIP	934	1,641	5,000	340	6.80	4,660	**3,000**
10-5810-51-51746	SUPPLIES-OFFICES	2,275	5,002	3,000	1,481	49.38	1,519	**3,000**
10-5810-51-51780	TRAVEL	1,284	3,686	7,500	17	0.23	7,483	**7,500**
TOTAL OPERATING		21,756	59,762	65,600	19,981	30.46	45,619	**63,100**
CONTRACTED SERVICES								
10-5810-54-51440	LEGAL FEES	-	1,770	5,000	2,508	50.15	2,493	**5,000**
TOTAL CONTRACTED SERVICES		-	1,770	5,000	2,508	50.15	2,493	**5,000**
TOTAL HUMAN RESOURCES EXPENDITURES		**146,375**	**237,689**	**301,471**	**127,876**	**42.42**	**173,595**	**301,005**

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FY2024-2025 PROPOSED ANNUAL BUDGET

COMMUNITY DEV. SVCS		FY 2021-22 ACTUAL	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
PERSONNEL								
10-5811-50-50010	SALARIES	814	70,937	89,124	13,636	15.30	75,488	**77,600**
10-5811-50-50075	LONGEVITY PAY	-	-	-	-	-	-	**100**
10-5811-50-50200	EMPLOYER PAID TAXES	-	6,130	6,818	1,043	15.30	5,775	**5,944**
10-5811-50-50255	WORKERS' COMPENSATION	-	-	100	13	12.96	87	**319**
10-5811-50-50325	HEALTH INSURANCE	-	5,857	8,346	2,446	29.30	5,900	**8,347**
10-5811-50-50410	EMPLOYER RETIREMENT CO	-	6,709	7,261	1,103	15.19	6,158	**6,047**
10-5811-50-50520	EMPLOYEE EDUCATION	-	675	3,500	-	-	3,500	**3,500**
10-5811-50-50650	VEHICLE ALLOWANCE	-	3,323	5,500	-	-	5,500	**0**
TOTAL PERSONNEL		814	93,630	120,649	18,241	15.12	102,408	**101,857**
OPERATING								
10-5811-51-51001	SESQUICENTENNIAL EXP	-	570	-	-	-	-	
10-5811-51-51010	ADVERTISING	-	2,701	20,000	28,210	141.05	(8,210)	**69,700**
10-5811-51-51011	SMALL BUSINESS RENTAL ASST	-	-	25,000	-	-	25,000	**0**
10-5811-51-51043	CITY EVENTS	-	115,224	100,000	137,969	137.97	(37,969)	**313,198**
10-5811-51-51480	MEETING EXPENSES	-	1,079	2,500	-	-	2,500	**2,500**
10-5811-51-51625	POSTAGE/DELIVERY	-	-	500	-	-	500	**200**
10-5811-51-51635	PROFESSIONAL/MEMBERSHIP	-	350	1,850	75	4.05	1,775	**23,525**
10-5811-51-51746	SUPPLIES-OFFICES	-	1,238	2,000	891	44.53	1,109	**2,000**
10-5811-51-51747	LEADERSHIP PROGRAM	-	78	-	-	-	-	**22,200**
10-5811-51-51780	TRAVEL	-	491	5,000	-	-	5,000	**7,000**
TOTAL OPERATING		-	121,730	156,850	167,144	106.56	(10,294)	**440,323**
TOTAL COMMUNITY DEV SVCS EXPENDITURES		**814**	**215,360**	**277,499**	**185,385**	**66.81**	**92,114**	**542,180**
TOTAL EXPENDITURES		**13,832,671**	**17,322,697**	**19,798,135**	**9,551,989**	**48.25**	**10,246,146**	**22,113,600**
REVENUES OVER/(UNDER) EXPENDITURES		**6,147,282**	**2,373,685**	**(1)**	**7,113,693**		**(7,113,694)**	**0**

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FY 2024-2025 Proposed Annual Budget

20 -UTILITY FUND FINANCIAL SUMMARY						Proposed	Annual BUDGET FY 2024-25
				50.00 % OF YEAR COMPLETE			
REVENUE SUMMARY	FY 2021-22 #REF!	FY 2022-23 ACTUAL	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	REQUESTED 2024-25 BUDGET
WATER							
MISCELLANEOUS	0	493,926	525	45,610	8,687.62	(45,085)	**10,000.00**
WATER/SEWER CHARGES	3,678,433	3,914,721	3,527,371	2,047,171	58.04	1,480,200	**4,149,190.00**
TRANSFERS	0	0	0	0	-	0	**-**
TOTAL WATER	3,678,433	4,408,647	3,527,896	2,092,781	59.32	1,435,115	**4,159,190.00**
WASTEWATER							
WATER/SEWER CHARGES	3,138,623	4,018,766	3,059,651	1,832,050	59.88	1,227,602	**3,535,000.00**
TOTAL WASTEWATER	3,138,623	4,018,766	3,059,651	1,832,050	59.88	1,227,602	**3,535,000.00**
STORMWATER							
STORMWATER CHARGES	0	0	0	0	-	0	**643,730.00**
	0	0	0	0	-	0	**643,730.00**
TOTAL REVENUES	**6,817,056**	**8,427,413**	**7,564,758**	**3,924,831**	**51.88**	**3,639,927**	**8,337,920.00**

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FY2024-2025 PROPOSED ANNUAL BUDGET

20 -UTILITY FUND
REVENUES

50.00 % OF YEAR COMPLETE

WATER REVENUES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	Proposed Annual Budget FY 2024-25 REQUESTED 2024-25 BUDGET
WATER CHARGES								
20-4250-42-42099	MISCELLANEOUS	0	493,926	525	45,610	8,687.62	(45,085)	**10,000**
TOTAL MISCELLANEOUS		0	493,926	525	45,610	8,687.62	-45,085	**10,000**
20-4250-43-42099	CREDIT CARD PAYMENT FEE	88,609	96,656	75,000	58,350	77.80	16,650	**95,000**
20-4250-43-43000	ADJUSTMENTS	0	0	0	0	-	0	**0**
20-4250-43-43010	WATER SALES	3,082,848	3,379,621	3,034,014	1,789,984	59.00	1,244,030	**3,600,000**
20-4250-43-43015	BULK WATER SALES	0	0	92	0	-	92	**0**
20-4250-43-43025	LATE FEES WATER	65,596	66,089	56,500	40,357	71.43	16,143	**85,000**
20-4250-43-43028	RETURN CHECK FEES	1,050	1,610	1,015	980	96.55	35	**2,000**
20-4250-43-43075	WATER TAP FEES	334,500	272,250	280,000	98,250	35.09	181,750	**280,000**
20-4250-43-43076	WATER METER FEE	0	98,495	250	0	-	250	**250**
20-4250-43-43080	CONNECTION CHARGES	105,830	0	80,500	59,250	73.60	21,250	**86,940**
TOTAL WATER CHARGES		3,678,433	3,914,721	3,527,371	2,047,171	58.04	1,480,200	**4,149,190**
TRANSFERS								
20-4250-49-50010	TRANSFER FROM CPF	0	0	0	0	-	0	**0**
TOTAL TRANSFERS		0	0	0	0	-	0	**0**
TOTAL WATER REVENUES		**3,678,433**	**4,408,647**	**3,527,896**	**2,092,781**	**59.32**	**1,435,115**	**4,159,190**

WASTEWATER REVENUES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	REQUESTED 2024-25 BUDGET
SEWER CHARGES								
20-4275-43-43110	SEWER SERVICE	2,750,154	3,640,891	2,774,651	1,614,498	58.19	1,160,154	**3,200,000**
20-4275-43-43125	LATE FEES SEWER	55,469	53,125	35,000	30,052	85.86	4,948	**60,000**
20-4275-43-43175	SEWER TAP FEES	333,000	324,750	250,000	187,500	75.00	62,500	**275,000**
TOTAL SEWER CHARGES		3,138,623	4,018,766	3,059,651	1,832,050	59.88	1,227,602	**3,535,000**
TOTAL WASTEWATER REVENUES		**3,138,623**	**4,018,766**	**3,059,651**	**1,832,050**	**59.88**	**1,227,602**	**3,535,000**

NON-DEPARTMENTAL REVENUES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL Y-T-D ACTUAL	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
TRANSFERS								
20-4275-49-50010	TRANSFER FROM CPF	0	0	977,211	0	-	977,211	**0**
TOTAL TRANSFERS		0	0	977,211	0	-	977,211	**0**
TOTAL NON-DEPARTMENTAL REVENUES		**0**	**0**	**977,211**	**0**	**-**	**977,211**	**0**

STORMWATER REVENUES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL Y-T-D ACTUAL	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
STORMWATER CHARGES								
20-4285-45-43010	STORMWATER FEES	0	0	0	0	0.0	0	**625,000**
20-4285-45-43025	LATE FEES STORMWATER	0	0	0	0	0.0	0	**18,730**
TOTAL STORMWATER CHARGES		0	0	0	0	-	0	**643,730**
TOTAL REVENUES		**6,817,056**	**8,427,413**	**7,564,758**	**3,924,831**	**51.88**	**3,639,927**	**8,337,920**

FY 2024-2025 Proposed Annual Budget

EXPENDITURE SUMMARY	FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	Proposed Annual BUDGET FY 2024-25 REQUESTED 2024-25 BUDGET
				50.00 % OF YEAR COMPLETE			
PUBLIC WORKS							
PERSONNEL	485,446	483,604	619,396	285,803	46.14	333,592	**843,918**
OPERATING	10,946	21,307	29,702	13,258	44.64	16,444	**43,113**
REPAIRS & MAINTENANCE	21,269	13,756	41,500	2,976	7.17	38,524	**26,500**
CONTRACTED SERVICES	34,064	120,893	31,445	15,093	48.00	16,352	**55,345**
TOTAL PUBLIC WORKS	551,725	647,193	731,543	330,389	45.16	401,154	**995,876**
WATER							
PERSONNEL	228,675	264,166	603,164	134,625	22.32	468,539	**581,587**
OPERATING	277,357	1,064,284	438,039	160,046	36.54	277,993	**530,078**
REPAIRS & MAINTENANCE	89,039	204,819	102,500	786,499	767.32	(683,999)	**223,853**
WATER/WASTEWATER	1,884,712	2,012,419	2,267,750	1,218,721	53.74	1,049,029	**2,567,750**
CONTRACTED SERVICES	9,361	115,048	138,300	40,864	29.55	97,436	**100,500**
DEBT PAYMENTS	81,618	61,295	129,308	66,137	51.15	63,172	**132,630**
CAPITAL OUTLAY < $5K	1,727	8,705	8,000	473	5.91	7,527	**78,425**
CAPITAL OUTLAY > $5K	28,009	331,944	848,058	8,700	1.03	839,358	**119,200**
TOTAL WATER	2,600,497	4,062,680	4,535,119	2,416,064	53.27	2,119,055	**4,334,023**
WASTEWATER							
PERSONNEL	162,265	205,304	468,982	226,602	48.32	242,380	**633,347**
OPERATING	495,209	427,288	533,412	382,775	71.76	150,637	**585,520**
REPAIRS & MAINTENANCE	43,305	224,792	92,000	193,647	210.49	(101,647)	**199,000**
WATER/WASTEWATER	253,803	71,507	80,500	44,621	55.43	35,879	**87,500**
CONTRACTED SERVICES	309,500	911,581	835,248	346,293	41.46	488,955	**1,035,248**
DEBT PAYMENTS	0	0	20,000	6,640	33.20	13,360	**20,000**
CAPITAL OUTLAY < $5K	0	0	5,000	0	-	5,000	**34,452**
CAPITAL OUTLAY > $5K	13,081	0	262,955	251,941	95.81	11,014	**262,955**
TOTAL WASTEWATER	1,277,163	1,840,471	2,298,097	1,452,519	63.21	845,578	**2,858,022**
STORMWATER							
CONTRACTED SERVICES	0	0	0	0	-	0	**150,000**
TOTAL STORMWATER	0	0	0	0	-	0	**150,000**
TOTAL EXPENDITURES	**4,429,386**	**6,550,344**	**7,564,759**	**4,198,972**	**55.51**	**3,365,787**	**8,337,920**
REVENUES OVER/(UNDER) EXPENDITURES	**2,387,670**	**1,877,069**	**(0)**	**(274,141)**		**274,141**	**(0)**

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FY2024-2025 PROPOSED ANNUAL BUDGET

20 -UTILITY FUND
EXPENDITURES

50.00 % OF YEAR COMPLETE

PUBLIC WORKS EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**Proposed Annual Budget FY 2024-25 REQUESTED 2024-25 BUDGET**
PERSONNEL								
20-5200-50-50010	SALARIES	389,636	388,899	475,806	217,418	45.69	258,388	**641,236**
20-5200-50-50050	OVERTIME	0	0	743	8,889	1,195.92	(8,146)	**2,517**
20-5200-50-50075	LONGEVITY	4,600	2,600	3,100	1,800	58.06	1,300	**4,300**
20-5200-50-50200	EMPLOYER PAID TAXES	30,138	28,293	36,693	17,180	46.82	19,513	**49,576**
20-5200-50-50255	WORKERS' COMPENSATION	292	333	400	1,232	308.00	(832)	**26,076**
20-5200-50-50325	HEALTH INSURANCE	21,496	26,390	56,074	19,644	35.03	36,430	**66,779**
20-5200-50-50326	TEAM BUILDING	0	0	2,000	340	16.98	1,660	**2,500**
20-5200-50-50335	HEALTH ASSISTANCE	0	0	0	0	-	0	**0**
20-5200-50-50410	EMPLOYER RETIREMENT CO	33,945	32,876	39,079	18,800	48.11	20,279	**50,435**
20-5200-50-50520	EMPLOYEE EDUCATION	540	4,212	5,000	500	10.00	4,500	
20-5200-50-50650	VEHICLE ALLOWANCE	4,800	0	0	0	-	0	**0**
20-5200-50-50700	REIMBURSABLE UNEMPLOYMEN	0	0	500	0	-	500	**500**
TOTAL PERSONNEL		485,446	483,604	619,396	285,803	46.14	333,592	**843,918**
OPERATING								
20-5200-51-51010	ADVERTISING/POSTING/NOTIFIC	419	3,970	1,100	889	80.85	211	**1,500**
20-5200-51-51011	PRE-EMPLOYMENT SCREENING	2	0	65	0	-	65	**65**
20-5200-51-51012	SAFETY & ACCESSORIES	1,927	2,263	2,000	1,782	89.10	218	**2,500**
20-5200-51-51040	BAD DEBTS	0	0	0	0	-	0	**0**
20-5200-51-51480	MEETING EXPENSES	0	55	500	0	-	500	**1,500**
20-5200-51-51485	MISCELLANEOUS	1,809	2,167	2,000	1,401	70.05	599	**2,000**
20-5200-51-51610	PERMITS & LICENSES	0	156	200	100	50.00	100	**200**
20-5200-51-51620	PHYSICALS/DRUG TESTING	0	0	85	0	-	85	**85**
20-5200-51-51625	POSTAGE/DELIVERY	72	191	200	42	20.98	158	**200**
20-5200-51-51635	PROFESSIONAL & MEMBERS	0	1,010	2,000	0	-	2,000	**2,500**
20-5200-51-51743	SUPPLIES-EQUIPMENT	0	0	0	0	-	0	**4,000**
20-5200-51-51746	SUPPLIES-OFFICE	4,761	6,706	6,000	5,457	90.94	544	**7,000**
20-5200-51-51780	TRAVEL	-217	882	300	274	91.43	26	**600**
20-5200-51-51800	UNIFORMS & ACCESSORIES	495	552	1,500	115	7.70	1,385	**7,700**
20-5200-51-51813	UTILITIES-ELECTRIC BLU	0	0	5,489	0	-	5,489	**5,000**
20-5200-51-52110	OFFICE EQUIPMENT LEASE	1,678	3,355	8,263	3,198	38.70	5,066	**8,263**
TOTAL OPERATING		10,946	21,307	29,702	13,258	44.64	16,444	**43,113**

REPAIRS & MAINTENANCE								
20-5200-52-52010	BUILDING REPAIRS & MAINT	16,471	9,726	35,000	897	2.56	34,103	**20,000**
20-5200-52-52012	CLEANING & MAINTENANCE	4,798	4,031	6,500	2,079	31.98	4,421	**6,500**
TOTAL REPAIRS & MAINTENANCE		21,269	13,756	41,500	2,976	7.17	38,524	**26,500**
CONTRACTED SERVICES								
20-5200-54-51001	CONSULTANT FEES - RATE STUDY	33,406	116,378	27,345	8,256	30.19	19,089	**27,345**
20-5200-54-51165	ENGINEERING/PLANNING SVCS	0	0	3,500	6,063	173.23	(2,563)	**27,000**
20-5200-54-51440	LEGAL FEES	658	4,515	600	773	128.89	(173)	**1,000**
TOTAL CONTRACTED SERVICES		34,064	120,893	31,445	15,093	48.00	16,352	**55,345**
DEBT PAYMENTS								
20-5200-55-52310	VEHICLE LEASE EXPENSE	0	7,633	9,500	13,259	139.57	(3,759)	**27,000**
TOTAL DEBT PAYMENTS		0	7,633	9,500	13,259	139.57	(3,759)	**27,000**
TOTAL PUBLIC WORKS EXPENDITURES		**551,725**	**647,193**	**731,543**	**330,389**	**45.16**	**401,154**	**995,876**

FY2024-2025 PROPOSED ANNUAL BUDGET

WATER EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
PERSONNEL								
20-5250-50-50010	SALARIES	153,801	163,591	423,610	79,443	18.75	344,167	**413,136**
20-5250-50-50050	OVERTIME	17,607	31,844	25,000	18,551	74.20	6,449	**16,193**
20-5250-50-50075	LONGEVITY PAY	1,000	1,300	1,600	1,200	75.00	400	**1,400**
20-5250-50-50200	EMPLOYER PAID TAXES	13,096	15,104	27,008	7,540	27.92	19,468	**32,951**
20-5250-50-50255	WORKERS' COMPENSATION	7,492	8,325	10,070	3,945	39.18	6,125	**19,382**
20-5250-50-50325	HEALTH INSURANCE	18,900	27,174	74,765	13,176	17.62	61,589	**58,431**
20-5250-50-50410	EMPLOYER RETIREMENT CO	14,730	16,528	36,111	8,153	22.58	27,958	**31,021**
20-5250-50-50520	EMPLOYEE EDUCATION	2,049	300	5,000	2,618	52.36	2,382	**8,572**
20-5250-50-50700	REIMB UNEMPLOYMENT	0	0	0	0	-	0	**500**
TOTAL PERSONNEL		228,675	264,166	603,164	134,625	22.32	468,539	**581,587**
OPERATING								
20-5250-51-51011	PRE-EMPLOYMENT SCREENING	2	0	200	0	-	200	**200**
20-5250-51-51335	INSURANCE-PROPERTY, CA	10,743	19,884	15,844	20,060	126.61	(4,217)	**28,200**
20-5250-51-51338	INSURANCE LIABILITY	3,293	2,872	4,640	1,802	38.83	2,838	**4,640**
20-5250-51-51485	MISCELLANEOUS	548	491,516	500	0	-	500	**500**
20-5250-51-51610	PERMITS & LICENSES	9,707	9,707	11,000	13,001	118.19	(2,001)	**13,500**
20-5250-51-51620	PHYSICALS/DRUG TESTING	0	0	200	0	-	200	**200**
20-5250-51-51635	PROFESSIONAL & MEMBERS	0	375	600	150	25.00	450	**600**
20-5250-51-51740	SUPPLIES - CHEMICALS & MATER	46,286	256,653	95,000	83,819	88.23	11,181	**167,638**
20-5250-51-51743	SUPPLIES-EQUIPMENT	10,087	38,669	40,000	0	-	40,000	**40,000**
20-5250-51-51747	METER PURCHASE	110,487	129,449	125,000	535	0.43	124,465	**125,000**
20-5250-51-51780	TRAVEL	0	227	1,000	2,136	213.57	(1,136)	**1,000**
20-5250-51-51800	UNIFORMS & ACCESSORIES	2,741	2,330	5,220	2,698	51.69	2,522	**8,100**
20-5250-51-51809	R.O.W FEES	689	14,388	25,000	1,425	5.70	23,575	**25,000**
20-5250-51-51810	UTILITIES-ELECTRIC AUS	39,921	34,468	45,000	13,913	30.92	31,087	**45,000**
20-5250-51-51813	UTILITIES-ELECTRIC BLU	24,149	17,701	23,335	6,783	29.07	16,552	**20,000**
20-5250-51-52340	FUEL & OIL	13,300	12,046	15,000	10,240	68.27	4,760	**20,000**
20-5250-51-52440	EQUIPMENT RENTAL	479	0	500	0	-	500	**500**
20-5250-51-53010	TESTING WATER	4,927	34,001	30,000	3,484	11.61	26,516	**30,000**
TOTAL OPERATING		277,357	1,064,284	438,039	160,046	36.54	277,993	**530,078**

REPAIRS & MAINTENANCE								
20-5250-52-52010	BUILDING REPAIRS & MAI	1,013	0	15,000	0	-	15,000	**20,000**
20-5250-52-52320	VEHICLE REPAIRS & MAIN	7,723	10,064	7,500	7,076	94.35	424	**10,000**
20-5250-52-52430	MACHINERY EQUIPMENT-RE	10,830	2,918	20,000	5,035	25.18	14,965	**20,000**
20-5250-52-52460	REPAIRS-WELLS,PUMPS,MO	69,472	191,838	60,000	774,388	1,290.65	(714,388)	**173,853**
TOTAL REPAIRS & MAINTENANCE		89,039	204,819	102,500	786,499	767.32	(683,999)	**223,853**
WATER								
20-5250-53-53030	WATER FEES-AUSTIN	353	417	500	237	47.42	263	**500**
20-5250-53-53040	WATER FEES-MANVILLE	495,974	560,859	532,250	215,906	40.56	316,344	**532,250**
20-5250-53-53050	WATER FEES-BLUEWATER	1,356,462	1,425,248	1,700,000	997,548	58.68	702,452	**2,000,000**
20-5250-53-53060	WELL ROYALTIES-FOWLER	22,876	17,498	25,000	4,082	16.33	20,918	**25,000**
20-5250-53-53070	WELL ROYALITIES-LEE	9,048	8,397	10,000	948	9.48	9,052	**10,000**
TOTAL WATER/WASTEWATER		1,884,712	2,012,419	2,267,750	1,218,721	53.74	1,049,029	**2,567,750**
CONTRACTED SERVICES								
20-5250-54-51165	ENGINEERING/PLANNING S	9,349	115,048	137,500	40,489	29.45	97,011	**100,000**
20-5250-54-51440	LEGAL FEES	0	0	0	375	-	(375)	**500**
20-5250-54-51595	MVBA UTIL COLLECTION	12	0	800	0	-	800	**0**
TOTAL CONTRACTED SERVICES		9,361	115,048	138,300	40,864	29.55	97,436	**100,500**
DEBT PAYMENTS								
20-5250-55-52310	VEHICLE LEASE EXPENSE	31,265	29,902	57,630	13,259	23.01	44,371	**57,630**
20-5250-55-52410	MACHINERY EQUIPMENT LE	50,352	31,392	71,679	52,878	73.77	18,801	**75,000**
TOTAL DEBT PAYMENTS		81,618	61,295	129,308	66,137	51.15	63,172	**132,630**
CAPITAL OUTLAY < $5K								
20-5250-57-52400	MACHINERY EQUIPMENT-PU	0	3,031	5,000	0	-	5,000	**74,425**
20-5250-57-52450	TOOLS	1,727	5,674	3,000	473	15.76	2,527	**4,000**
TOTAL CAPITAL OUTLAY < $5K		1,727	8,705	8,000	473	5.91	7,527	**78,425**
CAPITAL OUTLAY > $5K								
20-5250-58-52400	MACHINERY EQUIPMENT-PU	28,009	98,104	49,000	8,700	17.76	40,300	**119,200**
20-5250-58-58004	WATER TANK PURCHASE	0	233,840	799,058	0	-	799,058	**0**
TOTAL CAPITAL OUTLAY > $5K		28,009	331,944	848,058	8,700	1.03	839,358	**119,200**
TOTAL WATER EXPENDITURES		**2,600,497**	**4,062,680**	**4,535,119**	**2,416,064**	**53.27**	**2,119,055**	**4,334,023**

FY2024-2025 PROPOSED ANNUAL BUDGET

WASTEWATER EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
PERSONNEL								
20-5275-50-50010	SALARIES	111,969	108,874	310,841	156,624	50.39	154,217	**447,509**
20-5275-50-50050	OVERTIME	6,893	40,622	35,747	9,137	25.56	26,610	**18,336**
20-5275-50-50075	LONGEVITY PAY	1,100	1,300	1,700	1,300	76.47	400	**2,600**
20-5275-50-50200	EMPLOYER PAID TAXES	8,880	11,570	26,644	12,774	47.94	13,870	**35,836**
20-5275-50-50255	WORKERS' COMPENSATION	2,992	3,330	3,600	3,026	84.06	574	**21,080**
20-5275-50-50325	HEALTH INSURANCE	18,936	23,850	56,074	28,924	51.58	27,150	**66,779**
20-5275-50-50410	EMPLOYER RETIREMENT CO	10,226	12,685	28,377	13,709	48.31	14,667	**35,207**
20-5275-50-50520	EMPLOYEE EDUCATION	1,269	3,074	5,500	1,109	20.16	4,391	**5,500**
20-5275-50-50700	REIMB UNEMPLOYMENT	0	0	500	0	-	500	**500**
TOTAL PERSONNEL		162,265	205,304	468,982	226,602	48.32	242,380	**633,347**
OPERATING								
20-5275-51-51011	PRE-EMPLOYMENT SCREENING	72	64	100	1	1.00	99	**100**
20-5275-51-51335	INSURANCE-PROPERTY, CA	15,097	16,911	20,000	12,735	63.67	7,265	**20,000**
20-5275-51-51338	INSURANCE LIABILITY	2,059	1,867	1,900	1,135	59.74	765	**2,000**
20-5275-51-51603	PERIODICALS & PUBLICAT	0	0	100	0	-	100	**100**
20-5275-51-51610	PERMITS & LICENSES	7,593	7,558	7,542	8,069	106.99	(527)	**8,100**
20-5275-51-51620	PHYSICALS/DRUG TESTING	0	0	120	2	1.67	118	**120**
20-5275-51-51635	PROFESSIONAL & MEMBERS	0	0	600	150	25.00	450	**600**
20-5275-51-51740	SUPPLIES CHEMICALS & MATERI/	209,278	117,497	200,000	204,355	102.18	(4,355)	**250,000**
20-5275-51-51746	SUPPLIES-OFFICE	0	0	0	54	-	(54)	**200**
20-5275-51-51780	TRAVEL	0	0	500	0	-	500	**500**
20-5275-51-51800	UNIFORMS & ACCESSORIES	529	959	6,300	944	14.98	5,356	**6,300**
20-5275-51-51809	R.O.W. FEES	689	0	750	1,425	190.00	(675)	**2,000**
20-5275-51-51813	UTILITIES-ELECTRIC BLU	244,384	268,327	275,000	143,666	52.24	131,334	**275,000**
20-5275-51-51815	UTILITIES-ELECTRIC TX	9,444	11,844	15,000	6,804	45.36	8,196	**15,000**
20-5275-51-52340	FUEL & OIL	6,066	2,261	5,500	3,436	62.47	2,064	**5,500**
TOTAL OPERATING		495,209	427,288	533,412	382,775	71.76	150,637	**585,520**
REPAIRS & MAINTENANCE								
20-5275-52-52010	BUILDING REPAIRS & MAI	4,000	9,584	15,000	14,520	96.80	480	**20,000**
20-5275-52-52320	VEHICLE REPAIRS & MAIN	670	2,717	2,000	3,340	167.02	(1,340)	**4,000**
20-5275-52-52430	MACHINERY EQUIPMENT-RE	12,869	23,747	25,000	3,439	13.76	21,561	**25,000**
20-5275-52-52460	REPAIRS-LIFTSTATION,PUMPS,M	25,766	188,744	50,000	172,348	344.70	(122,348)	**150,000**
TOTAL REPAIRS & MAINTENANCE		43,305	224,792	92,000	193,647	210.49	(101,647)	**199,000**

WASTEWATER								
20-5275-53-53010	TESTING WASTEWATER	49,947	47,450	65,000	40,349	62.07	24,651	**72,000**
20-5275-53-53040	WATER FEES-MANVILLE	34,715	24,057	15,500	4,272	27.56	11,228	**15,500**
20-5275-53-53160	WASTEWATER FEES-AUSTIN	169,141	0	0	0	-	0	**0**
TOTAL WATER/WASTEWATER		253,803	71,507	80,500	44,621	55.43	35,879	**87,500**
CONTRACTED SERVICES								
20-5275-54-51165	ENGINEERING/PLANNING S	133,893	490,696	604,000	127,385	21.09	476,615	**604,000**
20-5275-54-51440	LEGAL FEES	0	1,248	1,248	0	-	1,248	**1,248**
20-5275-54-53150	SLUDGE DISPOSAL	175,607	419,636	230,000	218,908	95.18	11,092	**430,000**
TOTAL CONTRACTED SERVICES		309,500	911,581	835,248	346,293	41.46	488,955	**1,035,248**
DEBT PAYMENTS								
20-5275-55-52310	VEHICLE LEASE EXPENSE	0	0	20,000	6,640	33.20	13,360	**20,000**
TOTAL DEBT PAYMENTS		0	0	20,000	6,640	33.20	13,360	**20,000**
CAPITAL OUTLAY < $5K								
20-5275-57-52400	MACHINERY EQUIPMENT-PURCH	0	0	5,000	0	-	5,000	**34,452**
TOTAL CAPITAL OUTLAY < $5K		0	0	5,000	0	-	5,000	**34,452**
CAPITAL OUTLAY > $5K								
20-5275-58-52400	MACHINERY EQUIPMENT-PU	0	0	247,955	251,941	101.61	(3,986)	**247,955**
20-5275-58-52410	CAPITAL OUTLAY	13,081	0	15,000	0	-	15,000	**15,000**
TOTAL CAPITAL OUTLAY > $5K		13,081	0	262,955	251,941	95.81	11,014	**262,955**
TOTAL WASTEWATER EXPENDITURES		**1,277,163**	**1,840,471**	**2,298,097**	**1,452,519**	**63.21**	**845,578**	**2,858,022**

FY2024-2025 PROPOSED ANNUAL BUDGET

STORMWATER EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
CONTRACTED SERVICES								
20-5285-54-51165	CONSULTANT FEES	0	0	0	0	-	0	**150,000**
TOTAL CONTRACTED SERVICES		0	0	0	0	-	0	**150,000**
TOTAL STORMWATER EXPENDITURES		**0**	**0**	**0**	**0**	**-**	**0**	**150,000**
TOTAL EXPENDITURES		**4,429,386**	**6,550,344**	**7,564,759**	**4,198,972**	**55.51**	**3,365,787**	**8,337,920**
REVENUES OVER/(UNDER) EXPENDITURES		**2,387,670**	**1,877,069**	**0**	**-274,141**		**274,141**	**0**

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FY 2024-2025 Proposed Annual Budget

30 -DEBT SERVICE FUND
FINANCIAL SUMMARY

Proposed Annual BUDGET FY 2024-25

50.00 % OF YEAR COMPLETE

REVENUE SUMMARY	FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	REQUESTED 2024-25 BUDGET
NON-DEPARTMENTAL							
TAXES	2,193,922	4,177,694	4,176,588	4,247,239	101.69	(70,651)	**7,585,234.00**
OTHER	2,010	13,330	12,109	8,160	67.39	3,948	**13,000.00**
TRANSFERS	0	0	0	0	-	0	**-**
TOTAL NON-DEPARTMENTAL	2,195,932	4,191,024	4,188,697	4,255,400	101.59	(66,703)	**7,598,234.00**
TOTAL REVENUES	**2,195,932**	**4,191,024**	**4,188,697**	**4,255,400**	**101.59**	**(66,703)**	**7,598,234.00**

Proposed Annual BUDGET FY 2024-25

50.00 % OF YEAR COMPLETE

EXPENDITURE SUMMARY	FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	REQUESTED 2024-25 BUDGET
NON-DEPARTMENTAL							
OPERATING	300	300	150	150	100.00	0	**150.00**
DEBT PAYMENTS	2,816,769	4,177,614	4,177,374	360,560	8.63	3,816,813	**7,580,233.69**
TRANSFERS	0	0	0	0	-	0	**-**
TOTAL NON-DEPARTMENTAL	2,817,069	4,177,914	4,177,524	360,710	8.63	3,816,813	**7,580,383.69**
TOTAL EXPENDITURES	**2,817,069**	**4,177,914**	**4,177,524**	**360,710**	**8.63**	**3,816,813**	**7,580,383.69**
REVENUES OVER/(UNDER) EXPENDITURES	**(621,137)**	**13,110**	**11,173**	**3,894,689**		**(3,883,516)**	**17,850.31**

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30 -DEBT SERVICE FUND REVENUES							Proposed	Annual BUDGET FY 2024-25
NON-DEPARTMENTAL REVENUES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
TAXES								
30-4999-40-40000	ADVALOREM TAXES - CURR	2,159,070	4,175,043	4,176,588	4,227,576	101.22	(50,988)	**7,580,234**
30-4999-40-40010	ADVALOREM TAXES - DELI	34,852	2,651	0	19,663	-	(19,663)	**5,000**
TOTAL TAXES		2,193,922	4,177,694	4,176,588	4,247,239	101.69	(70,651)	**7,585,234**
OTHER								
30-4999-48-48000	INTEREST INCOME	2,010	13,330	12,109	8,160	67.39	3,948	**13,000**
30-4999-48-49000	BOND PROCEEDS	0	0	0	0	-	0	**-**
TOTAL OTHER		2,010	13,330	12,109	8,160	67.39	3,948	**13,000**
TRANSFERS								
30-4999-49-5000	TRANSFER FROM GF	0	0	0	0	-	0	**-**
30-4999-49-50005	TRANSFER FROM GF	0	0	0	0	-	0	**-**
30-4999-49-50010	TRANSFER FROM UF	0	0	0	0	-	0	**-**
30-4999-49-60010	TRANSFER FROM CPF	0	0	0	0	-	0	**-**
TOTAL TRANSFERS		0	0	0	0	-	0	**-**
TOTAL NON-DEPARTMENTAL REVENUES		**2,195,932**	**4,191,024**	**4,188,697**	**4,255,400**	**101.59**	**(66,703)**	**7,598,234**
TOTAL REVENUES		**2,195,932**	**4,191,024**	**4,188,697**	**4,255,400**	**101.59**	**(66,703)**	**7,598,234**

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FY2024-2025 PROPOSED ANNUAL BUDGET

30 -DEBT SERVICE FUND EXPENDITURES							Proposed	Annual BUDGET FY 2024-25
NON-DEPARTMENTAL EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	REQUESTED 2024-25 BUDGET
OPERATING								
30-5999-51-51050	BANK ADMIN FEES	300	300	150	150	100.00	0	**150**
TOTAL OPERATING		300	300	150	150	100.00	0	**150**
DEBT PAYMENTS								
30-5999-55-53000	BOND ADMIN FEES	935	635	635	0	-	635	**785**
30-5999-55-59030	INTEREST - 2010 GO BONDS	2,411	0	0	0	-	0	**-**
30-5999-55-59031	INTEREST - 2012 GO BONDS	27,158	19,253	11,220	5,610	50.00	5,610	**3,188**
30-5999-55-59032	INTEREST - 2012 CO BONDS	20,314	17,118	13,944	6,900	49.48	7,044	**10,583**
30-5999-55-59033	INTEREST - 2015 GO BONDS	67,108	56,934	46,487	23,007	49.49	23,480	**35,381**
30-5999-55-59034	INTEREST - 2016 CO BONDS	329,531	312,127	294,265	147,133	50.00	147,133	**275,945**
30-5999-55-59035	INTEREST - 2021 CO BONDS	74,313	105,072	98,472	49,236	50.00	49,236	**91,784**
30-5999-55-59036	INTEREST - 2022 TAX NOTES	0	266,475	257,351	128,675	50.00	128,675	**217,553**
30-5999-55-59037	INTEREST - 2023 CO BONDS	0	0	0	0	-	0	**1,812,250**
30-5999-55-59038	INTEREST - 2024 CO BONDS	0	0	0	0	-	0	**992,767**
30-5999-55-59530	PRINCIPAL -2010 GO BOND	255,000	0	0	0	-	0	**-**
30-5999-55-59531	PRINCIPAL -2012 GO BOND	310,000	315,000	315,000	0	-	315,000	**60,000**
30-5999-55-59532	PRINCIPAL -2012 CO BOND	130,000	130,000	135,000	0	-	135,000	**140,000**
30-5999-55-59533	PRINCIPAL -2015 GO BOND	450,000	465,000	485,000	0	-	485,000	**500,000**
30-5999-55-59534	PRINCIPAL -2016 CO BOND	760,000	780,000	800,000	0	-	800,000	**1,170,000**
30-5999-55-59535	PRINCIPAL -2021 CO BOND	390,000	375,000	380,000	0	-	380,000	**390,000**
30-5999-55-59536	PRINCIPAL -2022 TAX NOTES	0	1,335,000	1,340,000	0	-	1,340,000	**1,380,000**
30-5999-55-59537	PRINCIPAL - 2023 CO BOND	0	0	0	0	-	0	**500,000**
30-5999-55-59538	PRINCIPAL - 2024 GO BOND	0	0	0	0	-	0	-
TOTAL DEBT PAYMENTS		2,816,769	4,177,614	4,177,374	360,560	8.63	3,816,813	**7,580,234**
TRANSFERS								
30-5999-59-60000	2010 GO BOND ISSUE COS	0	0	0	0	-	0	**-**
30-5999-60-15000	TRANSFER TO UF	0	0	0	0	-	0	**-**
TOTAL TRANSFERS		0	0	0	0	-	0	**-**
TOTAL NON-DEPARTMENTAL EXPENDITURES		**2,817,069**	**4,177,914**	**4,177,524**	**360,710**	**8.63**	**3,816,813**	**7,580,384**
TOTAL EXPENDITURES		**2,817,069**	**4,177,914**	**4,177,524**	**360,710**	**8.63**	**3,816,813**	**7,580,384**
REVENUES OVER/(UNDER) EXPENDITURES		**(621,137)**	**13,110**	**11,173**	**3,894,689**		**(3,883,516)**	**17,850**

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FY 2024-2025 Proposed Approved Annual Budget

40 -CAPITAL PROJECTS FUND
FINANCIAL SUMMARY

50.00 % OF YEAR COMPLETE

REVENUE SUMMARY	FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	Proposed Annual BUDGET FY 2024-25 REQUESTED 2024-25 BUDGET
NON-DEPARTMENTAL							
OTHER	29,882	477,004	346,068	620,789	179.38	(274,721)	**1,200,000**
TOTAL NON-DEPARTMENTAL	29,882	477,004	346,068	620,789	179.38	(274,721)	**1,200,000**
TOTAL REVENUES	**29,882**	**477,004**	**346,068**	**620,789**	**179.38**	**(274,721)**	**1,200,000**

EXPENDITURE SUMMARY	FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	Proposed Annual BUDGET FY 2024-25 REQUESTED 2024-25 BUDGET
BOND PROJECTS							
CAPITAL OUTLAY > $5K	278,441	1,356,119	663,023	27,782,056	4,190.21	(27,119,033)	**19,674,333**
TOTAL BOND PROJECTS	278,441	1,356,119	663,023	27,782,056	4,190.21	(27,119,033)	**19,674,333**
TOTAL EXPENDITURES	**278,441**	**1,356,119**	**663,023**	**27,782,056**	**4,190.21**	**(27,119,033)**	**19,674,333**
REVENUES OVER/(UNDER) EXPENDITURES	**(248,559)**	**(879,114)**	**(316,955)**	**(27,161,268)**		**26,844,313**	**(18,474,333)**

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40 -CAPITAL PROJECTS FUND
REVENUES

NON-DEPARTMENTAL REVENUES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	Proposed Annual BUDGET FY 2024-25 REQUESTED 2024-25 BUDGET
				50.00 % OF YEAR COMPLETE				
OTHER								
40-4999-48-48000	INTEREST INCOME	29,882	477,004	346,068	620,789	179.38	(274,721)	**1,200,000**
TOTAL OTHER		29,882	477,004	346,068	620,789	179.38	(274,721)	**1,200,000**
TOTAL NON-DEPARTMENTAL REVENUES		**29,882**	**477,004**	**346,068**	**620,789**	**179.38**	**(274,721)**	**1,200,000**
TOTAL REVENUES		**29,882**	**477,004**	**346,068**	**620,789**	**179.38**	**(274,721)**	**1,200,000**

40 -CAPITAL PROJECTS FUND
EXPENDITURES

IMPACT FEE PROJECTS EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	Proposed Annual BUDGET FY 2024-25 REQUESTED 2024-25 BUDGET
				50.00 % OF YEAR COMPLETE				
CAPITAL OUTLAY > $5K								
40-5997-58-58006	2021 CO BOND EXPENSES	278,441	787,108	280,686	364,932	130.01	(84,246)	**3,269,258**
40-5997-58-58007	2022 TAX NOTE BOND EXP		569,011	382,337	208,772	54.60	173,565	**8,288,485**
40-5997-58-58008	2023 CO BOND EXPENSES	0	0	0	16,061,277	-	(16,061,277)	**7,116,590**
40-5997-58-58009	2024 CO BOND EXPENSES	0	0	0	11,147,075	-	(11,147,075)	**1,000,000**
TOTAL CAPITAL OUTLAY > $5K		278,441	1,356,119	663,023	27,782,056	4,190.21	(27,119,033)	**19,674,333**
TOTAL BOND PROJECTS EXPENDITURES		**278,441**	**1,356,119**	**663,023**	**27,782,056**	**4,190.21**	**(27,119,033)**	**19,674,333**
TOTAL EXPENDITURES		**278,441**	**1,356,119**	**663,023**	**27,782,056**	**4,190.21**	**(27,119,033)**	**19,674,333**
REVENUES OVER/(UNDER) EXPENDITURES		**(248,559)**	**(879,114)**	**(316,955)**	**(27,161,268)**		**26,844,313**	**(18,474,333)**

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FY 2024-2025 Proposed Annual Budget

60 -SPECIAL REVENUE FUND **Proposed** **Annual BUDGET**
FINANCIAL SUMMARY **FY 2024-25**

50.00 % OF YEAR COMPLETE

REVENUE SUMMARY	FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	REQUESTED 2024-25 BUDGET
ADMINISTRATION							
TAXES	81,215	225,987	212,652	55,616	26.2	157,036	**268,104**
OTHER	0	858	15,452	31,823	205.9	(16,371)	**114,000**
TOTAL ADMINISTRATION	81,215	226,844	228,104	87,439	38.3	140,665	**382,104**
TOTAL REVENUES	**81,215**	**226,844**	**228,104**	**87,439**	**38.3**	**140,665**	**382,104**

EXPENDITURE SUMMARY	FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	REQUESTED 2024-25 BUDGET
ADMINISTRATION							
OPERATING	120,545	66,657	100,000	88,996	89.0	11,004	**141,050**
TOTAL ADMINISTRATION	120,545	66,657	100,000	88,996	89.0	11,004	**141,050**
TOTAL EXPENDITURES	**120,545**	**66,657**	**100,000**	**88,996**	**89.0**	**11,004**	**141,050**
REVENUES OVER/(UNDER) EXPENDITURES	**(39,330)**	**160,187**	**128,104**	**(1,557)**		**129,661**	**241,054**

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FY 2024-2025 Proposed Annual Budget

60 -SPECIAL REVENUE FUND REVENUES					Proposed			Annual BUDGET FY 2024-25
					50.00 % OF YEAR COMPLETE			
ADMINISTRATION REVENUES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	REQUESTED 2024-25 BUDGET
TAXES								
60-4100-40-40020	MANOR HEIGHTS TIRZ TAX	0	128,104	128,104	0	-	128,104	**128,104**
60-4100-40-40030	HOTEL OCCUPANCY TAXES	76,458	71,069	65,110	38,139	58.58	26,971	**120,000**
60-4100-40-40031	LATE PENALTIES	0	5	0	0	-	0	**0**
60-4100-40-48000	HOT INTEREST INCOME	4,757	26,809	19,438	17,477	89.91	1,961	**20,000**
TOTAL TAXES		81,215	225,987	212,652	55,616	26.15	157,036	**268,104**
OTHER								
60-4100-48-48001	INTEREST INCOME - MH/TIRZ	0	858	15,427	2,139	13.86	13,288	**4,000**
60-4100-48-48002	INTEREST INCOME - RH	0	0	25	392	1,569.24	(367)	**10,000**
60-4100-48-48003	INTEREST INCOME - LAGOS	0	0	0	29,292	-	(29,292)	**50,000**
60-4100-48-48004	INTEREST INCOME - ENTRADA	0	0	0	0	-	0	**50,000**
TOTAL OTHER		0	858	15,452	31,823	205.95	(16,371)	**114,000**
TOTAL ADMINISTRATION REVENUES		**81,215**	**226,844**	**228,104**	**87,439**	**38.33**	**140,665**	**382,104**
TOTAL REVENUES		**81,215**	**226,844**	**228,104**	**87,439**	**38.33**	**140,665**	**382,104**

					Proposed			Annual BUDGET FY 2024-25
					50.00 % OF YEAR COMPLETE			
ADMINISTRATION EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	REQUESTED 2024-25 BUDGET
OPERATING								
60-5100-51-51000	HOTEL OCCUPANCY EXPENDITURES	62,756	66,626	100,000	0	-	100,000	**50,000**
60-5100-51-51001	SESQUICENTENNIAL EXP	57,789	0	0	0	-	0	**0**
60-5100-51-51020	MANOR HEIGHTS/TIRZ EXPENDITURES	0	31	0	911	-	(911)	**1,000**
60-5100-51-51030	ROSE HILL PID EXPENDITURES	0	0	0	24,866	-	(24,866)	**30,000**
60-5100-51-51040	LAGOS PID EXPENDITURES	0	0	0	63,213	-	(63,213)	**30,000**
60-5100-51-51050	ENTRADA GLEN EXPENDITURES	0	0	0	0	-	0	**30,000**
60-5100-51-51485	MISCELLANEOUS	0	0	0	6	-	(6)	**50**
TOTAL OPERATING		120,545	66,657	100,000	88,996	89.00	11,004	**141,050**
TOTAL ADMINISTRATION EXPENDITURES		**120,545**	**66,657**	**100,000**	**88,996**	**89.00**	**11,004**	**141,050**
TOTAL EXPENDITURES		**120,545**	**66,657**	**100,000**	**88,996**	**89.00**	**11,004**	**141,050**
REVENUES OVER/(UNDER) EXPENDITURES		**(39,330)**	**160,187**	**128,104**	**(1,557)**		**129,661**	**241,054**

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FY 2024-2025 Proposed Annual Budget

70 -CAPITAL IMPACT FEES FUND
FINANCIAL SUMMARY

Annual BUDGET FY 2024-25

50.00 % OF YEAR COMPLETE

REVENUE SUMMARY	FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	REQUESTED 2024-25 BUDGET
WATER							
OTHER	1,065,066	655,710	656,444	620,744	94.56	35,700	**844,358**
TOTAL WATER OTHER	1,065,066	655,710	656,444	620,744	94.56	35,700	**844,358**
WASTEWATER							
OTHER	4,703,534	2,013,103	1,682,352	2,478,503	147.32	(796,151)	**2,030,000**
TOTAL WASTEWATER OTHER	4,703,534	2,013,103	1,682,352	2,478,503	147.32	(796,151)	**2,030,000**
TOTAL REVENUES	**5,768,600**	**2,668,814**	**2,338,796**	**3,099,247**	**132.51**	**(760,451)**	**2,874,358**

EXPENDITURE SUMMARY	FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	REQUESTED 2024-25 BUDGET
WATER							
REPAIRS & MAINTENANCE	4,454	261,769	454,544	0	-	454,544	**454,544**
CONTRACTED SERVICES	4,454	0	6,500	124,299	1,912.28	(117,799)	**6,500**
TOTAL WATER	4,454	261,769	461,044	124,299	26.96	336,746	**461,044**
WASTEWATER							
REPAIRS & MAINTENANCE	5,699,357	1,918,711	1,852,752	2,378,875	128.40	(526,123)	**1,700,000**
CONTRACTED SERVICES	21,183	0	25,000	0	-	25,000	**25,000**
TOTAL WASTEWATER	5,720,540	1,918,711	1,877,752	2,378,875	126.69	(501,123)	**1,725,000**
TOTAL EXPENDITURES	**5,724,994**	**2,180,480**	**2,338,796**	**2,503,174**	107.03	**(164,378)**	**2,186,044**
REVENUES OVER/(UNDER) EXPENDITURES	**43,605**	**488,334**	**(0)**	**596,073**		**(596,073)**	**688,314**

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70 -CAPITAL IMPACT FEES FUND REVENUES					Proposed			Annual BUDGET FY 2024-25
					50.00 % OF YEAR COMPLETE			
WATER REVENUES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
OTHER								
70-4250-48-43090	CIF WATER	845,134	436,625	490,506	497,078	101.34	(6,572)	**650,000**
70-4250-48-43091	DR HORTONMH WATER FEE	216,630	186,970	144,358	62,958	43.61	81,400	**144,358**
70-4250-48-48000	INTEREST INCOME - WATER	3,302	32,116	21,580	60,708	281.32	(39,128)	**50,000**
TOTAL OTHER		1,065,066	655,710	656,444	620,744	94.56	35,700	**844,358**
TOTAL WATER REVENUES		**1,065,066**	**655,710**	**656,444**	**620,744**	**94.56**	**35,700**	**844,358**

WASTEWATER REVENUES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	**REQUESTED 2024-25 BUDGET**
OTHER								
70-4275-48-43190	CIF WASTEWATER	1,967,532	1,025,842	964,000	2,008,354	208.34	(1,044,354)	**1,200,000**
70-4275-48-43191	DDR HORTON MH WW FEES	1,198,142	969,258	717,852	390,879	54.45	326,973	**750,000**
70-4275-48-43192	KB HOMES OFFSITE WW	1,537,860	0	0	0	-	0	**0**
70-4275-48-48000	INTEREST INCOME - WASTEWATER	0	18,003	500	79,270	15,853.95	(78,770)	**80,000**
TOTAL OTHER		4,703,534	2,013,103	1,682,352	2,478,503	147.32	(796,151)	**2,030,000**
TOTAL WASTEWATER REVENUES		**4,703,534**	**2,013,103**	**1,682,352**	**2,478,503**	**147.32**	**(796,151)**	**2,030,000**
TOTAL REVENUES		**5,768,600**	**2,668,814**	**2,338,796**	**3,099,247**	**132.51**	**(760,451)**	**2,874,358**

70 -CAPITAL IMPACT FEES FUND EXPENDITURES								Proposed Annual BUDGET FY 2024-25
					50.00 % OF YEAR COMPLETE			
WATER EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	REQUESTED 2024-25 BUDGET
REPAIRS & MAINTENANCE								
70-5250-52-53001	WATER IMPROVEMENTS	832,975	79,970	254,544	19,359	7.61	235,185	**254,544**
70-5250-52-53002	DR HORTON MH 50% REPMNT	122,603	181,799	200,000	104,940	52.47	95,061	**200,000**
TOTAL REPAIRS & MAINTENANCE		955,577	261,769	454,544	124,299	27.35	330,246	**454,544**
CONTRACTED SERVICES								
70-5250-54-51165	IMPACT FEE STUDY - WAT	4,454	0	6,500	0	-	6,500	**6,500**
TOTAL CONTRACTED SERVICES		4,454	0	6,500	0	-	6,500	**6,500**
TOTAL WATER EXPENDITURES		**960,031**	**261,769**	**461,044**	**124,299**	**26.96**	**336,746**	**461,044**
WASTEWATER EXPENDITURES		FY 2021-22 ACTUAL	FY 2022-23 ORIG. BUDGET	FY 2023-24 CURR. BUDGET	Y-T-D ACTUAL AS OF 03/31/2024	% OF BUDGET	BUDGET BALANCE	REQUESTED 2024-25 BUDGET
REPAIRS & MAINTENANCE								
70-5275-52-53001	WASTEWATER IMPROVEMENTS	5,056,822	815,959	750,000	1,773,196	236.43	(1,023,196)	**1,000,000**
70-5275-52-53002	DR HORTON MH 100% REPMNT	642,535	1,102,752	1,102,752	605,679	54.92	497,073	**700,000**
TOTAL REPAIRS & MAINTENANCE		5,699,357	1,918,711	1,852,752	2,378,875	128.40	(526,123)	**1,700,000**
CONTRACTED SERVICES								
70-5275-54-51165	IMPACT FEE STUDY - WW	21,183	0	25,000	0	-	25,000	**25,000**
TOTAL CONTRACTED SERVICES		21,183	0	25,000	0	-	25,000	**25,000**
TOTAL WASTEWATER EXPENDITURES		**5,720,540**	**1,918,711**	**1,877,752**	**2,378,875**	**126.69**	**(501,123)**	**1,725,000**
TOTAL EXPENDITURES		**6,680,572**	**2,180,480**	**2,338,796**	**2,503,174**	**107.03**	**(164,378)**	**2,186,044**
REVENUES OVER/(UNDER) EXPENDITURES		**(911,972)**	**488,334**	**(0)**	**596,073**		**(596,073)**	**688,314**

City of Manor

New Positions
FY 24-25

General Fund	Fund 10	Sal&Ben
Administration	Assistant City Secretary	79,603.69
Finance	Sr. Accountant	109,041.33
Finance	PT Custodian	54,968.36
Streets	MS4 Inspector	80,240.80
Police	Police Clerk	65,184.62
	Total	**389,038.80**

Utility Fund	Fund 20	Sal&Ben
Public Works	PW Supervisor	95,484.05
Public Works	Utility Supervisor	103,765.62
Utility	Operator Crewman	73,622.79
Utility	Seasonal	18,015.78
Utility	Seasonal	18,015.78
Wastewater	W/WW Operator	73,622.79
Wastewater	Seasonal	18,015.78
	Total	**400,542.59**

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Debt Service Obligations
2024 AV Tax Year

BUDGET
FY 2024-2025

CITY OF MANOR DEBT OBLIGATIONS				Fiscal Year Oct 1, 2024 to Sept 30, 2025			
	Purpose	Amount of Issue	Outstanding as of Oct 1, 2024	Principal Due	Interest Due	Fees	Total
2012 Series GO Refunding	2001,2004 GO, & 2004 CO	3,510,000.00	125,000.00	60,000.00	3,187.50	150.00	63,337.50
2012 Certificate of Obligation	City Hall, PD Bldg., & PW Bldg.	1,835,000.00	425,000.00	140,000.00	10,582.50		150,582.50
2015 Series GO Refunding	2007 GO & 2007 CO	4,750,000.00	1,545,000.00	500,000.00	35,380.50		535,380.50
2016 Series CO Bond	W/WW Expansion & Streets	18,000,000.00	12,050,000.00	1,170,000.00	275,945.00	635.00	1,446,580.00
2021 CO Bond	W/WW Expansion	6,360,000.00	5,215,000.00	390,000.00	91,784.00		481,784.00
2022 Tax Note	W/WW Expansion	10,000,000.00	7,325,000.00	1,380,000.00	217,552.50		1,597,552.50
2023 Series Certificate of Obligations	W/WW Exp, P&R, Streets	36,245,000.00	36,245,000.00	500,000.00	1,812,250.00		2,312,250.00
2024 Series Certificate of Obligations	Infrastructure, Econ.Dev	15,000,000.00	15,000,000.00		992,766.69		992,766.69
Totals		**95,700,000.00**	**77,930,000.00**	**4,140,000.00**	**3,439,448.69**	**785.00**	**7,580,233.69**

	2023-24	2024-25	Change
Total Taxable Property Value	**2,101,439,419**	**2,256,097,556**	**154,658,137**
Adjusted -Total I&S Fund Pymts (Debt Service)	**4,177,524**	**7,580,234**	**3,402,710**
I&S Rate for Ad Valorem Tax	**0.1988**	**0.33599**	**0.13720**

LESS YEAR END BALANCE FORWARD: **0.00**

ADJUSTED 2024 DEBT SERVICE = **7,580,233.69**

Previous Tax Year De Minimis Tax Rate 0.6789
Current Tax Year De Minimis Tax Rate 0.8537

CO S2023 Interest due 8/2024 **$ 1,188,030.56**

Interest Earned:

Dec. 2023	44,410.29
Jan. 2024	124,863.54
Feb. 2024	105,072.70
Mar. 2024	105,469.24
Apr. 2024	116,819.07
May. 2024	110,144.77
Jun. 2024	97,413.93
Jul. 2024	
	704,193.54

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CITY OF MANOR

ANNUAL DEBT

YEAR	2012	2012	2015	2016	2021	2022	2023	2024	TOTALS
FY 23-24	326,220.00	148,944.00	531,487.00	1,094,265.00	478,472.00	1,597,350.50	1,188,030.56	-	5,364,769.06
FY 24-25	63,187.50	150,582.50	535,380.50	1,445,945.00	481,784.00	1,597,552.50	2,312,250.00	992,766.69	7,579,448.69
FY 25-26	66,657.50	147,096.50	538,930.50	1,449,152.00	479,920.00	1,596,566.50	2,287,250.00	906,763.00	7,472,336.00
FY 26-27		148,610.50	542,137.00	1,511,672.00	482,968.00	1,599,392.50	2,262,250.00	901,603.00	7,448,633.00
FY 27-28				2,207,131.00	480,840.00	1,595,882.00	2,237,250.00	896,433.00	7,417,536.00
FY 28-29				2,215,987.50	483,624.00	1,601,183.50	2,212,250.00	891,423.00	7,404,468.00
FY 29-30				2,223,584.50	486,232.00		1,862,250.00	1,351,453.00	5,923,519.50
FY 30-31				2,229,922.00	488,664.00		1,853,500.00	1,353,429.00	5,925,515.00
FY 31-32					485,920.00		3,789,750.00	1,648,143.50	5,923,813.50
FY 32-33					488,088.00		3,783,750.00	1,655,855.50	5,927,693.50
FY 33-34					490,080.00		3,787,750.00	1,655,350.50	5,933,180.50
FY 34-35					491,896.00		3,786,000.00	1,656,948.00	5,934,844.00
FY 35-36					493,536.00		3,783,500.00	1,660,032.00	5,937,068.00
FY 36-37							4,270,000.00	1,669,042.00	5,939,042.00
FY 37-38							4,275,750.00	1,663,460.00	5,939,210.00
FY 38-39							4,278,250.00	1,664,118.00	5,942,368.00
FY 39-40							4,277,250.00	1,665,016.00	5,942,266.00
FY 40-41							4,277,500.00	1,661,342.00	5,938,842.00
FY 41-42							4,273,500.00	1,663,200.00	5,936,700.00
	456,065.00	595,233.50	2,147,935.00	14,377,659.00	6,312,024.00	9,587,927.50	60,798,030.56	25,556,378.19	119,831,252.75
PRINCIPAL	3,510,000	1,835,000	4,750,000	18,000,000	6,360,000	10,000,000	36,245,000	15,000,000	
INTEREST	656,057.63	383,519.14	868,317.11	4,073,795.50	896,409.07	1,189,402.50	24,553,030.56	10,556,378.19	
AVG RATE	2.55%	2.49%	2.29%	2.90%	1.76%	2.97%	5%	5.27%	

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Ad Valorem Rate/Revenue Comparisons

2024

Taxable Value 2,256,097,556

Projected Debt Service 7,580,234

PROPOSED RATE FY 2024-25

	0.6789		0.6677		0.8489		0.8537		0.8316		0.6711	
	2023 (current) Ad ValoremTax Rate		2024 AV Rate to… NNR Rate		2024 AV Rate to… Voter Approval Tax Rate		2024 AV Rate to… De Minimis Rate		2024 No New Rev M&O Rate		2024 Unused Increment Rate	
Taxable Property Value		2,101,439,419	2,256,097,556		2,256,097,556		2,256,097,556		2,256,097,556		2,256,097,556	
Debt Service (I&S)	0.1987	4,177,524	7,580,234	0.3359	7,580,234	0.3359	7,580,234	0.3359	7,580,234	0.3359	7,580,234	0.3359
Operations (O&M)	0.4802	10,091,112	7,485,732	0.3318	11,573,780	0.5130	11,682,073	0.5178	11,183,476	0.4957	10,657,805	0.4724
Total AV Revenues		14,268,636	15,065,965		19,154,014		19,262,307		18,763,709		18,238,039	
Total AV Tax Rate	0.6789			0.6677		0.8489		0.8537		0.8316		0.8083
Change in O&M Revenues			(2,605,380.40)		1,482,668		1,590,961		1,092,363		566,693	
Change in AV Tax Rate				-0.0112		0.1700		0.1748		0.1527		0.1294
Tax on average residence @ last year's value		**275,301** ***1,869.02***										
Tax on average residence @ this year's value			**287,960** ***1,922.71***		**287,960** ***2,444.49***		**287,960** ***2,458.31***		**287,960** ***2,394.68***		**287,960** ***2,327.58***	
Difference			***53.69***		***575.47***		***589.30***		***525.66***		***458.56***	

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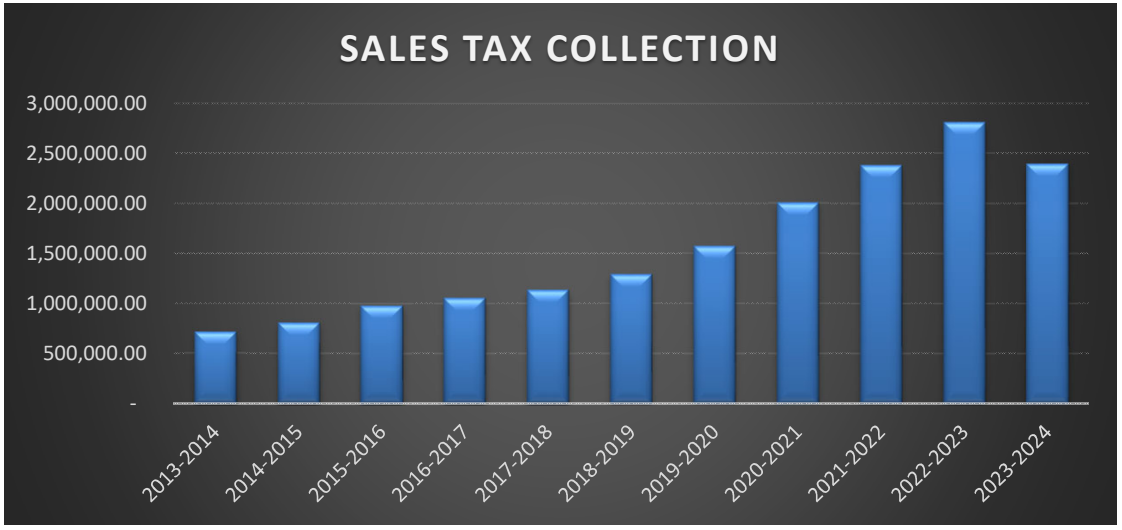
CITY OF MANOR, TEXAS
SALES TAX COLLECTION

MONTH	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
OCTOBER	38,158.42	50,826.45	59,106.57	77,610.62	78,922.90	85,635.16	104,974.43	125,287.67	168,991.65	233,083.02	229,427.72
NOVEMBER	66,112.75	74,601.37	86,757.45	107,153.54	121,211.04	134,032.33	168,389.87	180,749.02	230,535.22	246,801.16	291,723.42
DECEMBER	45,780.00	54,657.19	61,497.73	75,889.63	74,524.93	92,065.56	129,343.45	135,150.83	180,169.06	215,096.18	234,020.67
JANUARY	37,090.97	51,893.12	66,159.11	79,356.52	74,043.24	97,291.36	107,442.85	136,037.45	162,109.77	204,671.68	214,428.47
FEBRUARY	69,479.81	87,247.63	100,062.86	123,840.63	119,952.05	125,880.97	180,654.14	206,067.64	242,001.95	277,846.74	302,279.21
MARCH	36,578.64	51,547.97	67,515.98	70,697.39	77,308.15	80,858.82	100,248.30	126,256.16	155,816.34	203,717.25	187,067.73
APRIL	52,802.71	62,405.67	69,426.22	77,547.91	72,412.04	84,775.72	103,086.20	128,067.51	142,233.99	196,960.34	196,462.68
MAY	79,826.51	87,340.46	99,207.74	107,093.55	119,886.82	140,262.19	154,261.48	214,025.27	236,012.90	257,267.97	289,324.80
JUNE	51,746.26	66,977.60	78,229.01	75,354.18	95,287.39	105,071.11	114,010.89	171,234.02	179,888.02	194,979.38	223,407.96
JULY	77,803.71	59,213.17	78,192.50	74,361.13	88,052.67	100,514.69	122,454.71	161,382.19	225,308.00	216,659.77	226,334.42
AUGUST	86,030.90	89,920.54	106,542.72	107,873.23	122,309.48	138,889.92	178,318.95	219,156.68	244,911.27	298,817.15	
SEPTEMBER	69,027.15	69,542.85	105,728.73	79,805.86	91,941.82	105,029.10	108,768.28	198,386.09	213,600.89	262,439.17	
TOTALS	**710,437.83**	**806,174.02**	**978,426.62**	**1,056,584.19**	**1,135,852.53**	**1,290,306.93**	**1,571,953.55**	**2,001,800.53**	**2,381,579.06**	**2,808,339.81**	**2,394,477.08**



NOTE: SALES TAX IS RECEIVED TWO MONTHS AFTER COLLECTION

FOR EXAMPLE: OCTOBER SALES TAX IS RECEIVED IN DECEMBER

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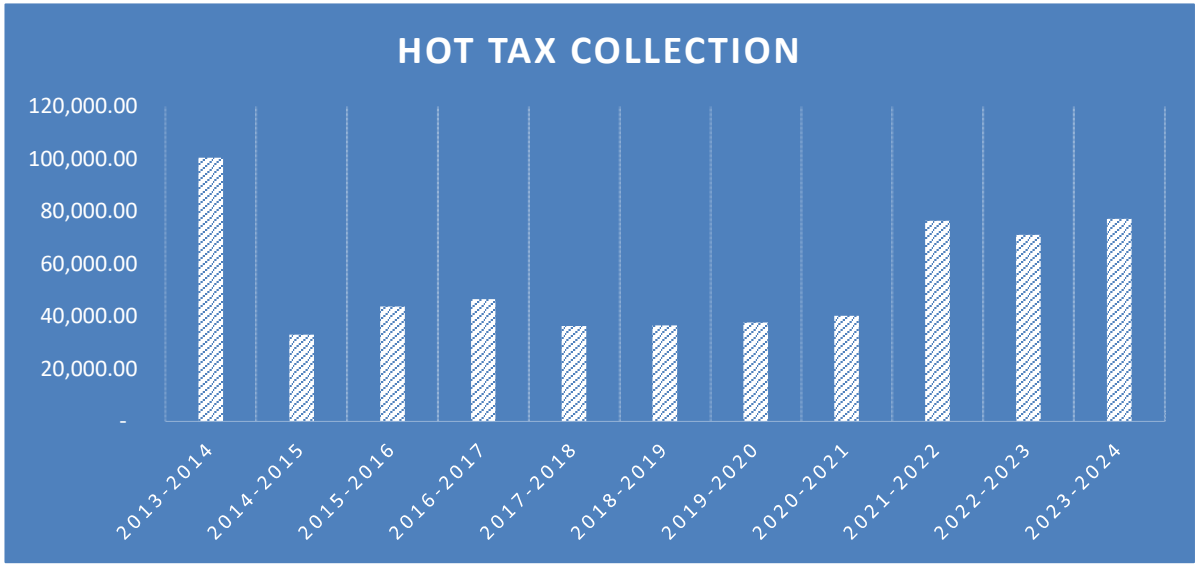
CITY OF MANOR, TEXAS
HOT TAX COLLECTION

YEAR	
2013-2014	100,445.16
2014-2015	33,050.47
2015-2016	43,752.28
2016-2017	46,553.66
2017-2018	36,270.56
2018-2019	36,511.47
2019-2020	37,693.67
2020-2021	40,238.38
2021-2022	76,458.38
2022-2023	71,068.77
2023-2024	77,123.17
	599,165.97



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CITY OF MANOR

OBSERVATION NOTES

1. Acccounting software (Incode) is Version 9 which is outdated. Version 10 has been ordered and implementation is schedule in the next few months.
2. Time cards are done manually in paper. Time and Attendance software is currently being implemented. This software is online and paperless.
3. Currently, bills are being outsourced to a third party to print and mail them out. The cost is about $80,000 per year. We are implementing in-house printing and mailing. The bills would be postcard format. Annual costs would drop to about half of the current cost.
4. Audit firm has been auditing City's books for 13 years, it is recommended to rotate auditors every 5 years. We are working on RFP for current year. Due to all the discrepancies found. Audit for FY22-23 just started in June 2024.
5. Purchasing policy needs to be updated. Latest version is dated back to 2019.
6. Investment policy was outdated. Latest version was 2005. Council recently approved a recent version. I will be working with banks to invest funds for better return to the City investments.
7. Bank agreements(Frontier and Independent) expired on 11/2023. Council approved new agreements with expiration of 9/25. City will work on RFA for banking services at start of 2025
8. Majority of vendors in Incode do not have a W9 on file, therefore no 1099 form is provided to vendors at the end of the calendar year. We are contacting vendors to provide an updated W9 form to implement the forms 1099 in 2025
9. FY2022-2023 is out of balance which goes back to a few years. And it carries forward to current fiscal year. Many accounts with activity were changed to “inactive” and that affects the balances. I already changed the accounts back to active for the past five years.
10. Many accounts on the balance sheet, for all funds, are negative due to misclassification or erroneous account type.
11. Many accounts in the asset section of the balance sheet are set as liability account type in Incode. The account number was used incorrectly and that is why those accounts are in the asset section instead of the liability.
12. FY2023-2024 some of the payments are misclassified as expenses when should be in another category. For example, there is a large amount for purchase of land classified as expenses instead of an asset. Some projects are coded to the incorrect account.
13. Projects expenses are all posted in one account instead of having an account for each project to keep a uniformed balance of expenses. Spreadsheets are being created for each funding source and its respective projects to keep track of all the expenses and balances
14. All bank reconciliations for fiscal year 23-24 were not reconciled. Currently working on reconciling December 2023.
15. Outstanding checks for the general fund goes back to 2011; approximately 700 checks and a few deposits. One transaction is for 2016 bond in the amount of $1.8 million. Outstanding items were cleared in the month of October 2023 reconciliation.
16. Most of the outstanding checks in the General Fund account are for utility refunds. Staff tried reaching out customers but weren't able to.
17. For credit cards, there are different cards currently used. I reached out to PNC Bank to obtain the P-cards for better track of expenses and also offers a rewards program. We can pay bills with that card to earn more rewards. PNC Bank approved the City with a $420k monthly limit.
18. Ad Valorem Levy posting in Incode has not been a practice in previous years. We posted the Levy for FY23-24 to keep track of outstanding taxes.
19. Bonds proceeds were posted in "Fund Balance" account instead of revenue and liability. It's been corrected.
20. In August 2024, interest payment for CO S2023 in the amount of $1.2m is due. The amount was not budgeted for, therefore we might have to use interest revenue and other funds to make the payment.

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July 19, 2024

CITY OF MANOR
THE HONORABLE DR. CHRISTOPHER HARVEY, MAYOR
PO BOX 387
MANOR, TX 78653

In accordance with Tax Code Section 26.01(a-1) enclosed is the **2024 Certified Net Taxable Value** for your taxing unit. The values in the Certified Estimate shall be used to calculate the no-new-revenue tax rate and the voter-approval tax rate, per Tax Code Section 26.04(c-2). The value remaining under protest is reported, pursuant to Tax Code Section 26.01(c), as the owner's opinion of value or the preceding year's value, whichever is lower. Therefore, it is a conservative estimate.

The information page included with your Certified Value is based on the last available worksheet (Tax Year 2024). It provides the information to assist you in completing the Truth in Taxation calculations and postings. Line 16 of the TNT worksheet 50-856, which covers taxes refunded for years preceding the prior tax year, has been provided for entities with a collection agreement with the Travis County Tax Office.

The calculated tax rates and hearing date information should be posted to the taxing unit portal maintained by the appraisal district, as required in Tax Code Section 26.17(e). For taxing units required to comply with Tax Code Section 26.04(e), the 26.17(e) postings should be completed by August 7, 2024. Please feel free to contact me if you have any questions or need additional information.

Approved Freeze Adjusted Taxable	$2,265,459,419
Certification Percentage	93.66%
Section 26.01(c) Value Under Protest	$136,814,892
Net Taxable Value	$2,402,274,311

Sincerely,

Leana H. Mann

Leana Mann, RPA, CCA, CGFO
Chief Appraiser
Lmann@tcadcentral.org
(512) 834-9317 Ext. 405

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Line	No-New-Revenue Tax Rate Worksheet		Amount/Rate
1	**Prior year total taxable value.** Enter the amount of the prior year taxable value on the prior year tax roll today. Include any adjustments since last year's certification; exclude Tax Code Section 25.25(d) one-fourth and one-third over-appraisal corrections from these adjustments. Exclude any property value subject to an appeal under Chapter 42 as of July 25 (will add undisputed value in Line 6). This total includes the taxable value of homesteads with tax ceilings (will deduct in Line 2) and the captured value for tax increment financing (adjustment is made by deducting TIF taxes, as reflected in Line 17).		$2,082,482,309
2	**Prior year tax ceilings.** Counties, cities and junior college districts. Enter the prior year total taxable value of homesteads with tax ceilings. These include the homesteads of homeowners age 65 or older or disabled. Other taxing units enter 0. If your taxing unit adopted the tax ceiling provision last year or a prior year for homeowners age 65 or older or disabled, use this step.		$ 0
3	**Preliminary prior year adjusted taxable value.** Subtract Line 2 from Line 1.		$2,082,482,309
4	**Prior year total adopted tax rate.**		0.678900 /$100
5	**Prior year taxable value lost because court appeals of ARB decisions reduced the prior year's appraised value.**		
	A. Original prior year ARB values:	$99,402,787	
	B. Prior year values resulting from final court decisions:	$92,243,606	
	C. Prior year value loss. Subtract B from A		$7,159,181
6	**Prior year taxable value subject to an appeal under Chapter 42, as of July 25.**		
	A. Prior year ARB certified value:	$83,568,004	
	B. Prior year disputed value:	$8,356,800	
	C. Prior year undisputed value. Subtract B from A.		$75,211,204
7	**Prior year Chapter 42 related adjusted values.** Add Line 5C and Line 6C.		$82,370,385
8	**Prior year taxable value, adjusted for actual and potential court-ordered adjustments.** Add Line 3 and Line 7.		$2,164,852,694
9	**Prior year taxable value of property in territory the taxing unit deannexed after Jan. 1, 2024.** Enter the prior year value of property in deannexed territory**.**		$ 0
10	**Prior year taxable value lost because property first qualified for an exemption in the current year.** If the taxing unit increased an original exemption, use the difference between the original exempted amount and the increased exempted amount. Do not include value lost due to freeport, goods-in-transit, temporary disaster exemptions. Note that lowering the amount or percentage of an existing exemption in the current year does not create a new exemption or reduce taxable value.		
	A. Absolute exemptions. Use prior year market value:	$8,134,208	
	B. Partial exemptions. Current year exemption amount or current year percentage exemption times prior year value:	$7,936,003	
	C. Value loss. Add A and B		$16,070,211
11	**Prior year taxable value lost because property first qualified for agricultural appraisal (1-d or 1-d-1), timber appraisal, recreational/ scenic appraisal or public access airport special appraisal in the current year.** Use only properties that qualified for the first time in the cur- rent year; do not use proper- ties that qualified in the prior year.		
	A. Prior year market value:	$ 0	
	B. Current year productivity or special appraised value:	$22,446	
	C. Value loss. Subtract B from A.		$-22,446
12	**Total adjustments for lost value.** Add Lines 9, 10C and 11C.		$16,047,765
13	**Prior year captured value of property in a TIF.** Enter the total value of the prior year captured appraised value of property taxable by a taxing unit in a tax increment financing zone for which the prior year taxes were deposited into the tax increment fund. 8 If the taxing unit has no captured appraised value in line 18D, enter 0.		$147,980,240
14	**Prior year total value.** Subtract Line 12 and Line 13 from Line 8.		$2,001,241,293
15	**Adjusted prior year total levy.** Multiply Line 4 by Line 14 and divide by $100.		$13,586,427
16	**Taxes refunded for years preceding the prior tax year.** Enter the amount of taxes refunded by the taxing unit for tax years preceding the prior tax year. Types of refunds include court decisions, Tax Code Section 25.25(b) and (c) corrections and Tax Code Section 31.11 payment errors. Do not include refunds for the prior tax year. This line applies only to tax years preceding the prior tax year.		$46,561

Line	No-New-Revenue Tax Rate Worksheet		Amount/Rate
17	**Adjusted prior year levy with refunds and TIF adjustment.** Add Lines 15 and 16.		$13,632,988
18	**Total current year taxable value on the current year certified appraisal roll today.** This value includes only certified values or certified estimate of values and includes the total taxable value of homesteads with tax ceilings (will deduct in Line 20). These homesteads include homeowners age 65 or older or disabled.		
	A. Certified values:	$2,265,459,419	
	B. Counties: Include railroad rolling stock values certified by the Comptroller's office:	$ 0	
	C. Pollution control and energy storage system exemption: Deduct the value of property exempted for the current tax year for the first time as pollution control or energy storage system property:	$2,711,852	
	D. Tax increment financing: Deduct the current year captured appraised value of property taxable by a taxing unit in a tax increment financing zone for which the current year taxes will be deposited into the tax increment fund. Do not include any new property value that will be included in Line 23 below:	$143,482,374	
	E. Total current year value. Add A and B, then subtract C and D.		$2,041,011,756
19	**Total value of properties under protest or not included on certified appraisal roll.**		
	A. Current year taxable value of properties under protest. The chief appraiser certifies a list of properties still under ARB protest. The list shows the appraisal district's value and the taxpayer's claimed value, if any, or an estimate of the value if the taxpayer wins. For each of the properties under protest, use the lowest of these values. Enter the total value under protest:	$136,814,892	
	B. Current year value of properties not under protest or included on certified appraisal roll. The chief appraiser gives taxing units a list of those taxable properties that the chief appraiser knows about but are not included in the appraisal roll certification. These properties also are not on the list of properties that are still under protest. On this list of properties, the chief appraiser includes the market value, appraised value and exemptions for the preceding year and a reasonable estimate of the market value, appraised value and exemptions for the current year. Use the lower market, appraised or taxable value (as appropriate). Enter the total value of property not on the certified roll:	$ 0	
	C. Total value under protest or not certified. Add A and B.		$136,814,892
20	**Current year tax ceilings.** Counties, cities and junior colleges enter current year total taxable value of homesteads with tax ceilings. These include the home- steads of homeowners age 65 or older or disabled. Other taxing units enter 0. If your taxing unit adopted the tax ceiling pro- vision in the prior year or a previous year for homeowners age 65 or older or disabled, use this step.		$ 0
21	**Current year total taxable value.** Add Lines 18E and 19C. Subtract Line 20.		$2,177,826,648
22	**Total current year taxable value of properties in territory annexed after Jan. 1, of the prior year.** Include both real and personal property. Enter the current year value of property in territory annexed.		$ 0
23	**Total current year taxable value of new improvements and new personal property located in new improvements.** New means the item was not on the appraisal roll in the prior year. An improvement is a building, structure, fixture or fence erected on or affixed to land. New additions to existing improvements may be included if the appraised value can be determined. New personal property in a new improvement must have been brought into the taxing unit after Jan. 1, of the prior year and be located in a new improvement. New improvements do include property on which a tax abatement agreement has expired for the current year.		$214,746,445
24	**Total adjustments to the current year taxable value.** Add Lines 22 and 23.		$214,746,445
25	**Adjusted current year taxable value.** Subtract Line 24 from Line 21.		$1,963,080,203
26	**Current year NNR tax rate.** Divide Line 17 by Line 25 and multiply by $100.		0.694500 /$100

Notice of Public Hearing – Budget/Tax Rate Information

2023 Average appraised value of properties with a homestead exemption	$354,162
2023 Total appraised value of all property	$2,689,608,751
2023 Total appraised value of all new property	$152,745,810
2023 Average taxable value of properties with a homestead exemption	$275,301
2023 Total taxable value of all property	$2,166,050,313
2023 Total taxable value of all new property	$147,885,110
2024 Average appraised value of properties with a homestead exemption	$324,697
2024 Total appraised value of all property	$2,848,266,520
2024 Total appraised value of all new property	$219,261,466
2024 Average taxable value of properties with a homestead exemption	$287,960
2024 Total taxable value of all property	$2,402,274,311
2024 Total taxable of all new property	$214,746,445

	NOT UNDER REVIEW	UNDER REVIEW	TOTAL
REAL PROPERTY & MFT HOMES	(Count) (7,089)	(Count) (777)	(Count) (7,866)
Land HS Value	187,113,866	11,707,133	198,820,999
Land NHS Value	314,221,227	32,005,692	346,226,919
Land Ag Market Value	89,865,950	2,164,856	92,030,806
Land Timber Market Value	0	0	0
Total Land Value	**591,201,043**	**45,877,681**	**637,078,724**
Improvement HS Value	1,550,952,916	107,698,838	1,658,651,754
Improvement NHS Value	494,465,942	26,422,684	520,888,626
Total Improvement	**2,045,418,858**	**134,121,522**	**2,179,540,380**
Market Value	**2,636,619,901**	**179,999,203**	**2,816,619,104**
BUSINESS PERSONAL PROPERTY	(341)	(13)	(354)
Market Value	**69,304,995**	**3,104,503**	**72,409,498**
OIL & GAS / MINERALS	(0)	(0)	(0)
Market Value	**0**	**0**	**0**
OTHER (Intangibles)	(0)	(0)	(0)
Market Value	**0**	**0**	**0**
	(Total Count) (7,430)	(Total Count) (790)	(Total Count) (8,220)
TOTAL MARKET	**2,705,924,896**	**183,103,706**	**2,889,028,602**
Ag Productivity	268,975	8,913	277,888
Ag Loss (-)	89,596,975	2,155,943	91,752,918
Timber Productivity	0	0	0
Timber Loss (-)	0	0	0
APPRAISED VALUE	**2,616,327,921**	**180,947,763**	**2,797,275,684**
	93.5%	6.9%	100.0%
HS CAP Limitation Value (-)	85,364,228	2,642,361	88,006,589
CB CAP Limitation Value (-)	22,906,294	3,232,127	26,138,421
NET APPRAISED VALUE	**2,508,057,399**	**175,073,275**	**2,683,130,674**
Total Exemption Amount	242,597,980	564,743	243,162,723
NET TAXABLE	**2,265,459,419**	**174,508,532**	**2,439,967,951**
TAX LIMIT/FREEZE ADJUSTMENT	**0**	**0**	**0**
LIMIT ADJ TAXABLE (I&S)	**2,265,459,419**	**174,508,532**	**2,439,967,951**
CHAPTER 313 ADJUSTMENT	**0**	**0**	**0**
LIMIT ADJ TAXABLE (M&O)	**2,265,459,419**	**174,508,532**	**2,439,967,951**

APPROX TOTAL LEVY = NET TAXABLE * (TAX RATE / 100)

$16,564,942.42 = 2,439,967,951 * 0.678900 / 100)

Tax Increment Refinance Zone	Tax Increment Loss
01_05	221,735,811

Tax Increment Finance Value:	221,735,811
Tax Increment Finance Levy:	1,505,364.42

EXEMPTIONS	NOT UNDER REVIEW		UNDER REVIEW		TOTAL	
Exemption	Total	Count	Total	Count	Total	Count
Homestead Exemptions						
OV65-Local	4,534,248	482	160,000	16	4,694,248	498
OV65-State	0	0	0	0	0	0
OV65-Prorated	0	0	0	0	0	0
OV65S-Local	120,000	13	0	0	120,000	13
OV65S-State	0	0	0	0	0	0
OV65S-Prorated	0	0	0	0	0	0
DVHS	32,975,256	97	0	0	32,975,256	97
DVHS-Prorated	854,332	5	124,210	1	978,542	6
DVHSS-UD	307,059	1	0	0	307,059	1
Subtotal for Homestead Exemptions	**38,790,895**	**598**	**284,210**	**17**	**39,075,105**	**615**
Disabled Veterans Exemptions						
DV1	128,000	20	5,000	1	133,000	21
DV2	100,500	11	0	0	100,500	11
DV3	206,000	20	10,000	1	216,000	21
DV4	612,000	86	48,000	4	660,000	90
DV4S	0	1	0	0	0	1
Subtotal for Disabled Veterans Exemptions	**1,046,500**	**138**	**63,000**	**6**	**1,109,500**	**144**
Special Exemptions						
FR	2,206,909	1	0	0	2,206,909	1
PC	9,100	1	0	0	9,100	1
SO	2,485,219	175	217,533	13	2,702,752	188
Subtotal for Special Exemptions	**4,701,228**	**177**	**217,533**	**13**	**4,918,761**	**190**
Absolute Exemptions						
EX-XI	21,182	1	0	0	21,182	1
EX-XI-PRORATED	0	0	0	0	0	0
EX-XJ	11,825,745	1	0	0	11,825,745	1
EX-XJ-PRORATED	0	0	0	0	0	0
EX-XO	0	0	0	0	0	0
EX-XO-PRORATED	0	0	0	0	0	0
EX-XR	149,520	1	0	0	149,520	1
EX-XR-PRORATED	0	0	0	0	0	0
EX-XU	1,009,174	1	0	0	1,009,174	1
EX-XU-PRORATED	0	0	0	0	0	0
EX-XV	184,459,215	132	0	0	184,459,215	132
EX-XV-PRORATED	545,003	5	0	0	545,003	5
EX366	49,518	57	0	0	49,518	57
Subtotal for Absolute Exemptions	**198,059,357**	**198**	**0**	**0**	**198,059,357**	**198**

EXEMPTIONS	NOT UNDER REVIEW		UNDER REVIEW		TOTAL	
Exemption	Total	Count	Total	Count	Total	Count
Other Exemptions						
CC	0	1	0	0	0	1
Subtotal for Other Exemptions	**0**	**1**	**0**	**0**	**0**	**1**
Total:	**242,597,980**	**1,112**	**564,743**	**36**	**243,162,723**	**1,148**

New Value

Total New Market Value: $219,261,466

Total New Taxable Value: $214,746,445

Exemption Loss

New Absolute Exemptions

Exemption	Description	Count	Last Year Market Value
EX-XU	11.23 Miscellaneous Exemptions	1	1,033,376
EX-XV	Other Exemptions (including public property, reli...	8	7,100,832
Absolute Exemption Value Loss:		**9**	**8,134,208**

New Partial Exemptions

Exemption	Description	Count	Partial Exemption Amt
CC	Childcare	1	0
DV1	Disabled Veterans 10% - 29%	2	10,000
DV3	Disabled Veterans 50% - 69%	2	22,000
DV4	Disabled Veterans 70% - 100%	9	72,000
DVHS	Disabled Veteran Homestead	14	4,030,055
FR	FREEPORT	1	2,206,909
OV65	Over 65	18	160,000
SO	Solar (Special Exemption)	92	1,435,039
Partial Exemption Value Loss:		**139**	**7,936,003**
Total NEW Exemption Value			**16,070,211**

Increased Exemptions

Exemption	Description	Count	Increased Exemption Amt
Increased Exemption Value Loss:		**0**	**0**
Total Exemption Value Loss:			**16,070,211**

New Special Use (Ag/Timber)

Count	2023 Market Value	2024 Market Value	2024 Special Use	Loss
2	0	null	22,446	22,446

Average Homestead Value

Category	Count of HS	Average Market	Average Exemption	Average Taxable
A Only	4,028	324,697	8,248	287,960
A & E	4,039	325,500	8,225	288,142

Property Under Review - Lower Value Used

Count	Market Value	Lower Market Value	Estimated Lower Taxable Value
790	183,103,706	142,341,624	136,814,892

Not Under Review

Code	Description	Count	Acres	New Value	Market Value	Taxable Value
A	Single-family Residential	5,654		82,774,921	1,678,714,493	1,554,455,283
B	Multifamily Residential	18		34,878,196	207,131,979	206,936,122
C1	Vacant Lots and Tracts	649		0	92,284,688	90,868,155
D1	Qualified Open-Space Land	46	2,149.37	0	89,865,950	266,905
E	Rural Land,Not Qualified for Open-Space Land	81		1,565,620	63,388,722	49,281,533
ERROR	ERROR	22		0	7,975,325	7,975,325
F1	Commercial Real Property	99		15,116,007	218,159,277	214,971,607
F2	Industrial Real Property	9		0	2,116,681	1,973,864
J4	Telephone Companies (including Co-ops)	3		0	1,032,743	1,032,743
L1	Commercial Personal Property	240		0	44,403,289	42,187,280
L2	Industrial and Manufacturing Personal Property	8		0	7,369,966	7,369,966
M1	Mobile Homes	46		21,552	1,041,908	901,946
O	Residential Inventory	750		54,640,496	79,471,876	79,047,829
S	Special Inventory	7		0	8,190,861	8,190,861
XB	Income Producing Tangible Personal	57		0	49,518	0
XI	Youth Spiritual, Mental and Physical	1		0	21,182	0
XJ	Private Schools (§11.21)	1		0	11,825,745	0
XR	Nonprofit Water or Wastewater Corporation	1		0	267,000	0
XU	MiscellaneousExemptions (§11.23)	1		0	1,009,174	0
XV	Other Totally Exempt Properties (including	134		0	191,604,519	0
		Totals:	2,149.37	188,996,792	2,705,924,896	2,265,459,419

Under Review

Code	Description	Count	Acres	New Value	Market Value	Taxable Value
A	Single-family Residential	358		14,013,598	110,229,496	107,023,310
B	Multifamily Residential	3		2,011,083	2,549,960	2,548,083
C1	Vacant Lots and Tracts	40		0	5,167,764	4,893,948
D1	Qualified Open-Space Land	4	58.6	0	2,164,856	6,980
E	Rural Land,Not Qualified for Open-Space Land	5		8,434	1,066,378	824,290
F1	Commercial Real Property	25		2,765,546	33,235,812	30,883,792
F2	Industrial Real Property	7		0	4,122,303	3,895,202
L1	Commercial Personal Property	13		0	3,104,503	3,104,503
M1	Mobile Homes	1		0	5,850	5,850
O	Residential Inventory	366		11,466,013	21,456,784	21,322,574
		Totals:	58.6	30,264,674	183,103,706	174,508,532

Grand Totals

Code	Description	Count	Acres	New Value	Market Value	Taxable Value
A	Single-family Residential	6,012		96,788,519	1,788,943,989	1,661,478,593
B	Multifamily Residential	21		36,889,279	209,681,939	209,484,205
C1	Vacant Lots and Tracts	689		0	97,452,452	95,762,103
D1	Qualified Open-Space Land	50	2,207.98	0	92,030,806	273,885
E	Rural Land,Not Qualified for Open-Space Land	86		1,574,054	64,455,100	50,105,823
ERROR	ERROR	22		0	7,975,325	7,975,325
F1	Commercial Real Property	124		17,881,553	251,395,089	245,855,399
F2	Industrial Real Property	16		0	6,238,984	5,869,066
J4	Telephone Companies (including Co-ops)	3		0	1,032,743	1,032,743
L1	Commercial Personal Property	253		0	47,507,792	45,291,783
L2	Industrial and Manufacturing Personal Property	8		0	7,369,966	7,369,966
M1	Mobile Homes	47		21,552	1,047,758	907,796
O	Residential Inventory	1,116		66,106,509	100,928,660	100,370,403
S	Special Inventory	7		0	8,190,861	8,190,861
XB	Income Producing Tangible Personal	57		0	49,518	0
XI	Youth Spiritual, Mental and Physical	1		0	21,182	0
XJ	Private Schools (§11.21)	1		0	11,825,745	0
XR	Nonprofit Water or Wastewater Corporation	1		0	267,000	0
XU	MiscellaneousExemptions (§11.23)	1		0	1,009,174	0
XV	Other Totally Exempt Properties (including	134		0	191,604,519	0
		Totals:	2,207.98	219,261,466	2,889,028,602	2,439,967,951

Rank	Owner ID	Taxpayer Name	Market Value	Taxable Value
1	1832172	GRASSDALE AT MANOR LLC	$59,500,000	$59,500,000
2	1915547	CV QOZP PROSE MANOR LLC	$58,500,000	$58,500,000
3	1852211	MANOR GRAND LLC	$44,858,579	$44,858,579
4	1945087	CH DOF I-RANGEWATER MF AUSTIN	$40,981,545	$40,981,545
5	1921798	HILL LANE OWNER LLC	$25,849,388	$25,849,388
6	2002503	ALLEGRA AUSTIN LLC	$17,724,387	$17,724,387
7	1303248	WAL-MART REAL ESTATE BUSINESS	$14,134,788	$14,134,788
8	1285824	SHADOWGLEN DEVELOPMENT	$12,982,735	$12,982,735
9	2003709	MC RETAIL LP	$11,813,472	$11,813,472
10	1596998	CUBE HHF LP	$9,830,946	$9,830,946
11	1657781	GREENVIEW MANOR COMMONS SW LP	$9,564,811	$9,564,811
12	1898399	SAI GEETA LLC	$9,200,000	$9,200,000
13	1980330	GG B2R PECAN PRESIDENTIAL	$8,749,217	$8,749,217
14	1744121	ASC MEDICAL 8 HOLDINGS LLC	$8,286,581	$8,286,581
15	1874222	FORESTAR REAL ESTATE GROUP INC	$9,364,176	$8,220,326
16	176360	COTTONWOOD HOLDINGS LTD	$8,077,299	$8,055,400
17	1968121	GG B2R PECAN PRESIDENTIAL HEIGHTS	$7,947,011	$7,947,011
18	509731	HOME DEPOT USA INC	$7,893,072	$7,893,072
19	1955354	GCP XXXI LTD	$7,699,666	$7,699,666
20	109336	RIVER CITY PARTNERS LTD	$7,511,318	$7,511,318
		Total	$380,468,991	$379,303,242

2024 Truth in Taxation Calculations
City of Manor

Data Input Summary
July 25, 2024

A.	2024 PROPERTY VALUES:	CERTIFIED VALUE	$	2,265,459,419	
		PROTESTED VALUE	$	136,814,892	
		UNLISTED VALUE	$	0	
		2024 TOTAL TAXABLE VALUE	$	2,402,274,311	
B.	2023 TOTAL TAXABLE VALUE		$	2,082,482,309	
C.	2023 TAXABLE VALUE OVER-65 & DISABLED CEILINGS		$	0	
D.	2023 TAXABLE VALUE LOST ON COURT APPEALS		$	7,159,181	
	D1. ORIGINAL 2023 ARB VALUES		$	99,402,787	
	D2. 2023 VALUES RESULTING FROM FINAL COURT DECISIONS		$	92,243,606	
E.	2023 UNDISPUTED TAXABLE VALUE SUBJECT TO CH 42 APPEAL AS OF JULY 2		$	75,211,204	
	E1. 2023 ARB CERTIFIED VALUES		$	83,568,004	
	E2. 2023 DISPUTED VALUE		$	8,356,800	
F.	2023 DEANNEXED TAX VALUE		$	0	
G.	2023 TAXABLE VALUE BECOMING EXEMPT IN 2024		$	16,070,211	
	G1. ABSOLUTE EXEMPTIONS		$	8,134,208	
	G2. PARTIAL EXEMPTIONS AND AMOUNT EXEMPT DUE TO AN INCREASE		$	7,936,003	
H.	2023 TAXABLE VALUE LOST ON SPECIAL APPRAISAL		$	(22,446)	
	H1. 2023 MARKET VALUE		$	0	
	H2. 2023 PRODUCTIVITY VALUE		$	22,446	
I.	2024 TAXABLE VALUE POLLUTION CONTROL EXEMPTION		$	2,711,852	
J.	2024 TAXABLE VALUE OVER-65 & DISABLED CEILINGS		$	0	
K.	2024 TAX. VALUE OF PROP. ANNEXED > JAN. 1, 2023		$	0	
L.	2024 TAX. VALUE OF NEW IMP. ADDED > JAN. 1, 2023		$	214,746,445	
M.	2023 TAX RATES	M & O	$	0.4802	/$100
		I & S	$	0.1987	/$100
		TOTAL TAX RATE	$	0.6789	/$100
N.	M&O YEAR END FUND BALANCE		$	0	
O.	I&S YEAR END FUND BALANCE		$	0	
P.	2024 TOTAL DEBT SERVICE NEEDED		$	7,580,233.69	
		AMOUNT PAID FROM FUNDS IN SCHEDULE A	$	0.00	
		AMOUNT PAID FROM OTHER SOURCES	$	0.00	
		ADJUSTED 2024 DEBT SERVICE	$	7,580,233.69	
Q.	2023 EXCESS DEBT TAX COLLECTIONS		$	0	
R.	CERTIFIED 2024 ANTICIPATED COLLECTION RATE		%	100.00%	
	R1. 2023 ACTUAL COLLECTION RATE		%	99.00%	
	R2. 2022 ACTUAL COLLECTION RATE		%	100.00%	
	R3. 2021 ACTUAL COLLECTION RATE		%	100.00%	
S.	FUNCTION OR ACTIVITY TRANSFER (+/-)		$	0	
T.	REFUNDS FOR TAX YEARS PRIOR TO 2023		$	46,561.14	
		M&O PORTION	$	32,933.66	
U.	TCEQ CERTIFIED POLLUTION CONTROL EXPENSES		$	0	
V.	2023 TAXES IN TAX INCREMENT FINANCING (TIF)		$	307,728.32	
W.	2023 TIF CAPTURED APPRAISED VALUE		$	147,962,769.00	
	2024 TIF CAPTURED APPRAISED VALUE		$	143,464,903	
X.	ENHANCED INDIGENT HEALTH CARE EXPENDITURES		$	0	
Y.	INCREASED AMOUNT OF INDIGENT HEALTH CARE		$	0	

Z. UNUSED INCREMENT RATE WORKSHEET

Z1.	2023 VOTER-APPROVAL TAX RATE (LINE 67).....	$	0.6711	/$100
	2022 VOTER-APPROVAL TAX RATE (LINE 67).....	$	0.7355	/$100
	2021 VOTER-APPROVAL TAX RATE (LINE 67).....	$	0.7667	/$100
Z2.	2023 UNUSED INCREMENT RATE (LINE 66).....	$	0.0000	/$100
	2022 UNUSED INCREMENT RATE (LINE 66).....	$	0.0000	/$100
	2021 UNUSED INCREMENT RATE (LINE 66).....	$	0.0054	/$100
Z3.	2023 ADOPTED TAX RATE.....	$	0.6789	/$100
	2022 ADOPTED TAX RATE.....	$	0.7470	/$100
	2021 ADOPTED TAX RATE.....	$	0.7827	/$100
Z4.	2023 TOTAL TAXABLE VALUE.....	$	2,101,439,419	
	2022 TOTAL TAXABLE VALUE.....	$	1,754,276,050	
	2021 TOTAL TAXABLE VALUE.....	$	1,217,505,804	

RATE ADJUSTMENTS	
Additional rate for unused increment rate	0.0000
No-new-revenue Tax Rate	**0.6677**
No-new-revenue M & O Tax Rate	0.4957
Voter-Approval M & O Tax Rate	0.5130
Debt Rate	**0.3359**
Schedule A Funds Needed for Above Debt Rate	2,002.00
Debt Rate Reduction Using Above Schedule A Funds	0.0000
Unadjusted Voter-Approval Rate	0.8489
Voter-Approval Rate adjusted for unused increment rate	0.8489
Voter-Approval Rate:	**0.8489**
De minimus Rate:	**0.8537**

Statement of Increase/Decrease: **INCREASE** by 320,217

City of Manor

2024
NO NEW REVENUE TAX RATE WORKSHEET

1.	**2023 total taxable value.** Enter the amount of 2023 taxable value on the 2023 tax roll today. Include any adjustments since last year's certification; exclude the Section 25. 25(d) one-fourth and one-third over-appraisal corrections from these adjustments. Exclude any property value subject to an appeal under Chapter 42 as of July 25 (will add undisputed value in Line 6). This total includes the taxable value of homesteads with tax ceilings (will deduct in Line 2) and the captured value for tax increment financing (adjustment is made by deducting TIF taxes, as reflected in Line 17).			$ 2,082,482,309	
2.	**2023 tax ceilings.**			$ 0	
3.	**Preliminary 2023 adjusted taxable value.** Subtract Line 2 from Line 1.			$ 2,082,482,309	
4.	**2023 total adopted tax rate.**			$ 0.6789	/$100
5.	**2023 taxable value lost because court appeals of ARB decisions reduced 2023 appraised value.**				
	A. Original 2023 ARB values:	$	99,402,787		
	B. 2023 values resulting from final court decisions:	-$	92,243,606		
	C. 2023 value loss. Subtract B from A:			$ 7,159,181	
6.	**2023 taxable value subject to an appeal under Chapter 42, as of July 25.**				
	A. 2023 ARB certified value:	$	83,568,004		
	B. 2023 disputed value:	-$	8,356,800		
	C. 2023 undisputed value. Subract B from A.			$ 75,211,204	
7.	**2023 Chapter 42 related adjusted values.** Add Line 5C and Line 6C.			$ 82,370,385	
8.	**2023 taxable value, adjusted for actual and potential court-ordered adjustments.** Add Line 3 and Line 7.			$ 2,164,852,694	
9.	**2023 taxable value of property in territory the unit deannexed after Jan. 1, 2023.** Enter the 2023 value of property in deannexed territory.			$ 0	
10.	**2023 taxable value lost because property first qualified for an exemption in 2024.** If the taxing unit increased an original exemption, use the difference between the original exempted amount and the increased exempted amount. Do not include value lost due to freeport, goods-in-transit, or temporary disaster exemptions. Note that lowering the amount or percentage of an existing exemption in 2024 does not create a new exemption or reduce taxable value.				
	A. Absolute exemptions. Use 2023 market value:	$	8,134,208		
	B. Partial exemptions. 2024 exemption amount or 2024 percentage exemption times 2023 value:	+$	7,936,003		
	C. Value loss. Add A and B.			$ 16,070,211	

11. **2023 taxable value lost because property first qualified for agricultural appraisal (1-d or 1-d-1), timber appraisal, recreational/scenic appraisal or public access airport special in 2024.** Use only properties that qualified in 2024 for the first time; do not use properties that qualified in 2023.

A. 2023 market value:	$	0		
B. 2024 productivity or special appraised value:	-$	22,446		
C. Value loss. Subract B from A.			$	(22,446)

12. **Total adjustments for lost value.** Add Lines 9, 10C, and 11C. $ 16,047,765

13. **2023 captured value of property in a TIF.** Enter the total value of 2023 captured appraised value of property taxable by a taxing unit in a tax increment financing zone for which 2023 taxes were deposited into the tax increment fund. If the taxing unit has no captured appraised value in line 18D, enter 0. $ 147,962,769

14. **2023 total value.** Subtract Line 12 and Line 13 from Line 8. $ 2,000,842,160

15. **Adjusted 2023 total levy.**
Multiply Line 4 by Line 14 and divide by $100. $ 13,583,717.42

16. **Taxes refunded for years preceding tax year 2023.** Enter the amount of taxes refunded by the taxing unit for tax years preceding tax year 2023. Types of refunds include court decisions, Tax Code Section 25.25 (b) and (c) corrections and Tax Code Section 31.11 payment errors. Do not include refunds for tax year 2023. This line applies only to tax years preceding tax year 2023. $ 46,561.14

17. **Adjusted 2023 levy with refunds and TIF adjustment.**
Add Lines 15 and 16. $ 13,630,278.56

18. **Total 2024 taxable value on the 2024 certified appraisal roll today.**
This value includes only certified values or certified estimate of values and includes the total taxable value of homesteads with tax ceilings (will deduct in Line 20). These homesteads include homeowners age 65 or older or disabled.

A. Certified values:	$	2,265,459,419		
B. Counties: Include railroad rolling stock values certified by the Comptroller's office.	+$	0		
C. Pollution control and energy storage system exemption: Deduct the value of property exempted for the current tax year for the first time as pollution control or energy storage system property	-$	2,711,852		
D. Tax increment financing: Deduct the 2024 captured appraised value of property taxable by a taxing unit in a tax increment zone for which the 2024 taxes will be deposited into the tax increment fund. Do not include any new property value that will be included in Line 23 below.	-$	143,464,903		
E. Total 2024 value. Add A and B, then subtract C and D.			$	2,119,282,664

19. **Total value of properties under protest or not included on certified appraisal roll.**

A. 2024 taxable value of properties under protest. The chief appraiser certified a list of properties still under ARB protest. The list shows the district's value and the taxpayer's claimed value, if any, or an estimate of the value if the taxpayer wins. For each of the properties under protest, use the lowest of these values.

Enter the total value under protest. $ 136,814,892

B. 2024 value of properties not under protest or included on certified appraisal roll. The chief appraiser gives taxing units a list of those taxable properties that the chief appraiser knows about but are not included in the appraisal roll certification. These properties are also not on the list of properties that are still under protest. On this list of properties, the chief appraiser includes the market value, appraised value, and exemptions for the preceding year and a reasonable estimate of the market value, appraised value, and exemptions for the current year. Use the lower market, appraised, or taxable value (as appropriate).

Enter the total value not on the certified roll. +$ 0.00

C. Total value under protest or not certified. Add A and B. $ 136,814,892

20. **2024 tax ceilings.** $ 0

21. **2024 total taxable value.**
Add Lines 18E and 19C. Subtract Line 20. $ 2,256,097,556

22. **Total 2024 taxable value of properties in territory annexed after Jan. 1, 2023.**
Include both real and personal property. Enter the 2024 value of property in territory annexed. $ 0

23. **Total 2024 taxable value of new improvements and new personal property located in new improvements.** New means the item was not on the appraisal roll in 2023. An improvement is a building, structure, fixture, or fence erected on or affixed to land. New additions to existing improvements may be included if the appraised value can be determined. New personal property in a new improvement must have been brought into the taxing unit after Jan. 1, 2023 and be located in a new improvement. New improvements do include property on which a tax abatement agreement has expired for 2024. $ 214,746,445

24. **Total adjustments to the 2024 taxable value.**
Add Lines 22 and 23. $ 214,746,445

25. **Adjusted 2024 taxable value.**
Subtract Line 24 from Line 21. $ 2,041,351,111

26. **2024 NNR tax rate.**
Divide Line 17 by Line 25 and multiply by $100. $ 0.6677 /$100

27. **COUNTIES ONLY.** Add together the NNR tax rates for each type of tax the county levies. The total is the 2024 county NNR tax rate. $ N/A

City of Manor

2024
VOTER-APPROVAL TAX RATE WORKSHEET

28. **2023 M&O tax rate.** $ 0.4802 /$100

29. **2023 taxable value, adjusted for actual and potential court-ordered adjustments.**
Enter the amount in Line 8 of the NNR Tax Rate Worksheet. $ 2,164,852,694

30. **Total 2023 M&O levy.** Multiply Line 28 by Line 29, and divide by $100. $ 10,395,622.64

31. **Adjusted 2023 levy for calculating NNR M&O rate.**

A. M&O taxes refunded for years preceding tax year 2023. Enter the amount of M&O taxes refunded in the preceding year for taxes before that year. Types of refunds include court decisions, Tax Code Section 25.25(b) and (c) corrections, and Tax Code 31.11 payment errors. Do not include refunds for tax year 2023. This line only applies to tax years preceding tax year 2023.
+$ 32,933.66

B. 2023 taxes in TIF. Enter the amount of taxes paid into the tax increment fund for a reinvestment zone as agreed by the taxing unit. If the taxing unit has no 2024 captured appraised value in Line 18D, enter 0.
-$ 307,728.32

C. 2023 transferred function. If discontinuing all of a department, function or activity and transferring it to another taxing unit by written contract, enter the amount spent by the taxing unit discontinuing the function in the 12 months preceding the month of this calculation. If the taxing unit did not operate this function for this 12-month period, use the amount spent in the last full fiscal year in which the taxing unit operated the function. The taxing unit discontinuing the function will subtract this amount in D below. Other taxing units, enter 0.
+/-$ 0.00

D. 2023 M&O levy adjustements. Subtract B from A. For a taxing unit with C, subtract if discontinuing function and add if receiving function.
$ (274,794.66)

E. Add Line 30 to Line 31D. $ 10,120,827.97

32. **Adjusted 2024 taxable value.**
Enter the amount in Line 25 of the NNR Tax Rate Worksheet. $ 2,041,351,111

33. **2024 NNR M&O rate (unadjusted).**
Divide Line 31E by Line 32 and multiply by $100. $ 0.4957 /$100

34. **Rate adjustment for state criminal justice mandate.**

A. 2024 state criminal justice mandate. Enter the amount spent by a county in the previous 12 months providing for the maintenance and operation cost of keeping inmates in county-paid facilities after they have been sentenced. Do not include any state reimbursement received by the county for the same purpose.
$ 0.00

B. 2023 state criminal justice mandate. Enter the amount spent by a county in the 12 months prior to the previous 12 months providing for the maintenance and operation cost of keeping inmates in county-paid facilities after they have been sentenced. Do not include any state reimbursement received by the county for the same purpose. Enter zero if this is the first time the mandate applies.
-$ 0.00

C. Subtract B from A and divide by Line 32, and multiply by $100.
$ 0.0000

D. Enter the rate calculated in C. If not applicable, enter 0. $ 0.0000 /$100

35. **Rate adjustment for indigent health care expenditures.**

A. 2024 indigent health care expenditures. Enter the amount paid by a taxing unit providing for the maintenance and operation cost of providing indigent health care for the period beginning on July 1, 2023 and ending on June 30, 2024, less any state assistance received for the same purpose.

$ 0.00

B. 2023 indigent health care expenditures. Enter the amount paid by a taxing unit providing for the maintenance and operation cost of providing indigent health care for the period beginning on July 1, 2020 and ending on June 30, 2023, less any state assistance received for the same purpose.

$ 0.00

C. Subtract B from A and divide by Line 32, and multiply by $100.

$ 0.0000

D. Enter the rate calculated in C. If not applicable, enter 0. $ 0.0000 /$100

36. **Rate adjustment for county indigent defense compenstation.**

A. 2024 indigent defense compensation expenditures. Enter the amount paid by a county to provide appointed counsel for indigent individuals for the period beginning on July 1, 2023 and ending on June 30, 2024, less any state grants received by the county for the same purpose.

$ 0.00

B. 2023 indigent defense compensation expenditures. Enter the amount paid by a county to provide appointed counsel for indigent individuals for the period beginning on July 1, 2020 and ending on June 30, 2023, less any state grants received by the county for the same purpose.

$ 0.00

C. Subtract B from A and divide by Line 32, and multiply by $100.

$ 0.0000

D. Multiply B by 0.05 and divide by Line 32 and muliply $100.

$ 0.0000

E. Enter the lesser of C and D. If not applicable, enter 0. $ 0.0000 /$100

37. **Rate adjustment for county hospital expenditures.**

A. 2024 eligible county hospital expenditures. Enter the amount paid by the county or municipality to maintain and operate an eligible county hospital for the period beginning on July 1, 2023 and ending on June 30, 2024.

$ 0.00

B. 2023 eligible county hospital expenditures. Enter the amount paid by the county or municipality to maintain and operate an eligible county hospital for the period beginning on July 1, 2020 and ending on June 30, 2023.

$ 0.00

C. Subtract B from A and divide by Line 32 and multiply by $100.

$ 0.0000

D. Multiply B by 0.08 and divide by Line 32 and multipy by $100.

$ 0.0000

E. Enter the lesser of C and D. If not applicable, enter 0. $ 0.0000 /$100

38. **Rate adjustment for defunding municipality.** This adjustment only applies to a municipality that is considered to be a defunding municipality for the current tax year under Chapter 109, Local Government Code, which only applies to municipalities with a population of more than 250,000 and includes a written determination by the Office of the Governor. See Tax Code 26.0444 for more information.

A. Amount appropriated for public safety in 2023. Enter the amount of money appropriated for public safety in the budget adopted by the municipality for the preceding fiscal year
$ 0.00

B. Expenditures for public safety in 2023. Enter the amount of money spent by the municipality for public safety during the preceding fiscal year.
$ 0.00

C. Subtract B from A and divide by Line 32 and multiply by $100.
$ 0.0000

D. Enter the rate calculated in C. If not applicable, enter 0. $ 0.0000 /$100

39. **Adjusted 2024 NNR M&O rate.**
Add Lines 33, 34D, 35D, 36E, and 37E. Subtract Line 38D. $ 0.4957

40. **Adjustment for 2023 sales tax specifically to reduce property taxes.** Cities, counties, and hospital districts that collected and spent additional sales tax on M&O expenses in 2023 should complete this line. These entities will deduct the sales tax gain rate for 2024 in Section 3. Other taxing units, enter zero.

A. Enter the amount of additional sales tax collected and spent on M&O expenses in 2023, if any. Counties must exclude any amount that was spent for economic development grants from the amount of sales tax spent.
$ 0.00

B. Divide Line 40A by Line 32 and multiply by $100 $ 0.0000 /$100

C. Add Line 40B to Line 39. $ 0.4957 /$100

41. **2024 voter-approval M&O rate.**
Enter the rate as calculated by the appropriate scenario below:

Special Taxing Unit. If the taxing unit qualifies as a special taxing unit, multiply Line 40C by 1.08.
-or-
Other Taxing Unit. If the taxing unit does not qualify as a special taxing unit, multiply Line 40C by 1.035
-or-
D41. Disaster Line 41: 2024 voter-approval M&O rate for a taxing unit affected by disaster declaration. If the taxing unit is located in an area declared a disaster area and at least on person is granted an exemption under Tax Code Section 11.35 for a property located in the taxing unit, the governing body may direct the person calculating the voter-approval rate to calculate in the manner provided for a special taxing unit. The taxing unit shall continue to calculate the voter-approval rate in this manner until the earlier of
1) the first year in which total taxable value on the certified appraisal roll exceeds the total taxable value of the tax year in which the disaster occurred, or
2) the third year after the tax year in which the disaster occurred.
If the taxing unit qualifies under this scenario, multiply Line 40C by 1.08. If the taxing unit does no qualify, do not complete Disaster Line 41 (Line D41). $ 0.5130 /$100

42. **Total 2024 debt to be paid with property taxes and additional sales tax revenue.**
Debt means the interest and principal that will be paid on debts that:
(1) are paid by property taxes,
(2) are secured by property taxes,
(3) are scheduled for payment over a period longer than one year, and
(4) are not classified in the unit's budget as M&O expenses.

A. Debt also includes contractutal payments to other taxing units that have incurred debt on behalf of this taxing unit, if those debts meet the four conditions above. Include only amounts that will be paid from property tax revenue. Do not include appraisal district budget payments. If the governing body of a taxing unit authorized or agreed to authorize a bond, warrant, certificate of obligation, or other evidence of indebtedness on or after Sept. 1, 2024, verify if it meets the amended definition of debt before including it here.

Enter debt amount. $ 7,580,233.69

B. Subtract **unencumbered fund amount** used to reduce total debt.
-$ 0.00 $

C. Subtract **certified amount spent from sales tax to reduce debt** (enter 0 if none).
-$ 0.00

D. Subtract **amount paid** from other resources.
$ 0.00

E. Adjusted debt. Subtract B, C, and D from A. $ 7,580,233.69

43. **Certified 2023 excess debt collections.**
Enter the amount certified by the collector. $ 0.00

44. **Adjusted 2024 debt.** Subtract Line 43 from Line 42E. $ 7,580,233.69

45. **2024 anticipated collection rate.**

A. Enter the 2024 anticipated collection rate certified by the collector. 100.00%

B. Enter the 2023 actual collection rate. 99%

C. Enter the 2022 actual collection rate. 100%

D. Enter the 2021 actual collection rate. 100%

E. If the anticipated collection rate is lower than the actual collection rates in B, C, and D, enter the lowest rate from B, C, and D. If the anticipated rate in A is higher than at least one of the rates in the prior three years, enter the rate from A. Not the rate can be greater than 100%. 100%

46. **2024 debt adjusted for collections.**
Divide Line 44 by Line 45E. $ 7,580,233.69

47. **2024 total taxable value.**
Enter the amount on Line 21 on the NNR Tax Rate Worksheet. $ 2,256,097,556

48. **2024 debt tax rate.** Divide Line 46 by Line 47 and multiply by $100. $ 0.3359 /$100

49. **2024 voter-approval tax rate.** Add Lines 41 and 48.
-or-
D49. Disaster Line 49: 2024 voter-approval tax rate for taxing unit affected by disaster declaration. Complete this line if the taxing unit calculated the voter-approval tax rate in the manner provided for a special taxing unit on Line D41.
$ 0.8489 /$100

50. **COUNTIES ONLY.** Add together the voter-approval tax rates for each type of tax the county levies. The total is the 2024 county voter-approval tax rate. $ N/A

City of Manor

2024
ADDITIONAL SALES TAX WORKSHEET

51. **Taxable sales.** For taxing units that adopted the sales tax in November 2023 or May 2024, enter the Comptroller's estimate of taxable sales for the previous four quarters. Estimates of taxable sales may be obtained through the Comptroller's Allocation Historical Summary webpage. Taxing units that adopted the sales tax before Nov 2023, skip this line.	$		
52. **Estimated sales tax revenue.** Counties exclude any amount that is or will be spent for economic development grants from the amount of estimated sales tax revenue. **UNITS THAT ADOPTED THE SALES TAX IN NOVEMBER OR MAY 2024.** Multiply the amount on Line 51 by the sales tax rate (.01, .005, or .0025, as applicable) and multiply the result by .95. - OR- **UNITS THAT ADOPTED THE SALES TAX BEFORE NOVEMBER 2023.** Enter the sales tax revenue for the previous four quarters. Do NOT multiply by .95.	$	0.00	
53. **2024 total taxable value.** Enter the amount from Line 21 of the NNR Tax Rate Worksheet.	$	2,256,097,556	
54. **Sales tax adjustment rate.** Divide Line 52 by Line 53 and multiply by $100.	$	0.0000	/$100
55. **2024 NNR tax rate, unadjusted for sales tax.** Enter the rate from Line 26 or 27, as applicable, on the NNR Tax Rate Worksheet.	$	0.6677	/$100
56. **2024 NNR tax rate, adjusted for sales tax.** Units that adopted the sales tax in November 2023 or in May 2024: Subtract Line 54 from Line 55. Skip to Line 57 if you adopted the additional sales tax before Nov 2023.	$	0.6677	/$100
57. **2024 voter-approval tax rate, unadjusted for sales tax.** Enter the rate from Line 49, Line D49 (disaster) or Line 50, as applicable, on the NNR Tax Rate Worksheet.	$	0.8489	/$100
58. **2024 voter-approval tax rate, adjusted for sales tax.** Subtract Line 54 from Line 57.	$	0.8489	/$100

City of Manor

2024
VOTER-APPROVAL RATE ADJUSTMENT FOR FOR POLLUTION CONTROL

59. **Certified expenses from TCEQ.** Enter the amount certified in the determination letter from TCEQ. The taxing unit shall provide its tax assessor-collector with a copy of the letter.	$	0.00	
60. **2024 total taxable value.** Enter the amount from Line 21 of the NNR Tax Rate Worksheet.	$	2,256,097,556	
61. **Additional rate for pollution control.** Divide Line 59 by Line 60 and multiply by $100.	$	0.0000	/$100
62. **2024 voter-approval tax rate, adjusted for pollution control.** Add Line 61 to one of the following lines (as applicable): Line 49, Line D49 (disaster), Line 50 (counties), or Line 58 (taxing units with the additional sales tax).	$	0.8489	/$100

2024
VOTER-APPROVAL RATE ADJUSTMENT FOR UNUSED INCREMENT RATE

63. **Year 3 Forgone Revenue Amount.** Subtract the 2023 unused increment rate and 2023 actual tax rate from the 2023 voter-approval tax rate. Multiply the result by the 2023 current total value.

A. Voter-approval tax rate, adjusted for unused increment rate (Line 67).	0.6711		
B. Unused increment rate (Line 66).	0.0000		
C. Subtract B from A.	0.6711		
D. Adopted Tax Rate.	0.6789		
E. Subtract D from C.	(0.0078)		
F. 2023 Total Taxabe Value (Line 60).	2,101,439,419		
G. Multiply E by F and divide the results by $100		$	0

64. **Year 2 Forgone Revenue Amount.** Subtract the 2022 unused increment rate and 2022 actual tax rate from the 2022 voter-approval tax rate. Multiply the result by the 2022 current total value.

A. Voter-approval tax rate, adjusted for unused increment rate (Line 67).	0.7355		
B. Unused increment rate (Line 66).	0.0000		
C. Subtract B from A.	0.7355		
D. Adopted Tax Rate.	0.7470		
E. Subtract D from C.	(0.0115)		
F. 2022 Total Taxabe Value (Line 60).	1,754,276,050		
G. Multiply E by F and divide the results by $100		$	0

65. **Year 1 Forgone Revenue Amount.** Subtract the 2021 unused increment rate and 2021 actual tax rate from the 2021 voter-approval tax rate. Multiply the result by the 2021 current total value.

A. Voter-approval tax rate, adjusted for unused increment rate (Line 67).	0.7667		
B. Unused increment rate (Line 66).	0.0054		
C. Subtract B from A.	0.7613		
D. Adopted Tax Rate.	0.7827		
E. Subtract D from C.	(0.0214)		
F. 2022 Total Taxabe Value (Line 60).	1,217,505,804		
G. Multiply E by F and divide the results by $100		$	0

66. **Total Foregone Revenue Amount.** Add Lines 63G, 64G, and 65G. $ 0

67. **2024 unused increment rate.** Divide Line 66 by Line 21 of the NNR Worksheet. Multiply the result by 100. $ 0.0000 /$100

68. **2024 voter-approval tax rate, adjusted for unused increment rate.** Add Line 67 to one of the following lines (as applicable): Line 49, Line D49 (disaster), Line 50 (counties), Line 58 (taxing units with the additional sales tax) or Line 62 (taxing units

with pollution control).	$	0.8489	/$100

City of Manor

2024
DE MINIMIS RATE

**THIS SECTION SHOULD ONLY BE COMPLETED BY A TAXING UNIT THAT IS A MUNICIPALITY OF LESS TH TAXING UNIT THAT DOES NOT MEET THE DEFINITION OF A SPECIAL TAXING UNIT. (Texas Tax Code Sectio

69. **Adjusted 2024 NNR M&O tax rate.** Enter the rate from Line 39 of the Voter-Approval Tax Rate Worksheet.	$	0.4957	/$100
70. **2024 total taxable value.** Enter the amount on Line 21 of the NNR Tax Rate Worksheet.	$	2,256,097,556	
71. **Rate necessary to impose $500,000 in taxes.** Divide $500,000 by Line 70 and multiply by $100.	$	0.0221	/$100
72. **2024 debt rate.** Enter the rate from Line 48 of the Voter-Approval Tax Rate Worksheet.	$	0.3359	/$100
73. **De minimus rate.** Add Lines 69, 71, and 72.	$	0.8537	/$100

City of Manor

2024
TOTAL TAX RATE

No-new-revenue tax rate As applicable, enter the 2024 NNR tax rate from: Line 26, Line 27 (counties), or Line 56 (adjusted for sales tax).	$	0.6677	/$100
Voter-approval tax rate. As applicable, enter the 2024 voter-approval tax rate from: Line 49, Line D49 (disaster) Line 50 (counties), Line 58 (adjusted for sales tax), Line 62 (adjusted for pollution control), or Line 68 (adjusted for unused increment).	$	0.8489	/$100
De minimis rate If applicable, enter the de minim rate from Line 73.	$	0.8537	/$100

City of Manor July 25, 2024

NOTICE OFTAX RATE, ESTIMATED UNENCUMBERED FUND BALANCES, AND DEBT SERVICE

I, Bruce Elfant, Tax Assessor-Collector for Travis County, in accordance with Sec. 26.04, Texas Property Tax Code, provide this notice on 2024 property tax rates for your jurisdiction. This notice presents incformation about two tax rates. The No-New-Revnue tax rate would impose the same amount of taxes as last year if you compare the propertie taxed in both years. The Voter-Approval tax rate is the highest tax rate a taxing unit can adopt without holding an election. In each case, these rates are calculated by dividing the total amount of taxes by the current taxable value with adjustments as they are required by state law. The rates are given per $100 of property value.

THIS YEAR'S NO-NEW-REVENUE TAX RATE:

	Last year's adjusted taxes (after subtracting taxes on lost property).....	$	13,630,278.56	
/	This year's adjusted tax base (after subtracting value of new property).....	$	2,041,351,111	
=	This year's no-new-revenue tax rate.....	$	0.6677	/$100

THIS YEAR'S VOTER-APPROVAL TAX RATE:

	Last year's adjusted operating taxes (after subtracting taxes on lost property and adjusting for any transferred function, tax increment financing, state criminal justice mandate, and/or enhanced indigent health care expenditures)……	$	10,120,827.97	
/	This year's adjusted tax base.....	$	2,041,351,111	
=	This year's no-new-revenue operating rate….....	$	0.0000	/$100
x	1.035 = This year's maximum operating rate.....	$	0.0000	/$100
+	This year's debt rate.....	$	0.3359	/$100
=	This year's voter-approval rate….....	$	0.8489	/$100

Schedule A: Unencumbered Fund Balances:

The following estimated balances will be left in the unit's property tax accounts at the end of the fiscal year. These balances are not encumbered by a corresponding debt obligation.

Maintenance & Operations	$	0
Interest & Sinking (Debt)	$	0
Total	$	0

Schedule B, 2024 Debt Service, Parts 1 and 2, are attached

_____ Prepared By: _____

Bruce Elfant Christina Cerda

Travis County Tax Assessor-Collector

Schedule B, 2024 Debt Service, Part 2 July 25, 2024

	Total Required for 2024 Debt Service.....…….....	$	7,580,233.69
-	Amount (if any) paid from funds listed in Schedule A..……....	$	0.00
-	Amount (if any) paid from other resources.....…….....	$	0.00
-	Excess collections last year.....…….....	$	0.00
=	Total to be paid from taxes in 2024.....…….....	$	7,580,233.69
+	Amount added in anticipation that the unit will collect only 100.00% of its taxes in 2024..……....	$	0.00
=	Total Debt Levy.....	$	0.00

Schedule B, 2024 Debt Services, Part 1 July 25, 2024

DESCRIPTION	PRINCIPAL	INTEREST	OTHER	TOTALS
2012 GO Bond	60,000.00	3,187.50	150.00	63,337.50
2012 CO Bond	140,000.00	10,582.50	0.00	150,582.50
2015 GO Bond	500,000.00	35,380.50	0.00	535,380.50
2016 CO Bond	1,170,000.00	275,945.00	635.00	1,446,580.00
2021 CO Bond	390,000.00	91,784.00	0.00	481,784.00
2022 Tax Note	1,380,000.00	217,552.50	0.00	1,597,552.50
2023 CO Bond	500,000.00	1,812,250.00	0.00	2,312,250.00
2024 GO Bond	0.00	992,766.69	0.00	992,766.69
TOTALS	**4,140,000.00**	**3,439,448.69**	**785.00**	**7,580,233.69**

2024 Truth in Taxation Calculations
City of Manor TIRZ

Data Input Detail

	Manor Heights TIRZ	Total
2023 Taxes in Tax Increment Fund	307,728.32	307,728.32
2023 Value	148,489,724	148,489,724
2023 Captured Appraised Value	147,962,769	147,962,769
TIRZ Base Value	526,955	526,955
2024 Value	222,653,614	222,653,614
New Construction Value	78,661,756	78,661,756
2024 Captured Appraised Value	143,464,903	143,464,903

AGENDA ITEM SUMMARY FORM

PROPOSED MEETING DATE: August 7, 2024
PREPARED BY: Scott Moore, City Manager
DEPARTMENT: Administration

AGENDA ITEM DESCRIPTION:

Consideration, discussion, and possible action on accepting the 2024 Third Quarter City Council Committee Reports.

BACKGROUND/SUMMARY:

- Park Committee
- Economic Development Committee
- Community Collaborative Committee
- HealthCare Committee
- Public Safety Committee

LEGAL REVIEW: Not Applicable
FISCAL IMPACT: Not Applicable
PRESENTATION: No
ATTACHMENTS: Yes

- 2024 Third Quarter City Council Committee Reports.

STAFF RECOMMENDATION:

The city staff recommends that the City Council approve and accept the 2024 Third Quarter City Council Committee Reports.

Manor City Council
3rd Quarterly Report

Committee:	Parks Committee		
Starting Date:	April 1, 2024	Ending Date:	June 30, 2024

Committee Members:

Sonia Wallace & Aaron Moreno

Accomplishments

Meetings were held with the Park Committee to discuss the plaque for the Veterans Day Memorial at Jennie Lane Park; and updated on the findings for Timmermann Park during the grant writing process. Request presentation to the council for further discussion.

Challenges

Creating a survey that targets specific genders and age range.

Needs

Council input on next steps and continue discussion on parks master plan.

Next Quarter Goals:

Bring a plan of action to the city council on our next steps.

Manor City Council
3rd Quarterly Report

Committee:	Economic Development		
Starting Date:	April 1, 2024	Ending Date:	June 30, 2024

Committee Members:

• Mayor Dr. Harvey • Councilwoman Weir • Scott Jones • Aldo Fritz • Amy Madison • Su Jones • Dusty McCormick	• Lezlie Tran • Michelle Anderson • Daffney Henry • Stacy Rhone • Sean Donnelly • Matthew Taylor

Accomplishments

- Meetings w/Chris Morris, Richie Butler, Elmer Fisher, Barney McAuley – Land in Manor
- Downtown Infill meeting
- Marking and branding for ManorPalooza
- Update on 47 projects
- ED Committee Meeting Agenda 06042024
- Movement with Wonik's move to Manor Texas

Challenges

- Limited sales tax

Next Quarter Goals:

- Letter of intent with Wonik
- Working towards recruiting more advanced manufacturing to Manor
- Exploring regional hospital
- Protecting regional treatment plan

Manor City Council
3rd Quarterly Report

Committee:	Community Collaborative		
Starting Date:	April 1, 2024	Ending Date:	June 30, 2024

Committee Members:

Mayor Dr. Chris Harvey
Mayor Pro Tem Emily Hill

Subcommittee:
Destiny – Urban League young professionals
Dr. Chinwe Efruibe – CCYC
Feliz Paiz –
Shonqualla West -

Accomplishments

Building subcommittee to help recruit participants

Challenges

Recruitment of HOA members

Needs

Next Quarter Goals:

Recruitment of HOA members

Manor City Council
3rd Quarterly Report

Committee:	Health Committee		
Starting Date:	April 1, 2024	Ending Date:	June 30, 2024

Committee Members:

Anne Weir & Aaron Moreno

Accomplishments

Working with Black Men's Health Clinic, ACC and Harvard Law on a survey tailored to our community and its needs. The survey should be ready to launch in August.

Challenges

Creating a survey best fits our community to obtain the proper data on how to serve them.

Needs

Continue discussion updates with the BMHC on our survey.

Next Quarter Goals:

Collect data from the survey and the next plan of action.

Manor City Council
3rd Quarterly Report

Committee:	Public Safety Committee		
Starting Date:	Apr 01, 2024	Ending Date:	June 01, 2024

Committee Members:

Mayor Harvey, MPT Hill, Councilmember Wallace, Scott Moore, Chief Ryan Phipps.

Accomplishments

TBD as the last meeting were up and coming items.

Challenges

Slow process on the speed bump for Hamilton Point

Needs

Process needs to be faster for long term pending issues

Next Quarter Goals:

Finalize and get approval from Council on the speed bump for Hamilton Point

AGENDA ITEM NO. _____

AGENDA ITEM SUMMARY FORM

PROPOSED MEETING DATE: August 7, 2024
PREPARED BY: Lluvia T. Almaraz, City Secretary
DEPARTMENT: Administration

AGENDA ITEM DESCRIPTION:

Consideration, discussion, and possible action on a Joint Agreement with Travis County for the November 5, 2024, General Election; and authorize the Mayor to execute the agreement.

BACKGROUND/SUMMARY:

Travis County will be conducting general and special elections for participating entities on November 5, 2024.

Under Texas Election Code Section 271.002, political subdivisions of the State of Texas are authorized to hold elections jointly in voting precincts that can be served by common polling places if elections are ordered by the authorities of two or more political subdivisions to be held on the same day in all or part of the same territory.

Texas Government Code Chapter 791 authorizes local governments to contract with one another and with state agencies for various governmental functions, including those in which the contracting parties are mutually interested.

It would benefit the County, the Participating Entities, and their respective citizens and voters to hold the elections jointly in the election precincts that common polling places can serve.

LEGAL REVIEW: Yes, Paige Saenz, City Attorney
FISCAL IMPACT: No
PRESENTATION: No
ATTACHMENTS: Yes

- Joint Election Agreement

STAFF RECOMMENDATION:

The city staff recommends that the City Council approve a Joint Agreement with Travis County for the November 5, 2024, Special Election and authorize the Mayor to execute the agreement.

PLANNING & ZONING COMMISSION: **Recommend Approval** **Disapproval** **None**

JOINT ELECTION AGREEMENT FOR NOVEMBER 5, 2024 ELECTIONS

Recitals

1. Travis County (the "County") will be conducting general and special elections for the participating entities (each, a "Participating Entity," and together, the "Participating Entities") listed in Exhibit A, which is attached to and incorporated into this agreement, on November 5, 2024. Each Participating Entity requires elections to be held on November 5, 2024 in those portions the Participating Entity's territory that are located in Travis County.

2. Under Texas Election Code Section 271.002, political subdivisions of the State of Texas are authorized to hold elections jointly in voting precincts that can be served by common polling places if elections are ordered by the authorities of two or more political subdivisions to be held on the same day in all or part of the same territory.

3. Texas Government Code Chapter 791 authorizes local governments to contract with one another and with state agencies for various governmental functions, including those in which the contracting parties are mutually interested.

4. It would benefit the County, the Participating Entities, and their respective citizens and voters to hold the elections jointly in the election precincts that common polling places can serve.

Pursuant to Texas Election Code Sections 271.002 and 271.003 and Texas Government Code Chapter 791, this Joint Election Agreement is entered into by and between Travis County, a political subdivision of the State of Texas acting by and through the Travis County Commissioners Court, and the Participating Entities, each acting by and through their respective governing bodies.

I. Scope of Joint Election Agreement

This agreement covers conducting the November 5, 2024 General and Special Elections for the Participating Entities. The Participating Entities will hold these elections on November 5, 2024 ("Election Day") jointly for the Participating Entities' voters who reside in Travis County.

II. Election Officer

The Participating Entities hereby appoint the Travis County Clerk, the election officer for Travis County, as the election officer to perform or supervise the County's duties and responsibilities involved in conducting the joint election covered by this agreement. **III. Early Voting**

Each of the Participating Entities agrees to conduct its early voting jointly. Each of the Participating Entities appoints the Travis County Clerk, the early voting clerk for Travis County, as the early voting clerk for the joint election. Early voting for the

Participating Entities will be conducted at the dates, times, and locations to be mutually agreed upon by the election officer and authorized and ordered by the governing body of each Participating Entity.

A. County Responsibilities

1. The County will provide to the governing body of each Participating Entity a list of places, times, and dates of early voting suitable for consideration and adoption by the governing body, under Texas Election Code chapter 85.

2. The Travis County Clerk, as the early voting clerk, will be responsible for conducting early voting by mail and by personal appearance for all Travis County voters voting in the joint election. The Travis County Clerk will receive from each Participating Entity's regular early voting clerk applications for early voting ballots to be voted by mail, under Texas Election Code Title 7. The Travis County Clerk will send early voting ballots by mail and receive early voting ballots for early voting by mail. The Travis County Clerk may appoint such deputy early voting clerks as necessary to assist the Travis County Clerk with voting to take place at the early voting locations.

3. The County will determine the number of election workers to hire to conduct early voting in the joint election. The Travis County Clerk will arrange or contract for training for all election workers and will assign all election workers employed for early voting in the joint election. The training of these election workers is mandatory; these individuals will be compensated for their time in training. The County will provide a training facility for election schools to train election workers employed in conducting early voting, including early voting by personal appearance at main and temporary branch early voting polling places, early voting by mail, and other aspects of the early voting program for the joint election. The County will name early voting deputies and clerks employed to conduct early voting.

4. The County will provide and deliver all supplies and equipment necessary to conduct early voting for the joint election, including ballots, election forms, any necessary ramps, utility hook-ups, signs, registration lists and ballot boxes, to early voting polling places. The County will designate and confirm all early voting polling place locations.

5. The County will be responsible for preparing and transporting the electronic voting equipment necessary to conduct early voting. The County will perform all tests of voting equipment as required, including posting notice of equipment testing.

6. Under Election Code sections 66.058 and 271.010, the Participating Entities appoint the Travis County Clerk as the joint custodian of records for the sole purpose of preserving all voted ballots securely in a locked room in

the locked ballot boxes for the preservation period that the Election Code requires.

7. The County will receive ballot language in both English and Spanish from each Participating Entity and format the ballots as needed to include these languages. The County will provide each Participating Entity with a final proof of ballot language for approval before printing the ballots. Upon final proof approval, ballots will be printed in an expedited timeframe so as to allow ballot allocations for the Early Voting by Personal Appearance Program, and the ballot mail outs for the Early Voting by Mail Program.

8. A single joint voter sign-in process consisting of a common list of registered voters, and common signature rosters will be used for early voting. A single, combined ballot and single ballot box will be used. The County will use an electronic voting system, as defined and described in Texas Election Code Title 8, and agrees to use ballots that are compatible with such equipment.

9. The County will be responsible for conducting the Early Voting Ballot Board. The County will designate a person to serve as the presiding judge for the Early Voting Ballot Board and will provide that information to the governing body of each Participating Entity for entry of an order by that authority appointing this official. The presiding judge for the Early Voting Ballot Board is eligible to serve in this capacity. The presiding judge for the Early Voting Ballot Board will appoint two or more election clerks, and the judge and clerks will comprise the Early Voting Ballot Board and will count and return early voting ballots, and perform other duties the Election Code requires of it.

B. Participating Entities' Responsibilities

1. Each Participating Entity will appoint a qualified person to serve as the regular early voting clerk for the Participating Entity. The regular early voting clerk for each respective Participating Entity will receive requests for applications for early voting ballots to be voted by mail and will forward in a timely manner, as prescribed by law, any and all applications for early voting ballots to be voted by mail, received in the Entity's office, to the Travis County Clerk.

2. Each Participating Entity will appoint a qualified person to act as custodian of records for the Participating Entity to perform the duties imposed by the Election Code on the custodian of records for its respective entity.

3. Each Participating Entity will provide ballot language for the respective portion of the official ballot to the County in both English and Spanish. The Participating Entity must make any additions, modifications, deletions, or other changes to such ballot contents or language before the Participating Entity's final proof approval. The County will provide the Participating Entity with a final proof of ballot language, as it is to appear on the ballot,

for final proof approval. Upon final proof approval, the ballot will be programmed for the voting equipment in an expedited timeframe so as to allow ballot allocations for the Early Voting by Personal Appearance Program, and the printed ballot mail outs for the Early Voting by Mail Program.

IV. Election Day

A. County Responsibilities

1. The County will designate and confirm all Election Day polling place locations for the joint election, and will forward such information to the Participating Entities in a timely fashion to allow the governing body of the respective Participating Entities to enter orders designating such polling places.

2. The County will designate the presiding election judge and the alternate presiding election judge to administer the election in the precinct in which a common polling place is to be used and will forward such information to the Participating Entities to allow the governing bodies of the respective Participating Entities to enter appropriate orders designating such officials before the election. The presiding election judge and alternate presiding election judge must be qualified voters of the Travis County election precinct in which the joint election is held. The presiding election judge for the precinct in which a common polling place is used may appoint election clerks as necessary to assist the judge in conducting the election at the precinct polling place. The alternate presiding election judge may be appointed as a clerk. The alternate presiding election judge may serve as the presiding election judge for the precinct in the presiding election judge's absence. Election judges and clerks will be compensated at the rate established by the County. The Texas Election Code and other applicable laws will determine compensable hours.

3. One set of election officials will preside over the election in the precinct using a common polling place. There will be a single joint voter sign-in process consisting of a common list of registered voters and common signature rosters in the precinct using a common polling place. A single, combined ballot and single ballot box will be used. The officer designated by law to be the custodian of the voted ballots for the County will be custodian of all materials used in common in the precinct using a common polling place. The County will use an electronic voting system, as defined and described by Texas Election Code Title 8, and agrees to use ballots that are compatible with such equipment.

4. The County will arrange for training and will provide the instructors, manuals and other training materials deemed necessary for training all judges and clerks. Training for election judges and alternate judges is mandatory, and these individuals will be compensated for their time in training.

5. The County will arrange for election-day voter registration precinct lists for the joint election. The County will determine the amount of election supplies needed for Election Day voting.

6. The County, by and through the County Clerk's Elections Division, and Administrative Operations, will be responsible for preparing and transporting voting equipment and election-day supplies for use on Election Day.

7. The County, by and through the County Voter Registrar, will provide the list of registered voters as needed in the overlapping jurisdictions identified in the attached exhibits, with designation of registered voters in each Participating Entity, for use at the joint election day polling place on Election Day.

8. The common polling place is designated as the polling place that the County uses. At the common polling place, a single ballot box will be used for depositing all ballots cast in the joint election. At this polling place, one voter registration list and one combination poll list and signature roster form will be kept for the joint election. The final returns for each Participating Entity and the County will be canvassed separately by each respective Participating Entity. The Travis County Clerk will maintain a return center on Election Day for the purpose of receiving returns from the County. The Travis County Clerk will provide unofficial election results to the qualified individual appointed by each Participating Entity.

9. On Election Day, the Travis County Clerk or the clerk's Elections Division will field all questions from election judges.

10. The County will make available translators capable of speaking English and Spanish to assist Spanish-speaking voters in understanding and participating in the election process in the territory covered by this agreement.

B. Participating Entities' Responsibilities

1. Before Election Day, each Participating Entity will answer questions from the public with respect to the Participating Entity's election during regular office hours of 8:00 a.m. – 5:00 p.m.

2. The custodian of records for each Participating Entity will receive returns from the Travis County Clerk on Election Day.

V. Election Night

A. County Responsibilities

1. The County will be responsible for all activities on election night, including setting up a central counting station, coordinating and supervising the results tabulation, coordinating and supervising the physical layout of the support stations that are the joint election's receiving substations, and coordinating and managing election media coverage.

2. The County is responsible for transporting voted ballot boxes to the central counting station.

3. The County will appoint the presiding judge and alternate presiding judge of the central counting station to maintain order at the central counting station, to administer oaths as necessary, to receive sealed ballot boxes, and to perform such other duties that the Texas Election Code requires, and will forward such information to each Participating Entity in a timely fashion to allow the governing body of each Participating Entity to enter appropriate orders designating such election officials before the election. The presiding judge of the central counting station may appoint clerks to serve at the central counting station. In addition, the County will appoint a tabulation supervisor to be in charge of operating the automatic tabulating equipment at the central counting station; an individual to serve as central counting station manager; and an assistant counting station manager to be in charge of administering the central counting station and generally supervising the personnel working at the central counting station. The County will forward such information to each Participating Entity in a timely fashion to allow the governing body of each Participating Entity to enter appropriate orders designating such election officials before the election.

4. The County will provide the Participating Entities with reasonable space in a public area adjacent to the central counting station at which each Participating Entity may have representatives or other interested persons present during the counting process.

B. Participating Entities' Responsibilities

Other than receiving returns from the Travis County Clerk, the Participating Entities have no role or responsibility on the night of the election.

VI. County Resources

A. The County will provide the Elections Division permanent staff and offices to administer the joint election, under the Travis County Clerk's direction.

B. For early voting, the County will provide a locked and secure area in which voted ballot boxes will be stored until the Early Voting Ballot Board convenes. The County, by and through Administrative Operations, will be responsible for transporting the ballot boxes to the central counting station for the Early Voting Ballot Board.

C. The County will be responsible for providing and maintaining voting equipment and testing any voting equipment as required by the Texas Election Code.

D. The County will process the payroll for all temporary staff hired to conduct the joint election. The payroll processing includes statutory reporting and providing W-2 forms where applicable.

E. The County will conduct early voting as indicated in this agreement.

VII. Joint Election Costs; Payment

A. Concurrently with its submittal of an executed copy of this agreement each Participating Entity must also submit payment via check or ACH, in the amount equal to the deposit identified for that Participating Entity in the Cost Estimate attached as Exhibit B, which is also incorporated into this agreement. The County is under no obligation to conduct a Participating Entity's elections until the County receives that Participating Entity's payment of Cost Estimate. All checks must be made payable to Travis County. This deposit represents approximately 60% of the costs of the Participating Entity's share of the estimated election costs, or $100, whichever amount is greater. The County will submit an invoice to each Participating Entity for the balance of the Participating Entity's actual joint election expenses upon the election's completion. Joint-election expenses include expenses for facilities, personnel, supplies, and training that the County actually incurs for establishing and operating all early voting and election-day activities at the polling place in the joint election territory as well as activities related to tabulating votes, all as reflected on the Cost Estimate. Each Participating Entity will pay the total amount of its invoice no later than 30 days of receiving it.

B. In the event of a recount, the expense of the recount will be borne by the Participating Entity involved in the recount on a pro-rata basis.

C. In the event a Participating Entity cancels its respective election because of unopposed candidates under Texas Election Code Title 1, the Participating Entity will be responsible for its respective share of election expenses incurred through the date that the election is canceled as allocated to the cancelling entity based on the formula in the Cost Estimate, adjusted for the actual expenses incurred by the County through the date of the cancellation. If a Participating Entity cancels its election, the County will recalculate the allocation percentages among the remaining Participating Entities according to the formula used in the Cost Estimate.

D. In the event there are any expenses associated with processing a ballot arising from a write-in candidate, the Participating Entity that received the declaration will bear the expenses.

E. A Participating Entity that establishes an early voting polling place, other than one that was mutually agreed upon by all Participating Entities, will bear the expense of doing so. The Cost Estimate for each individual Participating Entity will include additional polling locations for each Participating Entity, as set forth in Exhibit B.

VIII. General Provisions

A. Legal Notices

Each of the Participating Entities will be individually responsible for preparing the election orders, resolutions, notices, and other pertinent documents for adoption or execution by its own respective governing board and for all related expenses. The Travis County Clerk will provide each Participating Entity information on changes affecting the Participating Entity's election, such as polling place changes and changes in voting equipment, when such changes are confirmed, verified, or otherwise become known to the clerk's office. Each of the Participating Entities will be individually responsible for posting or publishing election notices and for all related expenses. Each of the Participating Entities further will be individually responsible for election expenses incurred in relation to any polling place that is not a common polling place as designated in this agreement.

B. Communication

Throughout this agreement's term, the Travis County Clerk or the clerk's employee will meet as necessary with the designated representative of each Participating Entity to discuss and resolve any problems that might arise regarding the joint election.

C. Custodian

The Travis County Clerk will serve as the custodian of the keys to the ballot boxes for voted ballots in the joint election.

D. Effective Date

This agreement takes effect upon its complete execution by all Participating Entities and the County. The obligation of each Participating Entity to the County under this agreement will not end until that Participating Entity pays the County its share of the joint election costs.

IX. Miscellaneous Provisions

A. Amendment/Modification of Exhibits A and B

1. The Participating Entities acknowledge and agree that Exhibit A and Exhibit B may be amended to add or remove entities wishing to participate or cease participating in the agreement. The Participating Entities agree to future amendments of Exhibit A and Exhibit B and authorize the County to enter into such amendments without the Participating Entities' having to sign the future amendments. The County agrees to notify all Participating Entities of any amendments to Exhibit A and Exhibit B.

2. Except as otherwise provided, this Agreement may not be amended in any respect whatsoever except by a further agreement in writing, duly executed by the parties to this agreement. No official, representative, agent, or employee of the County has any authority to modify this Agreement except by express authorization from the Travis County Commissioners Court. No official, representative, agent, or employee of any Participating Entity has any authority to modify this agreement except by express authorization from the governing body of the respective Participating Entity. The Travis County Clerk may propose necessary amendments to this agreement in writing in order to conduct the joint election smoothly and efficiently, except that any such proposed amendment must be approved by the Travis County Commissioners Court and the governing body of each respective Participating Entity before the amendment will be effective.

B. Notice

Any notice to be given in this agreement, by any party to the other, must be in writing and delivered personally or by certified mail, return receipt requested, to the proper party at the addresses listed in Exhibit A.

Each party may change the address for notice to it by giving notice of the change under this section's terms.

C. Force Majeure

In the event that the County cannot perform any of its obligations in this agreement or is interrupted or delayed by any occurrence not occasioned by its own conduct, whether it be an act of God, the result of war, riot, civil commotion, sovereign conduct, epidemic, pandemic, or other event declared a disaster (including a disaster declared by the County Judge), or like reason, then the County will be excused from performing for such period of time as is reasonably necessary after such occurrence to remedy its effects.

D. Venue and Choice of Law

The Participating Entities agree that venue for any dispute arising under this agreement will lie in the appropriate courts of Austin, Travis County, Texas. This agreement is governed by and is to be construed under the laws of Texas and the United States of America.

E. Entire Agreement

This agreement contains the parties' entire agreement relating to the rights granted and the obligations assumed in it, and it supersedes all prior agreements, including prior election services contracts relating to each Participating Entity's May 4, 2024 election. Any prior agreements, promises, negotiations, or representations not expressly contained in this agreement are of no force or effect. Any oral

representations or modifications concerning this agreement have no force or effect, except a subsequent amendment in writing as this agreement provides.

F. Severability

If any provision of this agreement is found to be invalid, illegal or unenforceable by a court of competent jurisdiction, such invalidity, illegality, or unenforceability will not affect the agreement's remaining provisions; and its parties will perform their obligations under the agreement's surviving terms and provisions.

G. Breach

In the event that any Participating Entity or the County breaches any of its obligations under this agreement, the non-breaching party will be entitled to pursue any and all rights and remedies allowed by law.

H. Payments from Current Revenues

Payments made by the Participating Entities in meeting their obligations under this agreement will be made from current revenue funds available to the governing body of the respective Participating Entity. Payments made by the County in meeting its obligations under this agreement will be made from current revenue funds available to the County.

I. Other Instruments

The Participating Entities agree that they will execute other and further instruments or any documents as may become necessary or convenient to effectuate and carry out this agreement's purposes.

J. Third-Party Beneficiaries

Except as otherwise provided in this agreement, nothing in this agreement, expressed or implied, is intended to confer upon any person, other than the parties to it, any of its benefits, rights, or remedies.

K. Other Joint Election Agreements

The County and the Participating Entities expressly understand and acknowledge that each may enter into other joint election agreements with other political subdivisions, to be held on Election Day and at common polling places covered by this agreement, and that the addition of other political subdivisions as parties to this agreement will require amending Exhibits A and B.

L. Mediation

When mediation is acceptable to both parties in resolving a dispute arising under this agreement, the parties agree to use a mutually agreed upon mediator, or a

person appointed by a court of competent jurisdiction, for mediation as described in Texas Civil Practice and Remedies Code section 154.023. Unless both parties are satisfied with the mediation's result, the mediation will not constitute a final and binding resolution to the dispute. All communications within the scope of the mediation will remain confidential as described in section 154.073, unless both parties agree, in writing, to waive the confidentiality. Despite this, the parties intend to fully comply with the Texas Open Meetings Act and the Texas Public Information Act whenever applicable. The term "confidential" as used in this agreement has the same meanings as defined and construed under the Texas Public Information Act and the Texas Open Meetings Act. Notwithstanding any provision to the contrary, nothing in this Agreement requires the County or a Participating Entity to waive any applicable exceptions to disclosure under the Texas Public Information Act.

M. Counterparts

This Agreement may be executed in multiple counterparts, all of which will be deemed originals and with the same effect as if all parties to it had signed the same document. Signatures transmitted electronically by e-mail in a "PDF" format or by DocuSign or similar e-signature service shall have the same force and effect as original signatures All of such counterparts will be construed together and will constitute one and the same agreement.

TRAVIS COUNTY

BY: _____
Dyana Limon-Mercado
County Clerk

Date: _____

AGENDA ITEM SUMMARY FORM

PROPOSED MEETING DATE: August 7, 2024

PREPARED BY: Lluvia T. Almaraz, City Secretary

DEPARTMENT: Administration

AGENDA ITEM DESCRIPTION:

Consideration, discussion, and possible action on a Resolution ordering the November 5, 2024, General Election to elect a Mayor and three (3) Council Members of the City Council (Place Nos. 1, 3, and 5); and Authorize the Mayor to execute the Notice of General Election.

BACKGROUND/SUMMARY:

The City of Manor will hold a General Election on November 5, 2024, for the following positions on the City Council: Mayor; Council Member, Place 1; Council Member, Place 3; and Council Member, Place 5. The Final Notice of General Election will address polling locations for both Early Voting and Election Day to the registered voters of the City of Manor, Texas. Notices will be published on the city's webpage and the local newspaper as required by the Texas Election Code.

LEGAL REVIEW: Yes, Paige Saenz, City Attorney

FISCAL IMPACT: Not Applicable

PRESENTATION: No

ATTACHMENTS: Yes

- Resolution No. 2024-24

STAFF RECOMMENDATION:

The City staff recommends that the City Council approve Resolution No. 2024-24 ordering the November 5, 2024, General Election; Authorize the Mayor to execute the final Notice of General Election.

PLANNING & ZONING COMMISSION: **Recommend Approval** **Disapproval** **None**

RESOLUTION NO.2024-24

A RESOLUTION OF THE CITY OF MANOR, TEXAS, ORDERING A GENERAL ELECTION TO BE HELD ON NOVEMBER 5, 2024, FOR THE PURPOSE OF ELECTING A MAYOR AND THREE (3) COUNCIL MEMBERS OF THE CITY COUNCIL (PLACE NOS. 1, 3, AND 5); MAKING PROVISIONS FOR THE CONDUCT OF THE ELECTION; PROVIDING FOR OTHER MATTERS RELATING TO THE ELECTION; AND PROVIDING AN EFFECTIVE DATE.

WHEREAS, the City Council of the City of Manor wishes to order a general election for the purpose of electing a Mayor and three (3) Council Members by the qualified voters of the City of Manor; and

WHEREAS, the City Council wishes to proceed with the ordering of an election to be held on November 5, 2024; and

WHEREAS, the Texas Election Code is applicable to said election, and in order to comply with said Code, a resolution should be passed calling the election and establishing the procedures to be followed in said election, and designating the voting place for said election; and

WHEREAS, the City Council wishes to designate certain officials to conduct various aspects of election services for the city.

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF MANOR, TEXAS THAT:

Section 1. General Election Ordered. A general election is hereby ordered to be held on November 5, 2024, for the purpose of electing a Mayor and three (3) Council Members: Council Member Place 1; Council Member Place 3; and Council Member Place 5; of the City of Manor, Texas. A candidate for Mayor and a candidate to fill Places 1, 3, and 5 will be elected for a four-year term.

Section 2. Joint Election Administration Contract. The City Secretary is hereby authorized to contract with Travis County ("County") for election administration services (the "Agreement"). The City Council further authorizes and agrees to the conduct of a joint election with other political subdivisions within Travis County, provided that such political subdivisions hold an election on November 5, 2024, in all or part of the same territory as the City (the "Political Subdivisions"). Any joint election shall be conducted in accordance with state law, this Resolution, the City Charter, and the Agreement with Travis County. In the event of a conflict between this Resolution and the Agreement, the Agreement shall control.

Section 3. Election Precincts and Election Day Polling Place. The election precincts shall be those established by the County. The polling locations shall be those designated by the Travis County Elections Division.

Section 4. Election Officers. The Travis County Election Officer is appointed to serve as the City's Election Officer and Early Voting Clerk and shall coordinate, supervise, and conduct all aspects of administering voting for the City's joint election. The Travis County Election Officer assumes the responsibility for recruiting election personnel and training thereof.

Section 5. Early Voting. Early voting in said election shall be designated by Travis County Elections Division in accordance with state law. Requests for applications for early voting ballots by mail should be mailed to Travis County Clerk–Elections Division, P.O. Box 149325, Austin, Texas 78714-9325.

Section 6. Candidate Filing Period. In accordance with Section 143.007 of the Texas Election Code ("Code"), the filing period for an application for a place on the ballot, for this election, is declared to begin at 8:00 a.m. on Saturday, July 20, 2024, and will conclude at 5:00 p.m. on Monday, August 19, 2024. All candidates for the offices to be filled, in the election, to be held on November 5, 2024, shall file their application to become candidates with the City Secretary at City Hall, 105 E. Eggleston Street, Manor, Texas, on any weekday that is not a City holiday between 8:00 a.m. and 5:00 p.m., and all of said applications shall be on a form as prescribed by the Election Code of the State of Texas.

Section 7. Drawing. The order in which the names of the candidates are to be printed on the ballot shall be determined by a drawing conducted by the City Secretary, as provided by the Election Code. Such drawing will be held at 9:00 a.m. on Monday, August 26, 2024, at City Hall in the Council Chamber.

Section 8. Notice and Publication. This Resolution shall serve as the Order of Election (as required by Section 3.001 of the Code) for the General Election. A copy of the Resolution shall be posted on the bulletin board used for posting notices of the meetings of the City Council at least twenty-one (21) days before the election. Notice of General Election (as required by Section 4.001 of the Code) shall be published in the newspaper in accordance with state law. A copy of the Notice of General Election shall be posted on the bulletin board used for posting notices of the meetings of the City Council at least twenty-one (21) days before the election.

Section 9. Governing Law. The election shall be held in accordance with the Constitution of the State of Texas and the Texas Election Code, and all resident, qualified voters of the City shall be eligible to vote at the election.

Section 10. Necessary Actions. The Mayor and the City Secretary, in consultation with the City Attorney, are authorized and directed to take all actions necessary to comply with the provisions of the Texas Election Code, the City Charter, and the City Code in carrying out and conducting the election, whether nor not expressly authorized by this Resolution.

Section 11. Election Results. The Travis County Elections Administrator shall conduct an unofficial tabulation of results after the closing of the polls on November 5, 2024. The official canvass, tabulations, and declaration of the results of the election shall be conducted by the City Council at a regular or special meeting held in accordance with provisions of the Texas Election Code.

Section 12. Effective Date. This resolution shall be effective immediately upon approval.

DULY PASSED AND APPROVED BY THE CITY COUNCIL OF THE CITY OF MANOR, TEXAS, ON THIS THE 7th DAY OF AUGUST 2024.

CITY OF MANOR, TEXAS

_____
Dr. Christopher Harvey,
Mayor

ATTEST:

_____
Lluvia T. Almaraz, TRMC
City Secretary

AGENDA ITEM NO. _____

AGENDA ITEM SUMMARY FORM

PROPOSED MEETING DATE: August 7, 2024
PREPARED BY: Scott Moore, City Manager
DEPARTMENT: Administration

AGENDA ITEM DESCRIPTION:

Consideration, discussion, and possible action on a resolution authorizing the acquisition of an accessible voting system in compliance with state and federal laws through a service agreement with Travis County.

BACKGROUND/SUMMARY:

Section 61.012 of the Texas Election Code requires that the City Council must provide at least one accessible voting system in each polling place used in a Texas election on or after August 1, 2023. This system must comply with state and federal laws setting the requirements for voting systems that permit voters with physical disabilities to cast a secret ballot.

Sections 123.032 and 123.035 of the Texas Election Code authorize the acquisition of voting systems by local political subdivisions and further mandate certain minimum requirements for contracts relating to the acquisition of such voting systems.

As chief elections officer of the City of Manor, the City Secretary shall provide at least one ExpressVote® Universal Voting System and DS200 Digital® Precinct Scanner in every early voting and election day polling place used to conduct any and every election ordered on or after August 1, 2023. The ES&S ExpressVote® Universal Voting System and DS200 Digital® Precinct Scanner may be acquired by any legal means available to the City of Manor, including but not limited to lease or rental from the County of Travis or from any other legal source, as authorized or required by Sections 123.032 and 123.035, Texas Election Code.

LEGAL REVIEW: Yes, Paige Saenz, City Attorney
FISCAL IMPACT: No
PRESENTATION: No
ATTACHMENTS: Yes

- Resolution No. 2024-25
- Election Service Agreement

STAFF RECOMMENDATION:

The city staff recommends that the City Council approve Resolution No. 2024-25 approving the acquisition of an accessible voting system in compliance with state and federal laws through a service agreement with Travis County and authorize the mayor to execute the Election Agreement.

PLANNING & ZONING COMMISSION: **Recommend Approval** **Disapproval** **None**

RESOLUTION NO. 2024-25

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF MANOR, TEXAS, AUTHORIZING THE ACQUISITION OF AN ACCESSIBLE VOTING SYSTEM IN COMPLIANCE WITH STATE AND FEDERAL LAWS THROUGH A SERVICE AGREEMENT WITH TRAVIS COUNTY FOR ELECTIONS HELD ON OR AFTER AUGUST 1, 2023.

WHEREAS, on August 7, 2024, the City Council of the City of Manor, Texas (the "City Council) adopted Resolution No. 2024-24 ordering a general election to be held on November 5, 2024;

WHEREAS, Section 61.012 of the Texas Election Code requires that the City Council must provide at least one accessible voting system in each polling place used in a Texas election on or after August 1, 2023. This system must comply with state and federal laws setting the requirements for voting systems that permit voters with physical disabilities to cast a secret ballot.

WHEREAS, the Office of the Texas Secretary of State has certified that the ExpressVote® Universal Voting System Version 6.3.0.0 provided by Election Systems & Software (ES&S) is an accessible voting system that may legally be used in Texas elections. Early voting and election day voting, including provisional ballots will take place on the ExpressVote® Universal Voting System, ballot marking device, in conjunction with the DS200 Digital® Precinct Scanner. The DS450, DS850 & DS950 Digital® Central Count Scanner will be used to process all by mail ballots.

WHEREAS, Sections 123.032 and 123.035 of the Texas Election Code authorize the acquisition of voting systems by local political subdivisions and further mandate certain minimum requirements for contracts relating to the acquisition of such voting systems.

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF MANOR, THAT:

SECTION 1. The City Council hereby approves the recitals contained in the preamble of this Resolution and finds that all the recitals are true and correct and incorporate the same in the body of this Resolution as findings of fact.

SECTION 2. As chief elections officer of the City of Manor, the City Secretary shall provide at least one ExpressVote® Universal Voting System and DS200 Digital® Precinct Scanner in every early voting and election day polling place used to conduct any and every election ordered on or after August 1, 2023. The ES&S ExpressVote® Universal Voting System and DS200 Digital® Precinct Scanner may be acquired by any legal means available to the City of Manor, including but not limited to lease or rental from the County of Travis or from any other legal source, as authorized or required by Sections 123.032 and 123.035, Texas Election Code.

SECTION 3. The City Council does hereby authorize the Mayor or the City Manager to enter into and execute the Agreement (a copy of which is attached hereto as Exhibit "A" and incorporated herein) with Travis County for the lease and use of the voting system described in the above Recitals and Section 2, among other things related to elections held after August 1, 2023.

SECTION 4. If any section, article, paragraph, sentence, clause, phrase or word in this resolution or application thereof to any persons or circumstances is held invalid or unconstitutional by a court of competent jurisdiction, such holding shall not affect the validity of the remaining portions of this resolution; and the City Council hereby declares it would have passed such remaining portions of the resolution despite such invalidity, which remaining portions shall remain in full force and effect.

PASSED AND APPROVED by the City Council of Manor, Texas, at a regular meeting on the 7th day of August 2024, at which a quorum was present, and for which due notice was given pursuant to Government Code, Chapter 551.

THE CITY OF MANOR, TEXAS

_____
Dr. Christopher Harvey
Mayor

ATTEST:

_____
Lluvia T. Almaraz, TRMC
City Secretary

Exhibit "A"
Travis County Election Agreement
[attached]

ELECTION AGREEMENT BETWEEN TRAVIS COUNTY AND CITY OF MANOR

Pursuant to Chapter 31, Subchapter D, Chapter 123, and Chapter 271 of the Texas Election Code and Chapter 791 of the Texas Government Code, Travis County (the "County") and City of Manor ("Participating Entity") enter into this agreement (this "Agreement") for the Travis County Clerk, as the County's election officer (the "Election Officer"), to conduct the Participating Entity's elections, including runoffs, and for the Participating Entity's use of the County's current or future-acquired election equipment for any voting system that the County adopts, as authorized under Title 8 of the Texas Election Code, for all Participating Entity elections. The purpose of this Agreement is to maintain consistency and accessibility in voting practices, polling places, and election procedures in order to best assist the voters of the Participating Entity.

Section 1. GENERAL PROVISIONS

(A) Except as otherwise provided in this Agreement, the term "election" refers to any Participating Entity election, occurring on any uniform election date prescribed by the Texas Election Code or a primary election date, along with any resulting runoff, if necessary, within all Participating Entity's territory located in Travis County. If a runoff is necessary, the Participating Entity shall work with the Election Officer to determine a mutually acceptable run-off date. In the event that the Participating Entity and the Election Officer do not agree on a run-off date, the Participating Entity agrees to the run-off date selected by the Election Officer.

(B) If the Participating Entity determines it is necessary to conduct an election during a time other than that specified in Section 1(A), the Election Officer and a representative designated by the Participating Entity will meet as soon as possible thereafter to determine the feasibility of the Election Officer conducting such an election. If both parties agree that the Election Officer will administer the election, the new election will be based on all other applicable provisions of this Agreement except provisions that are inconsistent and cannot be feasibly applied.

(C) Except as otherwise provided in this Agreement:

(1) The term "Election Officer" refers to the Travis County Clerk;
(2) The term "precinct" means all precincts in the territory of the Participating Entity located within Travis County.
(3) The term "election services" refers to services used to perform or supervise any or all of the duties and functions that the Election Officer determines necessary for the conduct of an election.
(4) The term "cost for election services" includes the costs for personnel, supplies, materials, or services needed for providing these services and an administrative fee as permitted by the Texas Election Code but does not refer to costs relating to the use of the voting equipment

(D) Except as otherwise provided in this Agreement, the cost for "use of voting equipment" for a particular election is the amount the County will charge the Participating Entity for use of the County's voting equipment in use at the time of that election.

(E) The Participating Entity agrees to commit the funds necessary to pay for all election-related expenses for Participating Entity elections in accordance with this Agreement.

(F) The Election Officer has the right to enter into agreements with other entities at any time, including during the dates listed in Section 1(A).

(G) As a condition for providing election services and equipment usage, the Election Officer may require authorities of political subdivisions holding elections on the same day in all or part of the same territory to enter into a joint election agreement as authorized in Chapter 271 of the Texas Election Code, and the Participating Entity agrees to enter into any joint election agreement required by the County.

SECTION 2. PARTICIPATING ENTITY'S USE OF VOTING EQUIPMENT; DUTIES OF THE ELECTION OFFICER AND OF THE PARTICIPATING ENTITY

The County shall make available to the Participating Entity the County's current voting system and any future-acquired voting system as authorized under Title 8 of the Texas Election Code, subject to restrictions and conditions imposed by the Election Officer to ensure availability of the equipment for County-ordered elections, primary elections, special elections, and subsequent runoff elections, if applicable. The Election Officer may also impose restrictions and conditions to protect the equipment from misuse or damage.

SECTION 3. APPOINTMENT OF ELECTION OFFICER

(A) The Travis County Election Officer ("Election Officer") is appointed to serve as the Participating Entity's Election Officer and Early Voting Clerk to conduct the Participating Entity's elections described in Section 1.

(B) As the Participating Entity's Election Officer and Early Voting Clerk, the Election Officer shall coordinate, supervise, and conduct all aspects of administering voting in Participating Entity elections in compliance with all applicable laws, subject to Section 3(C) below.

(C) The Participating Entity shall continue to perform those election duties listed in (1) through (6) below and any other election duties, such as receipt of candidate applications, that are not allowed to be delegated to another governmental entity:

(1) Preparing, adopting, and publishing all required election orders, resolutions, notices, and other documents, including bilingual materials, evidencing

action by the governing authority of the Participating Entity necessary to the conduct of an election, except that:

a. The Election Officer does not provide newspaper notices on behalf of the Participating Entity with respect to a specific election.

b. With respect to each debt obligation election the Election Officer conducts for the Participating Entity pursuant to this Agreement:

i. The Election Officer, after receiving from the Participating Entity a copy of the debt obligation election order, shall post the notice required by and in accordance with Texas Election Code Section 4.003(f)(1) on election day and during early voting by personal appearance, in a prominent location at each polling place;

ii. The Election Officer shall provide written confirmation to the Participating Entity that the debt obligation election order was posted in accordance with Texas Election Code Section 4.003(f)(1); and

iii. The Participating Entity shall pay any applicable expenses incurred by the Election Officer that directly relates to the posting required by Texas Election Code Section 4.003(f)(1).

(2) Preparing the text for the Participating Entity's official ballot in English and Spanish and any other languages as required by law;

(3) Providing the Election Officer with a list of candidates or propositions showing the order and the exact manner in which the candidates' names and the propositions are to appear on the official ballot;

(4) Conducting the official canvass of a Participating Entity election;

(5) Administering the Participating Entity's duties under state and local campaign finance laws;

(6) Filing the Participating Entity's annual voting system report to the Secretary of State as required under Texas Election Code Chapter 123.

(D) The Participating Entity shall also be responsible for proofing and attesting to the accuracy of all ballot language, including any required language translations, and format information programmed by the County. This includes any information programmed for use with the audio or tactile button features of the equipment. The Participating Entity may also monitor and review all logic and accuracy testing and mandatory tabulations. The Participating Entity will complete its duties within timeframes as prescribed by the County. If the Participating Entity finds any discrepancies or concerns, it will immediately report them to the Election Officer and work with her to resolve any issues so that final approval can be reached. The Participating Entity shall be responsible for any and all actual costs associated

with correcting the ballot and ballot programming if the error is discovered after the Participating Entity has signed off on its final proof containing the error.

(E) The City Secretary will assist the County whenever possible when the conduct of the election requires assistance from Participating Entity departments and staff. The City Secretary will serve as the Regular Early Voting Clerk for the Participating Entity to receive requests for applications for early voting ballots and forward these applications to the Joint Early Voting Clerk. The City Secretary will serve as the Custodian of Records for the Participating Entity to complete those tasks in the Texas Election Code that the Election Officer will not perform.

SECTION 4. ELECTION WORKERS AND POLLING PLACES

(A) For presentation to the governing body of the Participating Entity, the County shall provide a list containing the locations, times, and dates of early voting polling places suitable for consideration and adoption by the governing body in accordance with Texas Election Code Chapter 85. The Election Officer will designate and confirm all Election Day polling place locations.

(B) The Election Officer will assume the responsibility for recruiting election personnel; however, if by the 5th day before the Election, the Election Officer reports vacancies in positions for election judges, alternate judges, election day clerks, early voting ballot board, receiving substation clerks, or any other key election personnel, the Participating Entity shall provide emergency personnel in these positions.

(C) The Election Officer shall notify each of the election judges and alternates of their appointment and the eligibility requirements that pertain to them and to the selection of Election Day clerks. Included in this notification will be the number of clerks that each precinct should have in addition to the election judge and alternate judge. The election judges and/or the alternates are responsible for recruiting and supervising their clerks.

(D) All election workers must agree to attend training sessions as determined by the Election Officer. Costs for these training sessions and compensation for attendees will be included as part of the election services costs.

(E) During any election and any subsequent runoff election that involve entities in addition to the Participating Entity, the Election Officer will work with all parties to find a plan that can be agreed upon regarding the designation of polling places. If agreement cannot be reached, the Election Officer will resolve the differences. **In all cases, the Election Officer has sole discretion to determine whether polling place changes are necessary**.

SECTION 5. PAYMENTS FOR ELECTION SERVICES

(A) Costs and payments for the use of voting equipment are addressed separately in Section 6 of this Agreement.

(B) Requests for Election Services. For each election the Participating Entity desires the Election Officer to conduct, the Participating Entity must submit a written request to the Election Officer that describes the general nature of the election and specifies the date of the election.

(C) Cancellations. On or before 11:59 p.m. on the 68th day before an election for which the Participating Entity has requested election services, the Participating Entity shall notify the Election Officer as to whether the Participating Entity anticipates the cancellation of its election, and on or before 11:59 p.m. on the 60th day before the election the Participating Entity shall notify the Election Officer as to whether the Participating Entity will cancel that election. If the Election Officer receives written notice from the Participating Entity on or before 11:59 p.m. of the 60th day before an election that the Participating Entity's election will be cancelled in accordance with Subchapters C and D of Texas Election Code Chapter 2, the Contracting Officer shall only be entitled to receive the actual expenses incurred before the date of cancellation in connection with the election and an administrative fee of $100.

(D) Notice, Cost Estimate, Initial Invoicing, and Initial Payment.

(1) Notwithstanding the provisions in Section 9(B), the County and the Participating Entity agree that notice under Section 5 can be provided via e-mail. The following e-mail address will be used for e-mail communications to or from the County pursuant to Section 5: elections@traviscountytx.gov, with a copy to ElectionEntities@traviscountytx.gov. The Participating Entity has designated the City Secretary as the Participating Entity's representative for sending and receiving e-mail communications under Section 5, and the Participating Entity designates the following e-mail address as the Participating Entity's email address for sending and receiving e-mail communications pursuant to Section 5: lalmaraz@manortx.gov.

(2) Initial Cost Estimate. On or before the 60th day before an election for which the Participating Entity has requested election services, the Election Officer will mail and/or email to the Participating Entity a cost estimate for conducting the election. The cost estimate will include an administrative fee that is equal to 10% of the total estimated cost of conducting the Participating Entity's election, excluding the costs of voting equipment. In the event of a joint election, the cost estimate will reflect that election costs will be divided on a pro rata basis among all entities involved in the election in the manner set forth in this Section 5. The proportional cost for the Election Officer to conduct each participating entity's election will be calculated by dividing the number of registered voters in the territorial jurisdiction of each participating

entity by the total number of registered voters for all of the participating entities involved in the joint election and multiplying that quotient by the total cost of the election. The product of these numbers is the pro rata cost share for each participating entity. The Participating Entity acknowledges and understands that if any other participating entity listed in the cost estimate cancels its election, each remaining participating entity's pro rata cost (including the Participating Entity's pro rata cost share) will result in a proportionate cost increase.

(3) Initial Invoice and Initial Payment. Along with the initial cost estimate, the Election Officer will also include an initial invoice for the Participating Entity to pay 60% of the initial cost estimate. The Participating Entity must pay the County the amount specified in each invoice no later than 30 days after the Participating Entity's receipt of the invoice.

(4) Runoff Elections. For each runoff election the Participating Entity has requested that the Election Officer conduct, the Participating Entity must make a payment equal to 60% of the projected costs for the runoff election no later than three business days after receiving that cost estimate from the Election Officer. The projected share of election costs will include an administrative fee that is equal to 10% of the total estimated cost of conducting the Participating Entity's runoff election, excluding the costs of voting equipment.

(5) Each party may change its respective email addresses for e-mail communications under this Section 5, without the need to amend this Agreement, by sending notice to the other party in accordance with Section 9(B).

(F) Final Accounting and Final Invoice. The County will send the Participating Entity a final invoice of election expenses not later than 90 days after an election unless the Election Officer notifies the Participating Entity during that 90-day period following the election that the Election Officer requires additional time to send a final invoice to the Participating Entity. The final invoice will include a listing of additional costs incurred at the Participating Entity's behalf and specify the total payment due from the Participating Entity for any unpaid portion of the Participating Entity's costs.

(1) Within 30 days after receipt of an election cost invoice setting forth the Election Officer's actual contract expenses and charges incurred in the conduct of the election, the Participating Entity shall pay the Election Officer the balance due on each final invoice no later than 30 days after the Participating Entity's receipt of that invoice.

(2) A refund may be due from the County to the Participating Entity if the final costs are lower than the amount already paid by the Participating Entity or if,

at the end of the calendar year, the County Auditor's Office makes adjustments to the election workers' payroll and the amount already paid by the Participating Entity for election worker payroll costs exceeds the payroll amounts calculated by the County Auditor's Office.

(G) The Participating Entity shall promptly review an election invoice and any supporting documentation when received from the County. The Participating Entity may audit, during the County's normal business hours, relevant County election or accounting records upon reasonable notice to the County. The Participating Entity shall pay the entire final invoice or the undisputed portion of the final invoice not later than the 30th day after receiving the invoice. Failure by the Participating Entity to timely pay an invoice in full may impact the Election Officer's participation in future elections with the Participating Entity.

SECTION 6. PAYMENTS FOR USE OF VOTING EQUIPMENT

(A) The Election Officer shall conduct elections using a voting system certified by the Secretary of State in accordance with the Texas Election Code and that has been approved for use by the Travis County Commissioners Court unless otherwise agreed upon by the Participating Entity, the Travis County Clerk, and the Travis County Commissioners Court.

(B) The Participating Entity shall make payments to Travis County as consideration for the use of the County's voting equipment.

(1) For each election the Election Officer conducts for the Participating Entity after January 1, 2024, through January 1, 2025, the Participating Entity shall pay (a) the sum of four percent of the cost of the electronic voting system equipment installed at a polling place and four percent for each unit of other electronic equipment used by the Travis County Clerk's Office to conduct the election or provide election services, if the sum is greater than $100.00, and (b) $100.00 if the sum described in (a) is $100.00 or less.

(2) In this Agreement "other electronic equipment" includes ballot marking devices, ballot scanners, ballot printers, ballot tabulators, electronic pollbooks, and ballot programming software.

(C) Payment by the Participating Entity to the County for voting equipment is due no later than 30 days after the Participating Entity's receipt of an invoice from the County.

(D) If the County acquires additional equipment, different voting equipment, or upgrades to existing equipment during the term of this Agreement, the charge for the use of the equipment may be renegotiated.

SECTION 7. ADDITIONAL EARLY VOTING LOCATIONS

(A) All of the Participating Entity's voters within Travis County will have access to all of the Travis County Early Voting sites in each election at no additional cost.

(B) If the Participating Entity desires to have one or more early voting sites that are in addition to those sites the Election Officer has already selected for a specific election, the Participating Entity must submit the request to the Election Officer no later than 60 days before the election, and the Election Officer will thereafter provide a written estimate to the Participating Entity that sets forth the estimated cost for providing the additional early voting location(s) and the deadline by which the cost estimate must be paid. If, after receiving the cost estimate, the Participating Entity desires to move forward with having the additional early voting location(s), the Participating Entity will notify the Election Officer and include payment of the cost estimate with the Participating Entity's notice to the Election Officer no later than the deadline specified in the Election Officer's cost estimate. *Pursuant to Texas Election Code Section 85.064(b) and notwithstanding any provision to the contrary, the Election Officer has sole discretion to determine whether to provide any additional early voting sites requested by the Participating Entity*.

SECTION 8. COMMUNICATIONS

(A) The Participating Entity and the Election Officer shall each designate a member of their staff to serve as the primary contact for the respective offices under this Agreement and provide the name and contact information for that individual to the other party. Each party may change their designated staff members by sending notice to the other party without the further need to amend this Agreement.

(B) Throughout the term of this Agreement, the Participating Entity and the County will engage in ongoing communications on issues related to Participating Entity elections, the use of County's voting equipment, and the delivery of services under this Agreement and, when necessary, the County Clerk, Elections Division staff members, and other election workers shall meet with the Participating Entity to discuss and resolve any problems which might arise under this Agreement.

(C) The Election Officer shall be the main point of media contact for election information related to election administration. The Participating Entity shall designate a contact to be the main point of contact for matters related to the content of the Participating Entity's ballot or candidates.

SECTION 9. MISCELLANEOUS PROVISIONS

(A) Amendment/Modification

Except as otherwise provided, this Agreement may not be amended, modified, or changed in any respect whatsoever, except by a further Agreement in writing and

duly executed by the parties hereto. No official, representative, agent, or employee of the County has any authority to modify this Agreement except pursuant to such expressed authorization as may be granted by the Commissioners Court of Travis County, Texas. No official, representative, agent, or employee of the Participating Entity has any authority to modify this Agreement except pursuant to such expressed authorization as may be granted by the governing body of the Participating Entity. Dyana Limon-Mercado, Travis County Clerk (or her successor), may propose necessary amendments or modifications to this Agreement in writing in order to conduct a joint election smoothly and efficiently, except that any such proposals must be approved by the Commissioners Court of the County and the governing body of the Participating Entity.

(B) Notice

Unless otherwise provided herein, any notice to be given hereunder by any party to the other shall be in writing and may be affected by personal delivery, by certified mail, or by common carrier. Notice to a party shall be addressed as follows:

City of Manor
Scott Moore, City Manager
105 E. Eggleston St.
Manor, TX 78653

TRAVIS COUNTY
Honorable Dyana Limon-Mercado, Travis County Clerk (or her successor)
1000 Guadalupe Street, Room 222
Austin, Texas 78701

Cc: Honorable Delia Garza, Travis County Attorney (or her successor)
314 West 11th Street, 5th Floor
Austin, Texas 78701

Notice by hand-delivery is deemed effective immediately, notice by certified mail is deemed effective three days after deposit with a U.S. Postal Office or in a U.S. Mail Box, and notice by a common carrier, is deemed effective upon receipt. Each party may change the address for notice to it by giving notice of such change in accordance with the provisions of this Section. When notices by e-mail are permitted by this Agreement, (1) the notice is deemed effective upon the day it is sent if the e-mail is received before 5:00 p.m. on a business day; (2) the notice is deemed effective on the first business day after the e-mail was received if the email was received after 5:00 p.m. on a business day or anytime on a Saturday or Sunday. In this Agreement, “business day” means any weekday that is not a holiday designated by the Travis County Commissioners Court.

(C) Force Majeure

In the event that the performance by the County of any of its obligations or undertakings hereunder shall be interrupted or delayed by any occurrence not occasioned by its own conduct, whether such occurrence be an act of God or the result of war, riot, civil commotion, sovereign conduct, or the act or condition of any persons not a party hereto or in privity thereof, then it shall be excused from such performance for such period of time as is reasonably necessary after such occurrence to remedy the effects thereof.

(D) Venue and Choice of Law

The Participating Entity agrees that venue for any dispute arising under this Agreement will lie in the appropriate courts of Austin, Travis County, Texas. This Agreement shall be governed by and construed in accordance with the laws of the State of Texas and the United States of America.

(E) Entire Agreement

This Agreement contains the entire agreement of the parties relating to the rights herein granted and the obligations herein assumed and also supersedes all prior agreements, including prior election services contracts and prior agreements to conduct joint elections. Any prior agreements, promises, negotiations, or representations not expressly contained in this Agreement are of no force or effect. Any oral representations or modifications concerning this Agreement shall be of no force or effect, excepting a subsequent modification in writing as provided herein.

(F) Severability

If any provision of this Agreement is found to be invalid, illegal or unenforceable by a court of competent jurisdiction, such invalidity, illegality or unenforceability shall not affect the remaining provisions of this Agreement. Parties to this Agreement shall perform their obligations under this Agreement in accordance with the intent of the parties to this Agreement as expressed in the terms and provisions of this Agreement.

(G) Breach

In the event that Participating Entity or County breaches any of its obligations under this Agreement, the non-breaching party shall be entitled to pursue any and all rights and remedies allowed by law.

(H) Payments from Current Revenues

Payments made by the Participating Entity in meeting its obligations under this Agreement shall be made from current revenue funds available to the governing body of the Participating Entity. Payments made by the County in meeting its

obligations under this Agreement shall be made from current budget or revenue available to the County.

(I) Other Instruments

The County and the Participating Entity agree that they will execute other and further instruments, or any documents as may become necessary or convenient to effectuate and carry out the purposes of this Agreement.

(J) Third Party Beneficiaries

Except as otherwise provided herein, nothing in this Agreement, expressed or implied, is intended to confer upon any person, other than the parties hereto, any benefits, rights or remedies under or by reason of this Agreement.

(K) Joint Election Agreements

The County and the Participating Entity expressly understand and acknowledge that each may enter into other joint election agreements with other jurisdictions, to be held on Election Day and at common polling places covered by this Agreement. When mediation is acceptable to both parties in resolving a dispute arising under this Agreement, the parties agree to use a mutually agreed upon mediator, or a person appointed by a court of competent jurisdiction, for mediation as described in Section 154.023 of the Texas Civil Practice and Remedies Code. Unless both parties are satisfied with the result of the mediation, the mediation will not constitute a final and binding resolution of the dispute. All communications within the scope of the mediation shall remain confidential as described in Section 154.053 of the Texas Civil Practice and Remedies Code unless both parties agree, in writing, to waive the confidentiality. Notwithstanding the foregoing, the parties intend to fully comply with the Texas Open Meetings Act and the Texas Public Information Act whenever applicable. The term “confidential” as used in this Agreement has the same meaning as defined and construed under the Texas Public Information Act and the Texas Open Meetings Act.

(L) Addresses for Payments

Payments made to the County, or the Participating Entity under this Agreement shall be addressed to following respective addresses:

Travis County Clerk – Elections Division
P.O. Box 149325
Austin, Texas 78714
City of Manor
Scott Moore, City Manager
105 E. Eggleston St.
Manor, TX 78653

(M) This Agreement is effective upon execution by both parties and remains in effect until either party terminates this agreement for any reason upon providing 60 days written notice to the other party.

(N) All times referenced in this Agreement are to Central Time, and in all instances, the time-stamp clock used by the Travis County Clerk's Office at 5501 Airport Boulevard in Austin, Texas is the official clock for determining the correct time.

(O) The individuals below have been authorized to sign this Agreement.

IN TESTIMONY WHEREOF, the parties hereto have executed this Agreement in multiple copies, each of equal dignity, and this Agreement takes effect on the date it is fully executed by the Participation Entity, the Travis County Judge (on behalf of the Travis County Commissioners Court), and the Travis County Clerk.

[Signatures on following page]

CITY OF MANOR

BY: _____
Dr. Chrisotpher Harvey,
Mayor

DATE: _____

TRAVIS COUNTY

BY: _____
Dyana Limon-Mercado (or her successor)
County Clerk

DATE: _____

AGENDA ITEM NO. _____

AGENDA ITEM SUMMARY FORM

PROPOSED MEETING DATE: August 7, 2024
PREPARED BY: Tracey Vasquez, Director
DEPARTMENT: Human Resources

AGENDA ITEM DESCRIPTION:

Consideration, discussion, and possible action on the insurance policies for dental, life, vision, and short-term disability for FY 2024-2025 between the City of Manor and Renaissance Life and Health Insurance Company of America.

BACKGROUND/SUMMARY:

On July 3, 2024, the City Council approved the selection of Renaissance Life and Health Insurance Company of America as the dental, vision, disability, and life insurance benefits provider and directed staff to negotiate the terms with the insurance provider. The city will need to apply for the policies as part of the process for Renaissance to issue them. The attached policies are provided for the City Council's consideration.

LEGAL REVIEW: Yes, Veronica Rivera, Assistant City Attorney
FISCAL IMPACT:
PRESENTATION: No
ATTACHMENTS: Yes

- Policies for dental, life, vision, and short-term disability

STAFF RECOMMENDATION:

Staff recommends that the City Council approve the insurance policies for dental, life, vision, and short-term disability for FY 2024-2025 between the City of Manor and Renaissance Life and Health Insurance Company of America and authorize the City Manager to execute the application, policies and other documents needed by Renaissance to provide the dental, life, vision and short-term disability insurance benefits.

CITY COUNCIL: **Recommend Approval** **Disapproval** **None**

Renaissance℠
Life & Health Insurance Company of America

Renaissance Texas Group Dental Certificate

P.O. Box 1596 • Indianapolis, IN. 46206-1596 • 888-358-9484 • www.RenaissanceDental.com

RENAISSANCE
TEXAS GROUP DENTAL CERTIFICATE

Table of Contents

Summary of Dental Plan Benefits....1

I. Renaissance Group Dental Certificate....3

II. Definitions....3

III. General Eligibility Rules....5

IV. Benefits....6

V. Exclusions and Limitations....9

VI. Accessing Your Benefits....10

VII. Questions and Answers....12

VIII. Coordination of Benefits....12

IX. Disputed Claims Procedure....15

X. Termination of Coverage....16

XI. Continuation of Coverage....16

XII. General Conditions....17

Important Cancellation Information – Please Read Section X Entitled, "Termination of Coverage"

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company. Title II NCAC 12.0843 and Section 17.E.

NOTE: This Group Dental Certificate should be read in conjunction with the Summary of Dental Plan Benefits that is provided with the Certificate. The Summary of Dental Plan Benefits lists the specific provisions of your group dental plan. Your group dental plan is a legal contract between the Policyholder and Renaissance Life & Health Insurance Company of America ("RLHICA").

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

READ YOUR GROUP DENTAL CERTIFICATE CAREFULLY

Renaissance Life & Health Insurance Company of America
Renaissance Group Dental Certificate
Summary of Dental Plan Benefits
For Group# 000000
ABC Company

This Summary of Dental Plan Benefits is part of, and should be read in conjunction with your Group Dental Certificate. Your Group Dental Certificate will provide you with additional information about your RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA ("RLHICA") coverage, including information about exclusions and limitations.

Benefit Year – January 1 through December 31

Covered Services	**Contracting Dentist**		**Non-Contracting Dentist**		**Waiting Period**
	RLHICA Pays	**You Pay**	**RLHICA Pays**	**You Pay**	
Diagnostic and Preventive Services					
Diagnostic and Preventive Services - Used to evaluate existing conditions and/or to prevent dental abnormalities or disease (includes exams, cleanings, bitewing X-rays and fluoride treatments)	100%	0%	100%	0%	None
Brush Biopsy – Used to detect oral cancer	100%	0%	100%	0%	None
Basic Services					
Emergency Palliative Treatment - Used to temporarily relieve pain	80%	20%	80%	20%	None
Radiographs/Diagnostic Imaging/Diagnostic Casts - X-rays as required for routine care or as necessary for the diagnosis of a specific condition	100%	0%	100%	0%	None
Minor Restorative Services – Used to repair teeth damaged by disease or injury (for example, silver fillings and white fillings)	80%	20%	80%	20%	None
Simple Extractions – Simple extractions including local anesthesia, suturing, if needed, and routine post-operative care	80%	20%	80%	20%	None
Sealants – Sealants for the occlusal (biting) surface of unrestored permanent molars	100%	0%	100%	0%	None
Periodontal Maintenance – Periodontal maintenance following active periodontal therapy	80%	20%	80%	20%	None
Other Basic Services – Services performed by a Dentist during after-hours visits	80%	20%	80%	20%	None
Major Services					
Oral Surgery Services – Extractions and dental surgery, including local anesthesia, suturing, if needed, and routine post-operative	80%	20%	80%	20%	None
Endodontic Services – Used to treat teeth with diseased or damaged nerves (for example, root canals)	80%	20%	80%	20%	None
Periodontics Services – Used to treat diseases of the gums and supporting structures of the teeth	80%	20%	80%	20%	None
Major Restorative Services – Used when teeth can't be restored with another filling material (for example, crowns)	50%	50%	50%	50%	None
Prosthodontic Services – Used to replace missing natural teeth (for example, bridges, endosteal implants, partial dentures and complete dentures)	50%	50%	50%	50%	None
Relines and Repairs – Relines and repairs to fixed bridges, removable bridges, partial dentures, and complete dentures	50%	50%	50%	50%	None
Other Major Services – Occlusal guards, and limited occlusal adjustments	50%	50%	50%	50%	None

Orthodontic Services					
Orthodontic Services –Services, treatments, and procedures to correct malposed teeth (for example, braces) including Orthodontic Services for Children to the age of 19	50%	50%	50%	50%	None

Maximum Payment – $1,000 per person per Benefit Year on Diagnostic & Preventive, Basic and Major Services collectively.

$1,000 per person per lifetime for Orthodontic Services.

Deductible - $50 per person, per Benefit Year, limited to a maximum Deductible of $150 per family per Benefit Year. The Deductible does not apply to Diagnostic and Preventive, including Radiographs and Sealants.

Waiting Period – You (and your Eligible Dependents, if covered) will be eligible for coverage on the first of the month following 60 days after the date for which employment compensation begins.

Method of Payment – For services rendered or items provided by an In-Network Dentist, the Allowed Amount is a pre-negotiated fee that the provider has agreed to accept as payment in full. For services rendered or items provided by an Out-of-Network Dentist, RLHICA determines the Allowed Amount using statistically valid claims data submitted to RLHICA and its affiliates which show the most frequently charged fees by providers in the same geographic areas for comparable services or supplies. The claims data and fees are updated periodically using the most current codes and nomenclature developed and maintained by the American Dental Association. RLHICA will base Benefits on the lesser of the Submitted Amount and the Allowed Amount. If the Submitted Amount for an Out-of-Network Dentist is more than the Allowed Amount, you are not only responsible for paying the Dentist that percentage listed in the "You Pay" column, but are also responsible for paying the Dentist the difference between the Submitted Amount and the Allowed Amount.

Out of Country Services – Having Renaissance coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of Dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our website or contact your benefits representative to get a copy of our Passport Dental information sheet.

Eligibility (You or Your Eligible Dependents) – All full-time employees of the Policyholder working at least 32 hours per week, retirees, members of an association or trust, and all individuals who are eligible for and elect Continuation Coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 or similar applicable state law ("COBRA").

Also eligible are your Legal Spouse or Domestic Partner, and any individuals who meet the definition of Child(ren) as set forth in your Group Dental Certificate.

A Domestic Partner is defined as follows:

- each party is the sole Domestic Partner of the other;
- each party is at least 18 years of age or older and competent to enter into a contract in the state in which they reside;
- both parties currently share a common legal residence and have shared said residence for at least six months prior to application for Domestic Partner coverage;
- neither party is married to anyone or related to the other by adoption or blood to a degree of closeness that would otherwise bar marriage in the state in which they legally reside;
- both parties are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship in the indefinite future;
- both parties are jointly responsible for basic living expenses (basic living expenses are defined as the cost of basic food, shelter, and any other expenses of the common household-the partners need not contribute equally or jointly to the payment of these expenses as long as they agree that both are responsible for them); and
- neither party filed a Termination of Domestic Partnership within the preceding nine months.

Where two individuals are eligible under the same group and are legally married to each other, they will be enrolled under one application and will receive Benefits under a single Certificate without coordination of benefits under the Policy.

You pay the full cost of this coverage.

Benefits will cease on the last day of the month in which your employment is terminated, subject to all applicable laws or regulations.

PLEASE NOTE: RLHICA recommends Predetermination before any services are rendered where the total charges will exceed $200. You and your Dentist should review your Predetermination Notice before your Dentist proceeds with treatment.

I. Renaissance Group Dental Certificate

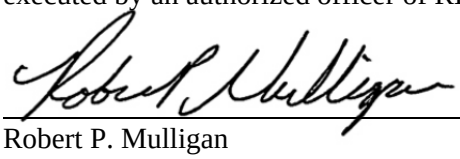
RLHICA issues this Renaissance Group Dental Certificate to you, the Certificate Holder. The Certificate is a summary of your dental benefits coverage. It reflects and is subject to the agreement between RLHICA and your employer or organization (the "Policyholder").

The Benefits provided under This Plan may change if any state or federal laws change.

RLHICA agrees to provide Benefits as described in this Certificate.

All the provisions in the following pages, read in conjunction with the Summary of Dental Plan Benefits and all attachments and addendums, form a part of this document as fully as if they were stated over the signature below.

IN WITNESS WHEREOF, this Certificate is executed by an authorized officer of RLHICA.



Robert P. Mulligan
President and CEO

Home Office:

RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA

Attn: Renaissance Administration
P.O. Box 30381
Lansing, Michigan 48909-7881

Administrative Direct Line: 1-800-745-7509
Customer Service Direct Line: 1-888-358-9484

II. Definitions

Adverse Benefit Determination

Means any denial, reduction or termination of the Benefits for which you filed a claim or a failure to provide or to make payment (in whole or in part) of the Benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which Benefits are otherwise provided was experimental or investigational, or was not medically necessary or appropriate.

Allowed Amount

Means the maximum dollar amount upon which RLHICA will base Benefits. RLHICA determines the Allowed Amount using statistically valid claims data submitted to RLHICA and its affiliates which show the most frequently charged fees by providers in the same geographic areas for comparable services or supplies. The claims data and fees are updated periodically using the most current codes and nomenclature developed and maintained by the American Dental Association. (This definition is only applicable if the Allowed Amount method for Benefits is shown in the Summary of Dental Plan Benefits Section).

Benefit Year

Means the calendar year, unless your employer or organization elects the Policy Year to serve as the Benefit Year. The Benefit Year is specified in the Summary of Dental Plan Benefits Section.

Benefits

Means payment for Covered Services.

Certificate

Means this document. RLHICA will provide dental Benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the Policy. Changes to the Certificate will be in the Summary of Dental Plan Benefits Section.

Certificate Holder

Means you, when your employer or organization certifies to RLHICA that you are eligible to receive Benefits under This Plan.

Child(ren)

Means your natural children, stepchildren, adopted children, foster children or children by virtue of legal guardianship during the waiting period for legal adoption or guardianship who are or meet one of the following:

- Your child(ren) who has not yet reached his or her 26th birthday; or,
- Your child(ren) who: (a) is under the age of 26; (b) is a resident of the same state as the youorand is a full-time student; (c) is dependent upon you or your Legal Spouse for support; and (d) does not have coverage, other than coverage as a dependent, under another dental insurance Plan; or,
- Your child(ren) or the child(ren) of your Legal Spouse if, pursuant to a court decree or medical support order issued under Chapter 154 of the Texas Family Code (or enforceable by a court in the state of Texas) you or your Legal Spouse is financially responsible for the dental care of the child; or
- Your unmarried grandchild(ren) or the unmarried grandchild(ren) of your Legal Spouse who are: (a) younger than 26 years of age; (b) Your or your Legal Spouse's dependent for federal income tax purposes at the time of application for coverage under this Certificate; or
- Your child(ren) who has reached the end of the calendar year of his or her 26th birthday and is both (a) incapable of self-sustaining employment by reason of a mental or physical condition and (b) chiefly dependent upon you for support and maintenance. In the event that RLHICA denies a claim for the reason that the child has attained the Limiting Age for dependent children, you have the burden of establishing that the child continues to meet the two criteria specified above. If requested by RLHICA, you must submit medical reports confirming that the child meets the two criteria specified above. Such requests will not be made more frequently than annually after the second anniversary of the date the child attains the Limiting Age.

Coinsurance

Means the percentage of the Allowed Amount for Covered Services that you will have to pay toward treatment.

Completion Dates

Means the date that treatment is complete. Treatment is complete:

- for dentures and partial dentures, on the delivery date;
- for crowns and bridgework, on the permanent cementation date;

for root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Copayment

Means the dollar amount you must pay toward treatment.

Covered Services

Means the unique dental services selected for coverage by your employer or organization under This Plan. The Summary of Dental Plan Benefits Section lists your Covered Services.

Deductible

Means the amount an individual and/or a family must pay toward Covered Services before RLHICA begins paying for those services. The Summary of Dental Plan Benefits Section lists the Deductible that applies to you, if any.

Dentist

Means a person licensed to practice dentistry in the state or jurisdiction in which dental services are rendered.

Eligible Dependent

Means (a) your Legal Spouse; (b) your Child(ren); and (c) any other dependents who meet the criteria for eligibility set forth in the Summary of Dental Plan Benefits Section. If dependent coverage has been selected, it will be indicated in the Summary of Dental Plan Benefits Section.

Legal Spouse

Means a person who is any of the following: (a) your spouse through a marriage legally recognized by the State in which the Policy was issued; (b) your partner through a civil union legally recognized by the State in which the Policy was issued .; or (c) your Domestic Partner so long as the requirements listed in the Summary of Dental Plan Benefits Section are met and proof that those requirements are met is provided to RLHICA at its request..

Limiting Age

Means the age at which a Child of yours is no longer eligible for Benefits under This Plan pursuant to the definition of Child above.

Maximum Payment

Means the maximum dollar amount RLHICA will pay in any Benefit Year or lifetime for Covered Services. (See the Summary of Dental Plan Benefits Section.)

Open Enrollment Period

Means the period of time during which an eligible person as indicated in the Summary of Dental Plan Benefits Section may enroll or be enrolled to receive Benefits.

Policy

Means the insurance contract for the provision of Benefits to you and your Eligible Dependents between RLHICA and your employer or organization.

Policy Year

Means the 12 month period beginning on the first Effective Date of the Policy and each 12 month renewal period thereafter.

Predetermination

Means a voluntary and optional process where, at the request of you, your Eligible Dependent or Dentist, RLHICA issues a written estimate of dental benefits which may be available for a proposed dental service under the terms of your coverage.

Predetermination is provided for informational purposes only and is not required in advance of obtaining dental care or as a prerequisite or condition for approval of future dental benefits payment. The benefits estimate provided on a Predetermination notice is determined based on the benefits available for you or your Eligible Dependent on the date the notice is issued, and is not a guarantee of future dental benefits payment.

Availability of dental benefits at the time a dental service is completed depends on factors such as, but not limited to, eligibility for Benefits, annual or lifetime Maximum Payments, coordination of benefits, Policy and Dentist status, Policy limitations and other provisions. A request for a Predetermination is not a claim for Benefits or a preauthorization, precertification or other reservation of future Benefits.

RLHICA

Means Renaissance Life & Health Insurance Company of America.

Submitted Amount

Means the fee a Dentist bills to RLHICA for a specific service or item.

Summary of Dental Plan Benefits

Means a list of the specific provisions of This Plan and is a part of this Certificate.

Table of Allowances

Means the maximum amount allowed per procedure as determined by your employer or organization and RLHICA. (If the Table of Allowances method for Benefits has been selected by your employer or organization, it will be reflected in the Summary of Dental Plan Benefits Section).

This Plan

Means the dental coverage as provided for you and your Eligible Dependents pursuant to this Certificate.

III. General Eligibility Rules

A. You are not eligible for Benefits unless you are either currently enrolled in This Plan or currently listed as an Eligible Dependent.

B. Effective Date of Eligibility

1. **Initial Effective Date**: All Certificate Holders and Eligible Dependents on the Effective Date of the Policy are immediately eligible for Benefits.
2. **After the initial Effective Date:** For all Certificate Holders (and their Eligible Dependents) not associated with the employer or organization on the initial Effective Date of the Policy, eligibility for Benefits will begin, unless otherwise stated as follows:
   a. Newly hired or rehired employees: Date for which employment compensation begins. Or, if applicable, that date plus the number of days specified as a waiting period in the Summary of Dental Plan Benefits Section;
   b. Spouse: Date of marriage, civil union or domestic partnership;
   c. Newborn: Child's actual date of birth;

d. Foster children, legal adoptions or guardianships: Date the Child is placed in the foster home or with the Certificate Holder; at which time this Child will be covered on the same basis as a natural child;

e. Stepchild: Date that the Child's natural parent becomes an Eligible Dependent;

f. All others: Date that RLHICA approves in writing the enrollment or listing of those people, unless compelled by a court or administrative order to otherwise provide Benefits for a Child or Eligible Dependent.

Once eligible, you and your Eligible Dependents must enroll for coverage within 30 days from the date upon which you or your Eligible Dependents become eligible for Benefits under the terms of Section III B immediately above. You and your Eligible Dependents may properly enroll for coverage by completing all enrollment forms required by RLHICA and submitting such forms to your employer or organization. If you and your Eligible Dependents are not properly enrolled for coverage within 30 days from the date upon which you and your Eligible Dependents become eligible for Benefits, then you and/or your Eligible Dependents must wait until the next Open Enrollment Period to enroll.

C. Termination of Eligibility

Eligibility for Benefits will terminate for you and your Eligible Dependents under This Plan at the earlier of:

1. The termination of the Policy; or

2. The last day of the month for which payment has been made if the employer or organization fails to make the payments required by their Policy.

Your eligibility, and that of your Eligible Dependents, will also terminate if you cease to be a Certificate Holder as defined in the Summary of Dental Plan Benefits Section. An Eligible Dependent's eligibility also terminates upon lack of compliance with the eligibility requirements of the Policy.

D. Conversion to an Individual Policy

A person whose eligibility is terminated or who loses coverage may be eligible to elect coverage under an individual conversion policy with RLHICA. Any request to obtain a conversion will be honored in accordance with applicable state law. Please contact RLHICA to obtain further information.

IV. Benefits

COVERED SERVICES

RLHICA agrees to provide Benefits to you and your Eligible Dependents under the policies and procedures of RLHICA and under the terms and conditions of This Plan, including, but not limited to, the categories of services, exclusions and limitations listed below.

Unless otherwise specified in the Summary of Dental Plan Benefits Section, Covered Services may be divided into the following categories and are subject to the exclusions and limitations listed below. **Please see the Summary of Dental Plan Benefits Section for the Benefits, exclusions and limitations applicable under This Plan.**

A detailed list of the Benefits provided under This Plan is available upon request. All time limitations are measured either from the last date of service in any RLHICA plan or, at the request of your employer or organization, from the last date of service in any dental Plan.

DIAGNOSTIC AND PREVENTIVE SERVICES

Services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease. These services include oral evaluations (examinations), prophylaxes (cleanings), bitewing X-rays and fluoride treatments. These services are subject to the following exclusions and limitations:

(i) Topical fluoride treatments are payable twice in any Benefit Year for Children under age 19;

(ii) Oral examinations submitted as a consultation or evaluation are payable twice in any Benefit Year, whether provided under one or more RLHICA Plans;

(iii) Prophylaxes, including periodontal maintenance procedures, are payable twice in any Benefit Year;

(iv) Bitewing X-rays are payable once in any Benefit Year;

(v) Space maintenance services are payable once per lifetime, per area on posterior teeth, for Children under age 14;

(vi) RLHICA will not make payment for preventive control programs, including home care items, oral hygiene instructions, nutritional counseling and

tobacco counseling and all charges for the same will be your responsibility;

(vii) RLHICA will not make payment for tests and laboratory examinations (including, but not limited to cytology, bacteriology or pathology) and caries susceptibility tests and all charges for the same will be your responsibility, unless otherwise indicated in the Summary of Dental Plan Benefits Section or in this Certificate.

Brush Biopsy

Oral brush biopsy procedure and laboratory analysis used to detect oral cancer, an important tool that identifies and analyzes precancerous and cancerous cells.

BASIC SERVICES

Emergency Palliative Treatment

Emergency treatment to temporarily relieve pain is not a Covered Service when done in conjunction with any services except X-rays, tests or examinations.

Radiographs (X-rays)/Diagnostic Imaging/Diagnostic Casts

X-rays as required for routine care or as necessary for the diagnosis of a specific condition, subject to the following exclusions and limitations:

(i) Full mouth X-rays (which include bitewing X-rays) or a panoramic X-ray (with or without bitewing X-rays) are payable once in any 5 year period;

(ii) A serial listing of X-rays is paid as a full mouth series if the total fee equals or exceeds the fee for a complete series;

(iii) Any supplemental films with a full mouth series are part of the complete procedure;

(iv) Cephalometric films, oral/facial images or diagnostic casts are not payable except in conjunction with Orthodontic Services and all charges for the same will be your responsibility;

(v) Posterior-anterior or lateral skull and facial bone survey, sialography, temporomandibular joint films (including arthrograms) or tomographic films are not payable and all charges for the same will be your responsibility.

Minor Restorative Services

Minor restorative services to rebuild and repair natural tooth structure when damaged by disease or injury. These services include amalgam (silver) and composite resin (white) restorations (fillings), subj the following exclusions and limitations:

(i) Amalgam and composite resin restorations are payable once per tooth surface within a 24 month period regardless of the number or combination of restorations placed on a surface;

(ii) RLHICA will not make payment for dentistry for aesthetic reasons and all charges for the same will be your responsibility.

Simple Extractions

Simple extractions including local anesthesia, suturing, if needed, and routine post-operative care.

Sealants

Sealants are payable only for the occlusal surface of first permanent molars for Children under age 16 and second permanent molars for Children under age 16. The surface must be free from decay and restorations. Sealants are a Benefit payable once in any 3 year period.

Periodontal Maintenance Following Therapy

Periodontal maintenance following active periodontal therapy procedures to treat diseases of the gums and supportive structures of the teeth, along with benefits for prophylaxes, including periodontal maintenance procedures, are payable twice in any Benefit Year.

Other Basic Services

After hours visits, not to exceed once per Benefit Year.

MAJOR SERVICES

Oral Surgery Services

Surgical extractions and dental surgery, including local anesthesia, suturing, if needed, and routine postoperative care are subject to the following exclusions and limitations:

(i) RLHICA will not make payment for the following services and items and all charges for the same will be your responsibility unless otherwise specified in the Summary of Dental Plan Benefits Section: appliances, restorations, X-rays or other services for the diagnosis or treatment of temporomandibular disorders ("TMD") including myofunctional therapy;

(ii) RLHICA will not make payment for the following services and items and all charges for the same will be your responsibility: charges related to hospitalization or general anesthesia and/or intravenous sedation for restorative dentistry or surgical procedure unless a specified need is shown.

Endodontic Services

The treatment of teeth with diseased or damaged nerves (for example, root canals) is subject to the following exclusions and limitations:

(i) Endodontic therapy, endodontic retreatment, and apicoectomy/periradicular services are payable once per tooth in any 24 month period;

(ii) Root canal fillings on primary teeth are limited to primary teeth without succedaneous (replacement) teeth;

(iii) RLHICA will not make payment for pulp caps and all charges for the same will be your responsibility.

Maxillofacial Prosthetics

RLHICA will not make payment for maxillofacial prosthetics and all charges for the same will be your responsibility.

Periodontic Services

The treatment of diseases of the gums and supporting structures of the teeth is subject to the following exclusions and limitations:

(i) Full mouth debridement will be payable once in your or your Eligible Dependent's lifetime;

(ii) Scaling and root planing are payable once per area in any 24 month period;

(iii) Periodontal surgery is payable once per area in any 3 year period.

Major Restorative Services

Major restorative services, such as crowns, used when teeth cannot be restored with another filling material. These services are subject to the following exclusions and limitations:

(i) Indirect restorations including porcelain/ceramic substrate, porcelain/resin processed to metal and cast restorations (including crowns and onlays) and associated procedures such as cores and post and core substructures on the same tooth are payable once in any 5 year period;

(ii) Substructures and indirect restorations, including porcelain/ceramic substrate, porcelain/resin processed to metal and cast restorations are not payable for Children under age 12 and all charges for the same will be your responsibility;

(iii) Optional treatment: if you or your Eligible Dependent selects a more expensive service than is customarily provided or for which RLHICA does not determine that a valid dental need is shown, RLHICA may make an allowance based on the fee for the customarily provided service. You are responsible for the difference in cost;

(iv) Inlays, regardless of the material used: RLHICA will pay only the applicable amount that it would have paid for a resin-based composite restoration. You will be responsible for any additional charges;

(v) RLHICA will not make payment for the following services and items and all charges for the same will be the responsibility of the Certificate Holder: charges related to hospitalization or general anesthesia and/or intravenous sedation for restorative dentistry or surgical procedure unless a specified need is shown;

(vi) RLHICA will not make payment for dentistry for aesthetic reasons and all charges for the same will be your responsibility;

(vii) Veneers are payable once in a 5 year period.

Prosthodontic Services

Services and appliances that replace missing natural teeth (such as fixed bridges, endosteal implants, partial dentures and complete dentures) are subject to the following exclusions and limitations:

(i) One complete upper and one complete lower denture is payable once in any 5 year period for any individual;

(ii) A partial denture, fixed bridge and any associated services are payable once in any 5 year period;

(iii) Fixed bridges, endosteal implants and cast metal partial dentures are not payable for Children under age 16 and all charges for the same will be your responsibility;

(iv) Optional treatment: if you or your Eligible Dependent selects a more expensive service than is customarily provided or for which RLHICA does not determine that a valid dental need is shown, RLHICA may make an allowance based on the fee for the customarily provided service. You are responsible for the difference in cost;

(v) Services for tissue conditioning are payable twice per denture unit in any 3 year period;

(vi) Endosteal implants are allowed once per tooth, per lifetime. RLHICA will not make payment if the implant is placed within 5 years following prosthodontic or major restorative services

involving that tooth and all charges for the same will be your responsibility;

(vii) RLHICA will not make payment for specialized implant surgical techniques, removal of an implant, implant maintenance procedures or implant repairs and all charges for the same will be your responsibility unless otherwise specified in the Summary of Dental Plan Benefits Section;

(viii) RLHICA will not make payment for the following services and items and all charges for the same will be your responsibility: lost, missing or stolen appliances of any type; temporary, provisional or interim prosthodontic appliances; precision or semi-precision attachment copings or myofunctional therapy;

(ix) RLHICA will not make payment for procedures to replace a missing tooth or teeth that were lost prior to becoming a Certificate Holder or Eligible Dependent under the Policy and all charges for the same will be your responsibility.

Relines and Repairs

Relines and repairs to fixed bridges, partial dentures and complete dentures. A reline or a complete replacement of denture base material is limited to once in any 3 year period per appliance.

Other Major Services

(i) An occlusal guard is payable once in you or your Eligible Dependent's lifetime;

(ii) Limited occlusal adjustments are limited to 1 in a lifetime;

(iii) RLHICA will not make payment for the following services and items and all charges for the same will be your responsibility: repair, relines or adjustments of occlusal guards.

ORTHODONTIC SERVICES

No person will be eligible for Orthodontic Services under the Policy unless Orthodontic Services are provided for in the Summary of Dental Plan Benefits Section. Services, treatment and procedures to correct malposed teeth (for example, braces), are subject to the following exclusions and limitations:

(i) RLHICA's payment for Orthodontic Services will be limited to the lifetime Maximum Payment specified in the Summary of Dental Plan Benefits Section;

(ii) Orthodontic Services are payable until the end of the calendar year of the 19th birthday of you or your Eligible Dependent unless otherwise specified in the Summary of Dental Plan Be Section;

(iii) RLHICA's payment for Orthodontic Retention Services (removal of appliances, construction and placement of retainer) is included in its payment of overall Orthodontic Services. If a Dentist bills these services separately, payment will be denied.

(iv) If the treatment plan is terminated before completion of the case for any reason, RLHICA's obligation will cease with payment up to the date of termination;

(v) The Dentist may terminate treatment, with written notification to RLHICA and to the patient, for lack of patient interest and cooperation. In those cases, RLHICA's obligation for payment ends on the last day of the month in which the patient was last treated;

(vi) RLHICA will not make payment for the following services and items and all charges for the same will be your responsibility: lost, missing, or stolen appliances of any type or replacement or repair of an orthodontic appliance.

Other Services

The Summary of Dental Plan Benefits Section lists any other Benefits that may have been selected.

V. Exclusions and Limitations

Exclusions

In addition to the exclusions listed above in the Benefits Section, RLHICA will not make payment for the following services, items or supplies and all charges for the same will be your responsibility, unless otherwise specified in the Summary of Dental Plan Benefits Section:

1. Services for injuries or conditions paid pursuant to Workers' Compensation or Employer's Liability laws. Services that are received from any government agency, political subdivision, community agency, foundation or similar entity. NOTE: This provision does not apply to any programs provided under Title XIX of the Social Security Act, that is, Medicaid;

2. Services or appliances started prior to the date the person became eligible under This Plan, excluding orthodontic treatment in progress (if a Covered Service);

3. Charges for failure to keep a scheduled visit with the Dentist;
4. Charges for completion of forms or submission of claims;
5. Services, items or supplies for which no valid dental need can be demonstrated, as determined by RLHICA;
6. Services, items or supplies that are specialized techniques, as determined by RLHICA;
7. Services, items or supplies that are investigational in nature, including services, items or supplies required to treat complications from investigational procedures, as determined by RLHICA;
8. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist or other licensed provider under the scope of his or her license as permitted by applicable state law;
9. Services, items or supplies excluded by the policies and procedures of RLHICA;
10. Services, items or supplies which are not rendered in accordance with accepted standards of dental practice, as determined by RLHICA;
11. Services, items or supplies for which no charge is made, for which the patient is not legally obligated to pay or for which no charge would be made in the absence of RLHICA coverage;
12. Services, items or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared;
13. Services, items or supplies that are generally covered under a hospital, surgical/medical or prescription drug program;
14. Services, items or supplies that are not within the categories of Benefits that have been selected by your employer or organization and are not covered in This Plan;
15. Prescription drugs, non-prescription drugs, premedications, localized delivery of chemotherapeutic agents, relative analgesia, non-intravenous conscious sedation, therapeutic drug injections, hospital visits, desensitizing medicaments and techniques, behavior management, athletic mouthguards, house/extended care facility visits, mounted occlusal analysis, complete occlusal adjustments, enamel microabrasions, odontoplasty or bleaching;
16. Correction of congenital or developmental malformations (except those for a newborn child added to the Policy after the initial Effective Date), cosmetic surgery or dentistry for aesthetic reasons as determined by RLHICA;
17. Any appliance or surgical procedure used to: (a) change vertical dimension; (b) restore or maintain occlusion; (c) replace tooth structure lost as a result of abrasion, attrition, abfraction or erosion; or (d) splint or stabilize teeth for periodontal reasons.

Limitations

In addition to the limitations listed above in the Benefits Section, the following limitations apply under This Plan, unless otherwise specified in the Summary of Dental Plan Benefits Section:

1. RLHICA's obligation for payment of Benefits ends on the last day of the month in which coverage is terminated under This Plan;
2. When services in progress are interrupted and completed later by another Dentist, RLHICA will review the claim to determine the amount of payment, if any, to each Dentist;
3. Care terminated due to the death of a Certificate Holder or Eligible Dependent will be paid to the limit of RLHICA's liability for the services completed or in progress;
4. The Maximum Payment will be limited to the amount specified in the Summary of Dental Plan Benefits Section;
5. If a Deductible amount is specified in the Summary of Dental Plan Benefits Section, RLHICA will not be obligated to pay, in whole or in part, for any services, items or supplies to which the Deductible applies, until the Deductible amount is met.

VI. Accessing Your Benefits

To access your Benefits, follow these steps:

1. Please read this Certificate, including the Summary of Dental Plan Benefits Section carefully to become familiar with the Benefits and provisions of This Plan;
2. Make an appointment with your Dentist and tell him or her that you have coverage with RLHICA. If the dental office needs a claim form, you may obtain one from your employer, organization, or plan administrator. If your Dentist is not familiar with This Plan or has any questions regarding This Plan, have him or her contact RLHICA by writing Attention: Customer Services Department, P.O. Box 1596,

Indianapolis, Indiana 46206 or by calling the toll-free number, 1-888-358-9484;

3. After receiving your dental treatment, you or the dental office staff will file a claim form, completing the information portion with:

   a. Your full name and address;

   b. Your Social Security number;

   c. The name and date of birth of the person receiving dental care; and

   d. The group's name and number.

Upon request, RLHICA will furnish to you, the claimant, such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after such request, you will be deemed to have complied with the requirements of This Plan as to proof of loss upon submitting, within the time frame for filing proofs of loss as described below, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Written proof of loss must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, RLHICA shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one (1) year from the time specified unless the claimant was legally incapacitated.

Claims, adjustment requests, and completed information requests should be mailed to:

RLHICA
P.O. Box 17250
Indianapolis, IN 46217

After receiving all required claim information, RLHICA will pay all Benefits due for Covered Services as soon as received and within 15 business days. If applicable, failure to pay within that period shall entitle you to interest at the state prescribed rate per annum from the 30th day. Interest amounts less than one dollar ($1.00) will not be paid.

Payment for services rendered is sent to either (1) you, and it is your responsibility to make full payment to the Dentist; or (2) directly to the Dentist if you or your Eligible Dependent have assigned Benefits to the Dentist who rendered Covered Services under This Plan.

Upon the payment of a claim under This Plan, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

If you file a claim for a Benefit that relates to a servic has already been rendered, and you receive notice of an Adverse Benefit Determination, RLHICA will notify you or your authorized representative of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. RLHICA may extend this period by up to 15 days if RLHICA determines that the extension is necessary due to matters out of RLHICA's control.

If RLHICA determines that an extension is necessary, it will notify you before the end of the original 30 day period of the circumstances requiring the extension and the date by which RLHICA expects to render a decision. If such an extension is necessary because you did not submit all the information necessary to decide the claim, the notice of extension will specifically describe the additional information required. You will have at least 45 days to provide the requested information. If you deliver the information within the time specified, the 15 day extension period will begin after you provide the information.

After written notice has been sent to RLHICA at its home office, benefits payable on behalf of an Eligible Dependent must be paid to the Texas Department of Human Services if:

1. The parent who is the Certificate Holder under this Policy is required to pay child support by a court order or court approved agreement and:

   a. Is a possessory conservator of the Eligible Dependent under a court order issued in the state of Texas; or

   b. Is not entitled to possession of or access to the Eligible Dependent;

2. The Texas Department of Human Services is paying benefits on behalf of the Eligible Dependent under Chapter 31 or 32 of the Texas Human Resources Code; and

3. RLHICA is notified, through an attachment to the claim for Benefits at the time the claim is first submitted to it, that the Benefits must be paid directly to the Texas Department of Human Services.

Note: RLHICA recommends Predetermination before any services are rendered where the total charges will exceed $200. You and your Dentist should review your Predetermination Notice before your Dentist proceeds with treatment.

If you have any questions about This Plan, please check with your employer, organization, or plan administrator or you may call RLHICA's Customer Services

Department toll-free at 1-888-358-9484. You may also write to RLHICA's Customer Services Department, P.O. Box 1596, Indianapolis, IN 46206. When writing to RLHICA please include your name, the group's name and number, the Certificate Holder's Social Security number, and your daytime telephone number.

VII. Questions and Answers

May I choose any Dentist?

Yes, you are free to choose any Dentist, as long as the Dentist is licensed to practice dentistry in the state or jurisdiction in which you receive care.

Will RLHICA send payment to the Dentist or will I receive payment?

RLHICA will either send payment to you or directly to the Dentist if you have assigned Benefit payments to the Dentist who rendered Covered Services.

When does my dental coverage begin?

See Waiting Period in the Summary of Dental Plan Benefits Section. This Plan will cover only those dental services received after you become eligible.

How much of the dental bill do I pay?

It depends on whether your employer or organization selected the Allowed Amount or the Table of Allowances payment method. If the "Allowed Amount" payment method has been selected, RLHICA will pay a certain percentage of the amount for each Covered Service, depending on the type of service rendered. Those Allowed Amounts are listed in the Summary of Dental Plan Benefits Section. If the Submitted Amount is more than the Allowed Amount for a specific Covered Service, then you are responsible for paying the Dentist that percentage listed in the "You Pay" column, as well as for paying the Dentist the difference between the Submitted Amount and the Allowed Amount. On the other hand, if your employer or organization selected the "Table of Allowances" payment method, RLHICA will only pay up to a specific dollar amount that is listed for each Covered Service in the Table of Allowances, which is listed in the Summary of Dental Plan Benefits Section.

In either case, you are responsible for the Copayment shown on your explanation of benefits plus any charges for optional treatment or specific exclusions / limitations of This Plan.

Am I covered for all dental services?

No, the Summary of Dental Plan Benefits Section describes the dental services that are covered by This Plan. Please read them carefully. The exclusions / limitations govern these covered dental services.

What if my spouse is covered by another plan?

If you are covered by more than one dental Plan, your out-of-pocket costs may be reduced or eliminated. Please see Section VIII Coordination of Benefits. It is important to tell your Dentist about any other dental coverage so that claims are submitted properly.

VIII. Coordination of Benefits

COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

All of the Benefits under this Certificate, if applicable, will be subject to a Coordination of Benefits **("COB")** provision that is designed to provide maximum coverage, but not result in payment of more than 100 percent of the total fee for a given treatment.

A. APPLICABILITY

1. This COB provision applies to This Plan when you or your Eligible Dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

2. If this COB provision applies, the order of benefit determination rules should be looked at first. These rules determine whether the Benefits of This Plan are determined before or after those of another Plan. The Benefits of This Plan:

   a. Shall not be reduced when, under the order of benefit determination rules, This Plan determines its Benefits before another Plan; but

   b. May be reduced when, under the order of benefits determination rules, another Plan determines its benefits first. The above reduction is described in Paragraph D. "Effect on the Benefits of This Plan."

B. DEFINITIONS

1. **"Allowable Expense"** means an expense covered under this Certificate when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

   When a Plan provides payment for services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

2. **"Claim Determination Period"** means a calendar year. However, it does not include a

part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

3. **"Plan"** is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

   a. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage;

   b. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

   Each contract or other arrangement for coverage under (a) or (b) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

4. **"Primary Plan/Secondary Plan:"** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

   When This Plan is a Primary Plan, its Benefits are determined before those of the other Plan and without considering the other Plan's benefits.

   When This Plan is a Secondary Plan, its Benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

   When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

5. **"This Plan"** means the dental coverage provided for you and your Eligible Dependents pursuant to this Certificate.

C. ORDER OF BENEFIT DETERMINATION RULES

1. General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its Benefits determined after those of the other Plan, u

   a. The other Plan has rules coordinating its benefits with those of This Plan; and

   b. Both those rules and This Plan's rules, in subparagraph (C)(2) below, require that This Plan's Benefits be determined before those of the other Plan.

2. Rules. This Plan determines its order of Benefits using the first of the following rules which applies:

   a. Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member, or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

      (i) Secondary to the Plan covering the person as a dependent and;

      (ii) Primary to the Plan covering the person as other than a dependent (*e.g.*, a retired employee), then the order of benefit determination is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

   b. Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph (C)(2)(c) below, when This Plan and another Plan cover the same Child as a dependent of different persons, called "parents:"

      (i) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

      (ii) If both parents have the same birthday, the benefits of the Plan which covered the parents longer are determined before those of the Plan which covered the other parent for a shorter period of time.

      However, if the other Plan does not have the rule described in subparagraph (C)(2)(b)(i) immediately above, but instead has a rule based upon the gender of the parent, and if

as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. Dependent Child/Parents Separated or Divorced. If two or more Plans cover a person as a dependent Child of divorced or separated parents, benefits for the Child are determined in this order:

(i) First, the Plan of the parent with custody of the Child;

(ii) Then, the Plan of the spouse of the parent with custody of the Child;

(iii) Then, the Plan of the parent not having custody of the Child; and

(iv) Then, the Plan of the spouse of the parent not having custody of the Child.

If the other Plan does not have this subparagraph (C)(2)(c) and if, as a result, the Plans do not agree on the order of benefits, this subparagraph (C)(2)(c) shall be ignored.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This subparagraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the Plans covering the Child shall be subject to the order of benefit determination contained in subparagraph (C)(2)(b) above.

d. Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). 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 subparagraph (C)(2)(d) is ignored.

e. Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal law (*i.e.*, COBRA) or state law also is covered under another Plan, the benefits of the Plan covering the person as employee, member, or subscriber (or that person's dependent) shall be determined before the benefits under the continuation coverage. 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 subparagraph (C)(2)(e) shall be ignored.

f. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

D. EFFECT ON THE BENEFITS OF THIS PLAN

1. When This Paragraph Applies. This Paragraph D. applies when, in accordance with Paragraph C. "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other Plans. In that event the Benefits of This Plan may be reduced under this Paragraph D. Such other Plan or Plans are referred to as "the other Plans" in subparagraph (D)(2) immediately below.

2. Reduction in This Plan's Benefits. The Benefits of This Plan will be reduced when the sum of:

a. The Benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

b. The Benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the Benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the Benefits of This Plan are reduced as described above, each benefit is reduced in

proportion. It is then charged against any applicable benefit limit of This Plan.

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. RLHICA has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person subject in all events, to all provisions of applicable law. RLHICA need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give RLHICA any facts it needs to pay the claim.

F. FACILITY OF PAYMENT

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, RLHICA may pay that amount to the organization which made that payment.

That amount will then be treated as though it were a Benefit paid under This Plan. RLHICA will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

G. RIGHT OF RECOVERY

If the amount of the payments made by RLHICA is more than it should have paid under this COB provision, it may recover the excess from one or more of the following:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

IX. Disputed Claims Procedure

If you receive notice of an Adverse Benefit Determination, and if you think that RLHICA incorrectly denied all or part of your claim, you or your Dentist should contact RLHICA's Customer Services Department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number,1-888-358-9484 and speaking to a telephone advisor. You may also mail your inquiry to the Customer Services Department at P.O. Box 1596, Indianapolis, IN. 46206.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your claim. This inquiry is not required and should not be considered a formal request for review of a denied claim. RLHICA provides this opportunity for you to describe problems and submit explanatory information that might indicate your claim was improperly denied and allow RLHICA to correct any errors quickly and without delay.

Whether or not you have asked RLHICA informally to recheck its initial determination, you can submit your claim to a formal review through the Disputed Claims Appeal Procedure described below.

If you receive notice of an Adverse Benefit Determination, you, or your authorized representative, should seek a review as soon as possible, but **you must file your request for review within 180 days** of the date on which you receive your notice of the Adverse Benefit Determination which you are asking RLHICA to review.

To request a formal review of your claim, send your request in writing to:

Dental Director
Renaissance Dental - RLHICA
P.O. Box 1596
Indianapolis, IN 46206

Please include your name and address, the Certificate Holder's Social Security number, the reason why you believe your claim was wrongly denied, and any other information you believe supports your claim. You also have the right to review This Plan and any documents related to it. If you would like a record of your request and proof that it was received by RLHICA, you should mail it certified mail, return receipt requested.

The Dental Director, or any other person(s) reviewing your claim, will not be the same as, nor will they be subordinate to, the person(s), who initially decided your claim. The reviewer will grant no deference to the prior decision about your claim, but rather will assess the information, including any additional information that you have provided, as if he/she were deciding the claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your claim even if the information was not available when your claim was initially decided.

If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is

experimental, investigational or not medically necessary or appropriate), the reviewer will, as necessary, consult a dental health care professional with appropriate training and experience. The dental health care professional will not be the same individual, or that person's subordinate, consulted during the initial determination.

The reviewer will make his/her determination on review within 60 days of his/her receipt of your request. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Disputed Claims Appeal Procedure will meet the requirements described below under the heading "Manner and Content of Notice."

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent Policy provisions(s) on which the denial is based, the applicable review procedures for dental claims, including applicable time limits, and that you are entitled to access, free of charge, upon request, all documents, records and other information relevant to your claim. The notice will also contain a description of any additional materials necessary to complete your claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your claim has been completely reviewed according to this Disputed Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

If you (a) need the assistance of a governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer, you may also contact the Consumer Protection Division of the Texas Insurance Department, P.O. Box 149104, Austin, Texas, 78714-9104.

X. Termination of Coverage

RLHICA must give your employer or organization at least 45 days advance notice of cancellation, expiration, nonrenewal, or change in rates. In the event RLHICA chooses to terminate the Policy due to nonpayment of premium, RLHICA will give your employer or organization notice of the termination within 45 days after the premium due date. The effective date of such termination shall be the first day of the period for which the premium is due.

Your RLHICA coverage may be automatically terminated:

1. When your employer or organization advises RLHICA to terminate your coverage;
2. On the last day of the month for which your employer or organization has failed to pay RLHICA;
3. Or for any other reason stated in the Policy.

A person whose eligibility is terminated may be eligible to transfer to an individual direct payment contract with RLHICA. Please contact RLHICA to obtain further information.

XI. Continuation of Coverage

A. Loss of Eligibility During Treatment

1. If you and/or an Eligible Dependent lose eligibility while receiving dental treatment, only those Covered Services received while you and/or your Eligible Dependent were eligible under the Policy will be payable.
2. Certain procedures begun before the loss of eligibility may be covered if the services were completed within a 30 day period measured from the date of termination. In those cases, RLHICA evaluates those services in progress to determine what portion may be paid by RLHICA. The difference between RLHICA's payment and the total fee for those procedures is your responsibility.

B. Continuation Coverage - COBRA

If your employer or organization is required to comply with provisions under the Consolidated omnibus Budget Reconciliation Act of 1985 ("COBRA") and your coverage would otherwise end, you and/or your covered Eligible Dependents may have the right under certain circumstances to continue coverage in the

group health plans sponsored by your employer or organization, at your expense, beyond the time coverage would normally end.

COBRA continuation coverage may be available if your coverage or a covered Eligible Dependent's coverage would otherwise end because of one of the following COBRA qualifying events:

1. Voluntary or involuntary termination of employment for any reason other than your gross misconduct;
2. Reduction in the number of hours worked so that you are no longer an eligible employee under the terms of the group health plan;
3. Divorce or legal separation;
4. Death;
5. Loss of dependent status under the terms of the group health plan; or
6. You become entitled to Medicare (if applicable).

If you are called to active duty in the armed forces of the United States, you and your covered Eligible Dependents may also have continuation coverage rights under the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

If you believe you are entitled to continuation coverage either under COBRA or USERRA, you should contact your employer or organization to receive additional information about your rights and to learn more about the applicable procedures for applying for such continuation coverage.

C. Continuation Coverage – Death of Certificate Holder

Upon the death of the Certificate Holder, coverage for Eligible Dependents (if any) shall continue for a period of 90 days, subject to the termination provisions found in Section III and Section X of this Certificate.

D. Continuation Coverage – Eligible Dependents

Eligible Dependents may elect to continue coverage under this Certificate in the event of the divorce, retirement or death of the Certificate Holder. To elect coverage, Eligible Dependents should contact the Certificate Holder's employer or organization immediately following the occurrence of one of the above-mentioned events.

E. Continuation Coverage – Total Disability

In the event the Policy is terminated for any re[illegible] the Benefits paid pursuant to the Policy shall continue for a period of 90 days in the event of total disability (on the date of such termination) of the Certificate Holder or an Eligible Dependent.

XII. General Conditions

Change of Status

You must notify RLHICA through your employer or organization, of any event causing a change in the status of an Eligible Dependent. Events that can affect the status of an Eligible Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

Assignment

Benefits to you or your Eligible Dependent are for the personal benefit of you or your Eligible Dependent and cannot be transferred or assigned. You or your Eligible Dependent, however, may assign Benefits to the Dentist who rendered Covered Services under This Plan. Benefits paid pursuant to such assignment shall discharge the obligation of RLHICA with respect to the amount of the Benefits so paid.

Subrogation

If RLHICA pays a claim for which another person or company is liable, RLHICA has the right to recover its payment from the other person or company.

Obtaining and Releasing Information

While you are covered by RLHICA, you agree to provide RLHICA with any information it needs to process your claims and administer your Benefits. This includes allowing RLHICA to have access to your dental records.

Dentist-Patient Relationship

You and your Eligible Dependents have the freedom to choose any Dentist. Each Dentist maintains the dentist-patient relationship with the patient and is solely responsible to the patient for dental advice and treatment and any resulting liability.

Late Claims Submission

Except as otherwise provided in this Certificate, RLHICA will not honor and no payment will be made for services, items or supplies if a claim for those services, items or supplies has not been received by RLHICA within one year from the date that the services, items or supplies were provided.

Change of Certificate or Policy

No agent has the authority to change any provisions in this Certificate or the provisions of the Policy on which it is based. No changes to this Certificate or the underlying Policy are valid unless approved in writing by an officer of RLHICA.

Note: This Certificate and the Policy are subject to change if, in the future, federal and state privacy laws and regulations require RLHICA or your employer or organization to comply with such laws and regulations. Should any such change to this Certificate or the Policy be necessary by law, you will receive written notice from RLHICA informing you of the reasons for any change to this Certificate or the Policy and the process by which you will receive an amended Certificate or the amended section of this Certificate.

Legal Actions

No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy, unless otherwise provided by applicable state law. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given. This provision does not preclude the Policyholder or Certificate Holder from seeking a decision from a jury trial once all administrative appeals have been exhausted.

Representations

In the absence of fraud, all statements made by your employer or organization or by you or your Eligible Dependents, shall be deemed to be representations and not warranties. No such statement shall be used in defense to a claim under the Policy, unless it is contained in a written application.

IMPORTANT NOTICE

To obtain information or to make a complaint:

You may call Renaissance Life & Health Insurance Company of America's toll-free telephone number for information or to make a complaint at:

1-888-358-9484

You may also write to Renaissance Life & Health Insurance Company of America at:

Renaissance Life & Health Insurance Company of America
P.O. Box 1596
Indianapolis, IN 46206-1596

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at: P.O. Box 149104
Austin, TX 78714-9104

Fax: (512) 490-1007
Web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact Renaissance Life & Health Insurance Company of America first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Renaissance Life & Health Insurance Company of America para obtener información o para prensentar una queja al:

1-888-358-9484

Usted tambien puede escribir a Renaissance Life & Health Insurance Company of America:

Renaissance Life & Health Insurance Company of America
P.O. Box 1596
Indianapolis, IN 46206-1596

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías,coberturas, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104

Fax: (512) 490-1007
Web: http://www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con Renaissance Life & Health Insurance Company of America primero. Si la disputa no es resuelta, puede comunicarse con el departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU POLIZA: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

CERTIFICATE CONTRACTING DENTIST BENEFIT RIDER

By attachment of this rider, the Certificate is amended as follows:

This Certificate is amended to provide Benefits that are based on whether you or your Eligible Dependent receives dental services from a Contracting Dentist or a Non-Contracting Dentist.

If you or your Eligible Dependent receive Covered Services from a Contracting Dentist, RLHICA will pay the applicable Copayment in excess of the applicable Deductible for Covered Services.

If you or your Eligible Dependents receive Covered Services from a Non-Contracting Dentist, Benefits may be less than the amount that would have otherwise been payable with a Contracting Dentist. The same level of Benefits is paid for both Contracting and Non-Contracting Dentists. However, Contracting Dentists have agreed to accept pre-negotiated fees as payment in full for Covered Services, while you are responsible for any amount in excess of the Allowed Amount billed by a Non-Contracting Dentist.

Payment of Dental Bills When You See a Contracting Dentist

If you or your Eligible Dependents receive Covered Services from a Contracting Dentist, the fee for services has already been agreed to between the Dentist and RLHICA. Contracting Dentists accept these pre-negotiated fees as payment in full for the dental care provided. You will be responsible for paying the Dentist that percentage of the Allowed Amount listed in the "You Pay" column of the Summary of Dental Plan Benefits for the categories of services rendered.

You are also responsible for any charges for optional treatment or specific exclusions/limitations of the Certificate.

Payment of Dental Bills When You See a Non-Contracting Dentist

If you or your Eligible Dependents receive Covered Services from a Non-Contracting Dentist, payment will be based upon the percentage of the Allowed Amount that is set forth in the Summary of Dental Plan Benefits Section. You will be responsible for paying the Dentist that percentage of the Allowed Amount listed in the “You Pay” column of the Summary of Dental Plan Benefits Section for the categories of services rendered. In addition, if the Submitted Amount for a Non-Contracting Dentist is more than the Allowed Amount, you will also be responsible for paying the Dentist the difference between the Submitted Amount and the Allowed Amount.

You are also responsible for any charges for optional treatment or specific exclusions/limitations of the Certificate.

Termination of a Contracting Dentist’s Participation under the Certificate

In the event a Contracting Dentist terminates his or here participation under the Certificate, RLHICA will provide reasonable advance notice of the impending termination, with a notice of the availability of a current listing of Contracting Dentists.

Definitions (As used in this rider):

Allowed Amount – is revised to mean the maximum dollar amount upon which RLHICA will base Benefits. For services rendered or items provided by a Contracting Dentist, the Allowed Amount is a pre-negotiated fee that the provider has agreed to accept as payment in full. For services rendered or items provided by a Non-Contracting Dentist, RLHICA determines the Allowed Amount using statistically valid claims data submitted to RLHICA and its affiliates which show the most frequently charged fees by providers in the same geographic areas for comparable services or supplies. The claims data and fees are updated periodically using the most current codes and nomenclature developed and maintained by the American Dental Association. This definition is only applicable if the Allowed Amount method for Benefits is shown in the Summary of Dental Plan Benefits Section.

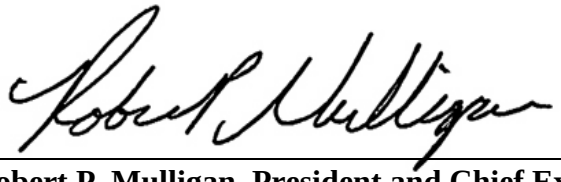
Contracting Dentist – means a Dentist who has entered into a contract to provide Covered Services for pre-negotiated fees that the Dentist has agreed to accept as payment in full. You will be provided with a current list of Contracting Dentists.

Non-Contracting Dentist – means a Dentist who has not entered into a contract to provide Covered Services for pre-negotiated fees.

This rider does not change, waive or extend any part of the Certificate other than as set forth above.

This rider is effective at the same time as the Certificate.

Renaissance Life & Health Insurance Company of America



Robert P. Mulligan, President and Chief Executive Officer

NOTICE OF PRIVACY PRACTICES

Date of This Notice: February 12, 2020

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the privacy practices of Delta Dental Plan of Michigan, Inc., Delta Dental Plan of Ohio, Inc., Delta Dental Plan of Indiana, Inc., Delta Dental Plan of Arkansas, Inc., Delta Dental of Kentucky, Inc., Delta Dental Plan of New Mexico, Inc., Delta Dental of North Carolina, Delta Dental of Tennessee, Renaissance Life & Health Insurance Company of America, Renaissance Life & Health Insurance Company of New York (collectively, "we" or "us" or the "Plan"). These entities have designated themselves as a single affiliated covered entity for purposes of the privacy rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and each has agreed to abide by the terms of this Notice and may share protected health information with each other as necessary for treatment, payment or to carry out health care operations, or as otherwise permitted by law.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information" ("PHI"). Generally, PHI is individually identifiable health information, including demographic information, collected from you or received by a health care provider, a health care clearinghouse, a health plan or your employer on behalf of a group health plan that relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

We are required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are committed to protecting your health information.

We comply with the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. We maintain a breach reporting policy and have in place appropriate safeguards to track required disclosures and meet appropriate reporting obligations. We will notify you promptly in the event a breach occurs that may have compromised the security or privacy of your PHI. In addition, we comply with the "Minimum Necessary" requirements of HIPAA and the HITECH amendments. We also comply with all applicable laws relating to retention and destruction of your PHI.

For more information concerning this Notice please see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we may use or disclose your PHI.

For Treatment We may use or disclose your PHI to facilitate medical treatment or services by providers. We may disclose PHI about you to providers, including dentists, doctors, nurses, or technicians, who are involved in taking care of you. For example, we might disclose information about your prior dental X-ray to a dentist to determine if the prior X-ray affects your current treatment.

For Payment We may use or disclose PHI about you to obtain payment for your treatment and to conduct other payment related activities, such as determining eligibility for Plan benefits, obtaining customer payment for benefits, processing your claims, making coverage decisions, administering Plan benefits, and coordinating benefits.

For Health Care Operations We may use and disclose PHI about you for other Plan operations, including setting rates, conducting quality assessment and improvement activities, reviewing your treatment, obtaining legal and audit services, detecting fraud and abuse, business planning and other general administration activities. In accordance with the Genetic Information and Nondiscrimination Act of 2008, we are prohibited from using your genetic information for underwriting purposes.

To Business Associates We may contract with individuals or entities known as Business Associates to perform various functions or to provide certain types of services on the Plan's behalf. In order to perform these functions or provide these services, Business Associates may receive, create, maintain, use and/or disclose your PHI, but only if they agree in writing with the Plan to implement appropriate safeguards regarding your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide support services, such as utilization management, quality assessment, billing and collection or audit services, but only after the Business Associate enters into a Business Associate Agreement with the Plan.

Health-Related Benefits and Services We may use or disclose health information about you to communicate to you about health-related benefits and services. For example, we may communicate to you about health-related benefits and services that add value to, but are not part of, your health plan.

To Avert a Serious Threat to Health or Safety We may use and disclose PHI about you to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

Military and Veterans If you are a member of the armed forces, we may release PHI about you if required by military command authorities.

Worker's Compensation We may release PHI about you as necessary to comply with worker's compensation or similar programs.

Public Health Risks We may release PHI about you for public health activities, such as to prevent or control disease, injury or disability, or to report child abuse, domestic violence, or disease or infection exposure.

Health Oversight Activities We may release PHI to help health agencies during audits, investigations or inspections.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We also may disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement We may release PHI if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

To Plan Sponsor We may disclose your PHI to certain employees of the Plan Sponsor (i.e., the Company) for the purpose of administering the Plan. These employees will only use or disclose your PHI as necessary to perform Plan administrative functions or as otherwise required by HIPAA.

Disclosure to Others We may use or disclose your PHI to your family members and friends who are involved in your care or the payment for your care. We may also disclose PHI to an individual who has legal authority to make health care decisions on your behalf.

REQUIRED DISCLOSURES

The following is a description of disclosures of your PHI the Plan is required to make:

As Required By Law We will disclose PHI about you when required to do so by federal, state or local law. For example, we may disclose PHI when required by a court order in a litigation proceeding, such as a malpractice action.

Government Audits The Plan is required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with HIPAA.

Disclosures to You Upon your request, the Plan is required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits.

WRITTEN AUTHORIZATION

We will use or disclose your PHI only as described in this Notice**. It is not necessary for you to do anything to allow us to disclose your PHI as described here.** If you want us to use or disclose your PHI for another purpose, you must authorize us in writing to do so. For example, we may use your PHI for research purposes if you provide us with written authorization to do so. You may revoke your authorization in writing at any time. When we receive your revocation, it will be effective only for future uses and disclosures. It will not be effective for any PHI that we may have used or disclosed in reliance upon your written authorization. We will never sell your PHI or use it for marketing purposes without your express written authorization. We cannot condition treatment, payment, enrollment in a Health Plan, or eligibility for benefits on your agreement to sign an authorization.

ADDITIONAL INFORMATION REGARDING USES OR DISCLOSURES OF YOUR PHI

For additional information regarding the ways in which we are allowed or required to use of disclosure your PHI, please see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

YOUR RIGHTS REGARDING PHI THAT WE MAINTAIN

You have the following rights regarding PHI we maintain about you:

Your Right to Inspect and Copy Your PHI You have the right to inspect and copy your PHI. You must submit your request in writing and if you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request. A copy will be provided within 30 days of your request.

The Plan may deny your request to inspect and copy PHI in certain limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed by submitting a written request to the Contact Person listed below.

Your Right to Amend Incorrect or Incomplete Information If you believe that the PHI the Plan has about you is incorrect or incomplete, you may request that we change your PHI by submitting a written request. You also must provide a reason for your request. We are not required to amend your PHI but if we deny your request, we will provide you with information about our denial and how you can disagree with the denial within 60 days of your request.

Your Right to Request Restrictions on Disclosures to Health Plans. Where applicable, you may request that restrictions be placed on disclosures of your PHI.

Your Right to an Accounting of Disclosures We Have Made You may request an accounting of disclosures of your PHI that we have made, except for disclosures we made to you or pursuant to your written authorization, or that were made for treatment, payment or health care operations. You must submit your request in writing. Your request may specify a time period of up to six years prior to the date of your request. We will provide one list of disclosures to you per 12-month period free of charge; we may charge you for additional lists.

Your Right to Request Restrictions on Uses and Disclosures You have the right to request restrictions or limitations on the way that we use or disclose PHI. You must submit a request for such restrictions in writing, including the information you wish to limit, the scope of the limitation and the persons to whom the limits apply. We may deny your request.

Your Right to Request Confidential Communications Through a Reasonable Alternative Means or at an Alternative Location You may request that we direct confidential communications to you in an alternative manner (i.e., by facsimile or e-mail). You must submit your request in writing. We are not required to agree to your request, however we will accommodate your request if doing otherwise would place you in any danger.

Your Right to a Paper Copy of This Notice

To obtain a paper copy of this Notice or a more detailed explanation of these rights, send us a written request at the address listed below. You may also obtain a copy of this Notice at one of our websites:
www.deltadentalmi.com,
www.deltadentaloh.com,
www.deltadentalin.com,
www.deltadentalar.com
www.deltadentalky.com,
www.deltadentalnc.com,
www.deltadentalnm.com,
www.deltadentaltn.com, or
www.renaissancedental.com.

Your Right to Appoint a Personal Representative

Upon receipt of appropriate documentation appointing an individual as your personal representative, medical power of attorney or legal guardian, that individual will be permitted to act on your behalf and make decisions regarding your healthcare.

CHANGES TO THIS NOTICE

We may amend this Notice of Privacy Practices at any time in the future and make the new Notice provisions effective for all PHI that we maintain. We will advise you of any significant changes to the Notice. We are required by law to comply with the current version of this Notice.

COMPLAINTS

If you believe your privacy rights or rights to notification in the event of a breach of your PHI have been violated, you may file a complaint with us or with the Office of Civil Rights. Complaints about this Notice or about how we handle your PHI should be submitted in writing to the Contact Person listed below.

A complaint to the Office of Civil Rights should be sent to Office of Civil Rights, U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, 1-877-696-6775. You also may visit OCR's website at http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html for more information.

You will not be penalized, or in any other way retaliated against for filing a complaint with us or the Office of Civil Rights.

SEND ALL WRITTEN REQUESTS REGARDING THIS PRIVACY NOTICE TO:

Chief Privacy Officer
P.O. Box 30416
Lansing, MI 48909-7916
517-347-5451 (TTY users call 711)

FACTS	WHAT DOES RENAISSANCE FAMILY OF COMPANIES DO WITH YOUR PERSONAL INFORMATION?

Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: ▪ Social Security Number and Insurance claim information ▪ Transaction history and Medical information ▪ Credit card payments and Employment information When you are *no longer* our customer, we continue to share your information as described in this notice.
Why?	All financial companies need to share members' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their members' personal information; the reasons Renaissance Family of Companies chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	**Does Renaissance Family of Companies share?**	**Can you limit this sharing?**
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	**Yes**	**No**
For our marketing purposes – to offer our products and services to you	**Yes**	**No**
For joint marketing with other financial companies	**No**	**We do not share**
For our affiliates' everyday business purposes – information about your transactions and experiences	**Yes**	**No**
For our affiliates' everyday business purposes – information about your creditworthiness	**No**	**We do not share**
For nonaffiliates to market to you	**No**	**We do not share**

For Privacy Concerns:	Call 517-347-5451 (TTY users call 711). All other questions must be answered by calling your general customer service number.

Who we are	
Who is providing this notice?	All of the members of the Renaissance Family of Companies listed as Affiliates in the Definitions section located on the back of this notice.

Page 2	
What we do	
How does Renaissance Family of Companies protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.
How does Renaissance Family of Companies collect my personal information?	We collect your personal information, for example: ▪ When you apply for insurance ▪ When you file an insurance claim ▪ When you give us your contact information ▪ When you use your credit or debit card ▪ When we pay your insurance claims
Why can't I limit all sharing?	Federal law gives you the right to limit only: ▪ Sharing for affiliates' everyday business purposes—information about your creditworthiness ▪ Affiliates from using your information to market to you ▪ Sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing.
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. ▪ *Our affiliates include companies with the Delta Dental name in Michigan, Ohio, Indiana, Kentucky, Tennessee, New Mexico, Arkansas and North Carolina; insurance companies such as Renaissance Life & Health Insurance Company of America and Renaissance Life & Health Insurance Company of New York.*
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ▪ *Renaissance Family of Companies does not share your personal information with nonaffiliates so they can market to you.*
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. ▪ *Renaissance Family of Companies does not jointly market with nonaffiliated financial companies.*
Other important information	
For customers in AZ, CA, CT, GA, IL, ME, MA, MN, MT, NV, NJ, NC, OH, OR and VA: To review your personal information, write to Privacy Officer, 4100 Okemos Road, Okemos, MI 48864. You must state your full name, address, policy number (if applicable) and the information you would like to see. We will tell you what information we have, and you may review and copy it at our office or ask that we mail a copy to you for a fee. If you think that personal information that we have about you is wrong, you may write to us. We will tell you what actions we take because of your letter. If you do not agree with our actions, you may send us a statement.	

Renaissance
Life & Health Insurance Company of America
P.O. Box 1596
Indianapolis, IN 46202-1596
800-894-4532

GROUP SHORT TERM DISABILITY INSURANCE
CERTIFICATE OF COVERAGE

Policyholder: ABC COMPANY

Policy Number: MP0000000000/ 000000

Policy Effective Date: January 1, 2024

Renaissance Life & Health Insurance Company of America (referred to as "we," "us," or "our") welcomes your Employer as a Policyholder. “You” and “your” as used in this Certificate of Coverage (“Certificate”) means an Employee who is eligible for coverage under the Policy.

This is your Certificate as long as you are eligible for coverage and you become insured. We certify that you are insured for the benefits described in this Certificate, subject to the provisions and requirements detailed in this Certificate. THIS CERTIFICATE MAY CONTAIN EXCLUSIONS, LIMITATIONS, REDUCTIONS IN COVERAGE, AND TERMINATION PROVISIONS. PLEASE READ YOUR CERTIFICATE CAREFULLY AND KEEP IT IN A SAFE PLACE.

We have written the Certificate in plain English. There are a few terms and provisions written as required by insurance law. If you have any questions about any of the terms and provisions, please contact us at the toll-free telephone number included above. We will assist you in understanding your benefits.

If the terms and provisions of the Certificate (issued to you) differ from the Policy (issued to the Policyholder), the Policy will govern. Contact the Policyholder if you wish to inspect a copy of the Policy. Your coverage may be canceled or changed in whole or in part under the terms and provisions of the Policy.

The Policy is delivered in and is governed by the laws of Texas and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. The Texas Department of Insurance may be reached at (512) 676-6000. The Policy and this Certificate have been approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of the Policy or Certificate that on the provision’s effective date is in conflict with Interstate Insurance Product Regulation Commission standards for group disability income insurance in effect on the date of the Commission’s approval of the Policy and Certificate is hereby amended to conform to such standards as of the provision’s effective date.

For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 A.M. and end at 12:00 midnight, local time, at the Policyholder’s place of business in the state where the Policy is issued.

ABOUT YOUR COVERAGE

Like other disability income coverages, this Plan provides a benefit which replaces a portion of the income you lose if you are out of work due to Sickness or Injury.

We believe the similarities end there.

That's because our Plan gives you more. Besides providing a partial income replacement benefit, our Plan also emphasizes helping you make a successful re-entry into the work force.

Our philosophy is rooted in some key beliefs that have emerged from our experience:

- Most people want to return to work.
- Work itself often plays a valuable therapeutic role in the recovery process.
- Impairments in work capabilities can often be accommodated with special equipment.

Re-employment most often holds the key to a higher standard of living and a better quality of life.

By working with the key people in your life and building on your abilities, we hope to promote results that work for everyone: you, your family, your Employer, and your co-workers.

TABLE OF CONTENTS

Your Certificate is divided into the following sections:

SECTION 1: PLAN HIGHLIGHTS - STD 4
SECTION 2: GENERAL INFORMATION 5
SECTION 3: ELIGIBILITY FOR COVERAGE 7
WHEN ARE YOU ELIGIBLE FOR COVERAGE? 7
WHEN DOES YOUR COVERAGE BECOME EFFECTIVE? 7
WHEN IS EVIDENCE OF INSURABILITY REQUIRED? 7
WHEN CAN YOUR COVERAGE UNDER THIS PLAN CHANGE? 7
WHEN DOES YOUR COVERAGE UNDER THIS PLAN END? 8
SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS 9
WHAT DOES DISABILITY MEAN? 9
WHEN WILL WE NOT COVER A DISABILITY? 10
HOW DO I CALCULATE MY STD BENEFIT? 11
WHAT ARE OTHER INCOME AMOUNTS? 11
WHEN WILL OUR PAYMENTS TO YOU STOP? 13
SECTION 5: CLAIM INFORMATION 14
WHEN DO YOU NOTIFY US OF A CLAIM? 14
WHEN DO YOU NEED TO GIVE US PROOF OF YOUR CLAIM? 15
HOW DO YOU FILE A CLAIM? 15
SECTION 6: ADDITIONS TO YOUR PLAN 17
SECTION 7: DEFINITIONS 17

SECTION 1: PLAN HIGHLIGHTS - STD

This is a brief overview of your Short Term Disability ("STD") benefits. These benefits and other important information about your coverage are described further in the Certificate. We have tried to make the language and format of the Certificate easy to understand. Defined terms and provision titles such as those below are italicized and have initial letters capitalized when used throughout the Certificate.

Plan Effective Date: January 1, 2024

Eligible Class: Class 3: All Full Time Eligible Employees
You must be working at least 30 hours per week.

Benefit Percentage: 60%

Maximum Weekly Benefit: $3,000*

*We will reduce the amount we pay you by Other Income Amounts, as defined in the provision titled WHAT ARE OTHER INCOME AMOUNTS? in Section 4, SHORT TERM DISABILITY BENEFIT SPECIFICS.

Minimum Weekly Benefit: $25

We may apply all payments we owe you toward any outstanding overpayment balances under the Policy.

Elimination Period: If Disability is due to an Injury: 14 days.
If Disability is due to a Sickness: 14 days.

Maximum Payment Duration: 11 weeks

Non-Occupational STD Coverage: See the provision titled WHEN WILL WE NOT COVER A DISABILITY? in Section 4, SHORT TERM DISABILITY BENEFIT SPECIFICS, for STD exclusions and limitations.

Pre-existing Conditions Provision: None

Waiting Period:

- If you are in an Eligible Class on or before the Plan Effective Date: None.
- If you are entering an Eligible Class after the Plan Effective Date: 30 days.

Individual Effective Date: The first day of the month following completion of the Waiting Period, if applicable.

Cost of Coverage:

- The Employer pays the cost of your coverage.

The cost of your coverage must be paid for any period of time during which you are Disabled under this Plan.

For your STD coverage, **Pre-disability Earnings** is defined as shown below:

If you are a partner, **Pre-disability Earnings** means your average weekly earnings as figured:

- From the line showing "self-employment earnings (loss)" from the partner's Schedule K-1 (Form 1065) of the partnership's federal income tax return for the two calendar years just prior to the date Disability begins; or
- If you have not been a partner during the two calendar years for which the most recent partnership federal income tax return was filed, then your average weekly earnings will be figured for the employment period during which you have been a partner.

If you are a sole proprietor, **Pre-disability Earnings** means your weekly net profit averaged over:

- The two most recent years; or
- The period you have been a sole proprietor, if you have been a sole proprietor for less than two years.

Annual net profit is figured from Form 1040 Schedule C as the gross income less all deducted expenses (other than depreciation).

If you are a shareholder of a Subchapter S corporation, **Pre-disability Earnings** means your average weekly income from the Employer in effect just prior to the date Disability begins. It includes income from Schedule K-1 (Ordinary business income (loss)), and your W-2 from the S Corporation just prior to the date Disability begins.

Weekly income for K-1 and W-2 income will be averaged over the lesser of:

- The two most recent years; or
- The period of your employment with the Employer if you have been employed for less than two years.

Your W-2 income will include the amount of salary you elected to defer as part of a deferred compensation plan. The deferred compensation plan is defined by a documented, pre-determined formula, as shown on your W-2, and other salary reductions you have agreed to for purposes of funding Employee contributions toward the cost of coverage under employee welfare benefit plans sponsored by the Employer.

If you are a shareholder of a C-Corporation, **Pre-disability Earnings** means your average weekly earnings as figured:

- From the W-2 form (from the box which reflects wages, tips and other compensation) received from the Employer for the two calendar years just prior to the date Disability begins; or
- For the period you were a shareholder, if you have been a shareholder for less than two calendar years.

Your W-2 income will include the amount of salary you elected to defer as part of a deferred compensation plan. The deferred compensation plan is defined by a documented, pre-determined formula, as shown on your W-2, and other salary reductions you have agreed to for purposes of funding Employee contributions toward the cost of coverage under employee welfare benefit plans sponsored by the Employer.

For all other Employees, **Pre-disability Earnings** means your gross weekly rate of earnings from the Employer just prior to the date Disability begins. It does not include commissions, bonuses, overtime, and other extra compensation.

If your Disability begins while you are on a covered Layoff or Leave of Absence, we will use your Pre-disability Earnings from the Employer in effect just before the date your absence begins.

Our payments to you will be based on the amount of your Covered Pre-disability Earnings ; premium payments must be based on the correct definition of Pre-disability Earnings.

SECTION 2: GENERAL INFORMATION

WHAT IS THE CERTIFICATE OF COVERAGE?

This Certificate is a written statement prepared by us and may include attachments. It tells you:

- The coverage to which you may be entitled;
- To whom we make payments; and
- The limitations, exclusions, and requirements applying to the Plan.

It is the responsibility of the Policyholder to distribute the appropriate Certificate and any updates or other notices from us to each insured individual.

TO WHAT INFORMATION DO WE HAVE ACCESS?

The Employer will give us information about you including:

- If you are eligible for coverage;
- If your amount of coverage changes, including salary change information;
- If your coverage terminates; and
- Other information we may reasonably require.

The Employer's records that we believe have a bearing on coverage under the Plan(s) are open for our inspection at any reasonable time.
Clerical error or omission by the Employer, you, or us will not:

- Terminate coverage which should otherwise be in effect;
- Continue coverage which should otherwise terminate;
- Create coverage which should not be in effect; or
- Change the amount of coverage that should otherwise be in effect.

WHAT IS THE INCONTESTABILITY PERIOD FOR YOUR COVERAGE?
Any statement you or the Employer makes to obtain coverage or an increase in coverage is a representation and not a warranty. No misrepresentation by you or the Employer will be used to reduce or deny a claim or to deny the validity of your coverage or an increase in coverage unless:

- The misrepresentation is material to the risk accepted;
- our coverage or increase in coverage would not have been approved if the truth had been known;
- Your misrepresentation is contained in a written instrument signed by you; and
- You or your beneficiary, if applicable, have been given a copy of the written instrument containing your misrepresentation.

After your coverage or increase in coverage under the Policy has been in effect for two continuous years during your lifetime, we will not use a misrepresentation by you or by the Employer to:

- Reduce or deny a claim; or
- Deny the validity of your coverage or increase in coverage;

unless it was a fraudulent misrepresentation made with actual intent to deceive, where permitted by applicable law in the state of where the Policy was issued.

However, we have the right at any time to assert as a defense to a claim that you were not eligible to become covered because you did not meet the eligibility requirements in this Certificate, including, but not limited to, the requirements that you: (1) be in an Eligible Class; (2) submit and have approved Evidence of Insurability, if required; and (3) meet the Active Employment requirement.

WHAT CONSTITUTES THE ENTIRE CONTRACT?
Coverage is provided for eligible Employees under a contract of group insurance between the Policyholder and us. The contract consists of:

- All Policy provisions and any amendments and/or attachments issued;
- The Policyholder’s application;
- Employees' signed Evidence of Insurability forms, if any; and
- The Certificate of Coverage.

HOW WILL WE HANDLE INSURANCE FRAUD?
We promise to focus on all means necessary to support fraud detection, investigation, and prosecution. It is a crime if you or the Employer knowingly, and with intent to injure, defraud or deceive us, file a claim containing any false, incomplete or misleading information. These actions, as well as submission of false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

WHAT IF YOUR AGE OR OTHER DATA IS MISSTATED?

If your age or other data on you is misstated, we have the right to make an equitable adjustment in the premium or coverage due for you. The true facts will be used to determine if and for what amount coverage should have been provided for you.

DOES THE EMPLOYER ACT AS YOUR AGENT?
For all purposes of the Policy, the Employer acts on its own behalf or as your agent. The Employer is not our agent.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?
You can start legal action regarding your claim 60 days after the date you sent us proof of claim. No action can be brought after the applicable statute of limitations has expired, but in any case, not more than three years after the date of your loss.

DOES THIS PLAN REPLACE OR AFFECT ANY REQUIREMENT FOR WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?
The Plan does not replace or affect requirements for coverage by Workers' Compensation insurance or state disability insurance.

SECTION 3: ELIGIBILITY FOR COVERAGE

WHEN ARE YOU ELIGIBLE FOR COVERAGE?
If you are in an Eligible Class, you are eligible for coverage under a Plan on the later of:

- The Plan Effective Date; or
- The date you complete the Waiting Period.

WHEN DOES YOUR COVERAGE BECOME EFFECTIVE?
Your coverage will be effective on the date determined as follows:

If you are not required to contribute toward the cost of your coverage: Coverage starts on the 1st day of the month coinciding with or next following the date you have satisfied the Waiting Period.

If you are required to contribute toward the cost of your coverage: Coverage starts on the later of the date you have:

- Applied for coverage and authorized the required payroll deduction for the cost of your coverage;
- Submitted satisfactory Evidence of Insurability which we have approved; and
- Satisfied the Waiting Period.

If you apply for coverage more than 31 days after the date you are first eligible to apply, satisfactory Evidence of Insurability will be required before your coverage will become effective.

WHEN IS EVIDENCE OF INSURABILITY REQUIRED?
You will need to provide Evidence of Insurability to us with your application if you:

- Apply for coverage more than 31 days after the date you are first eligible to apply or if required during an Enrollment Period; or
- Voluntarily terminate your coverage and want to reapply for coverage.

You must apply for coverage in writing through the Employer and use an application form that is satisfactory to us. Coverage for amounts of insurance subject to such Evidence of Insurability will become effective on the 1st day of the month coinciding with or next following the date we approve your Evidence of Insurability.

WHEN CAN YOUR COVERAGE UNDER THIS PLAN CHANGE?
For changes in the Plan, your Pre-disability Earnings, or your class - Coverage changes become effective on the later of:

- The date of the change; or
- The first of the month coinciding with or next following the date we approve your Evidence of Insurability, if you are required to provide it.

Increases in coverage due to changes in the Plan or your class are also subject to the terms of the Active Employment and Pre-existing Conditions provisions. Increases in coverage due to changes in your Pre-disability Earnings are subject to the terms of the Active Employment provision.

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT ON THE DATE YOUR COVERAGE WOULD BE EFFECTIVE?
If you are not in Active Employment as a result of your Sickness or Injury, then your coverage will be effective on the date you return to Active Employment. This applies to your initial coverage, as well as any increases or additions to coverage occurring after your initial coverage is effective.

WHEN DOES YOUR COVERAGE UNDER THIS PLAN END?
Your coverage under this Plan will end on the earliest of the following:

- The date the Policy or Plan terminates;
- The date you are no longer in an Eligible Class;
- The date your class is no longer eligible for coverage;
- The last day for which premium for your coverage has been paid;
- The date you cease Active Employment due to a labor dispute, including but not limited to strike, work slowdown, or lockout; or
- The date you cease Active Employment with the Employer, unless you are Disabled or on a Layoff or Leave of Absence;
- The first day of the month coinciding with or next following the date you enter military service (not including Reserve or National Guard).

We will provide coverage for a payable Disability claim that occurs while you are covered under the Plan.

WILL YOUR COVERAGE CONTINUE IF YOU ARE ON A LAY-OFF OR LEAVE OF ABSENCE?
Your Employer may continue your coverage if you are on a Layoff or Leave of Absence. Your coverage may continue through the end of the month following the month in which your Layoff or Leave of Absence begins. The cost of your coverage must be paid during the Layoff or Leave of Absence period. If you return to Active Employment at the end of the Layoff or Leave of Absence, your coverage will continue under the Policy. If you do not return to Active Employment at the end of the Layoff or Leave of Absence, your coverage will end in accordance with WHEN DOES YOUR COVERAGE UNDER THIS PLAN END? provision.

WHAT IF YOU ARE REHIRED BY THE EMPLOYER WITHIN THE SAME PLAN YEAR DURING WHICH YOUR EMPLOYMENT TERMINATED?
If you are rehired by the Employer within the same Plan Year that your employment terminated, then:

- You will be insured for the same benefits and class of coverage that were in effect for you on the date your employment terminated; and
- You may not change the plan of benefits or class of coverage during the rest of the Plan Year.

WHAT HAPPENS TO YOUR COVERAGE IF YOU ARE ON A FAMILY OR MEDICAL LEAVE OF ABSENCE?
If you are on a Family or Medical Leave of Absence, your coverage will be governed by the Employer's Human Resource policy on Family or Medical Leaves of Absence.

We will continue your coverage if the following conditions are met:

- Premiums for the cost of your continued coverage are paid; and
- Your leave is approved in advance and in writing by the Employer.

Your coverage will continue for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993, and any amendments; or
- The leave period required by applicable state law.

While you are on an approved Family or Medical Leave of Absence, we will use earnings from your Regular Occupation you were performing just prior to the date your Leave of Absence started to determine our payments to you.

If you return to Active Employment at the end of the approved Family or Medical Leave of Absence, your coverage will continue under the Policy. If you do not return to Active Employment at the end of the Family or Medical Leave of Absence, your coverage will end in accordance with WHEN DOES YOUR COVERAGE UNDER THIS PLAN END? provision.

If your coverage does not continue during a Family or Medical Leave of Absence, then when you return to Active Employment:

- You will not have to meet a new Waiting Period, including a Waiting Period for coverage of a Pre-existing Condition; and
- You will not have to give us Evidence of Insurability to reinstate the coverage you had in effect before your leave began.

WHAT HAPPENS TO YOUR COVERAGE IF YOU ARE ON A MILITARY SERVICES LEAVE OF ABSENCE?
We will allow your coverage to continue, for up to 4 weeks in a 12 month period, if you enter the military service of the United States. While you are on a Military Services Leave of Absence, the premium must be paid according to the terms specified in the Policy to keep the insurance in force. Changes such as revisions to coverage because of age, class, or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective for you until you have returned to work from Military Services Leave of Absence for one full day.

All other terms and conditions of the Policy will remain in force during this continuation period. Your continued coverage will cease on the earliest of the following dates:

- The date the Policy terminates; or
- The date ending the last period for which any required premium was paid; or
- 4 weeks from the date your continued coverage began.

The Plan, however, does not cover any loss which occurs while on active duty in the military service if such loss is caused by or arises out of such military service, including but not limited to war or act of war (whether declared or undeclared). Benefits are also subject to any other exclusions listed in the WHEN WILL WE NOT COVER A DISABILITY? provisions in Section 4.

If you return to Active Employment at the end of the Military Services Leave of Absence, your coverage will continue under the Policy. If you do not return to Active Employment at the end of the Military Services Leave of Absence, your coverage will end in accordance with WHEN DOES YOUR COVERAGE UNDER THIS PLAN END? provision.

SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS

WHAT DOES DISABILITY MEAN?

Disability or Disabled means our determination that your Sickness or Injury:

- Prevents you from performing with reasonable continuity one or more of the Material and Substantial Duties of your Own Job; and
- As a result, the income you are able to earn is less than or equal to 80% of your Pre-disability Earnings.

Related Rules:
We will not consider you Disabled from work in an occupation because of a reduction in your earnings if such reduction results from a change in economic conditions or other factors not directly related to your Sickness or Injury. Examples of factors that we will not consider in determining whether you are Disabled include, but are not limited to, recession, job obsolescence, job restructuring or elimination, pay cuts, and job sharing.

We will not consider you Disabled from work in an occupation solely because of:

- Your Employer's work schedule that is inconsistent with the normal work schedule of your Regular Occupation;
- Issues in your relationship with your Employer or other employees of the Employer; or

- The physical relationship of your Employer's workplace that is inconsistent with the normal physical environment of your Regular Occupation.

We will not be consider you Disabled from work in an occupation solely because of the loss, suspension, restriction, surrender, or failure to maintain a required state or federal license to engage in the occupation.

We will not consider you Disabled from work in an occupation solely because of your inability to work more than 40 hours per week in the occupation, even if you were regularly required to work more than 40 hours per week prior to becoming Disabled.

Your Disability must begin while you are covered under the Plan. Your loss of earnings must be as a result of or due to the same Sickness or Injury for which you are Disabled.

DOES YOUR DISABILITY NEED TO CONTINUE FOR A PERIOD OF TIME BEFORE OUR PAYMENTS TO YOU BEGIN?
Your Disability must continue through the Elimination Period before STD Benefits become payable.

WHAT HAPPENS IF YOU RETURN TO WORK DURING THE ELIMINATION PERIOD?
We will consider your Disability continuous if you have one or more periods of Temporary Recovery during the Elimination Period for a maximum of 14 days and become Disabled again due to the same Sickness or Injury.

DO YOU NEED TO BE UNDER THE CARE OF A DOCTOR?
We require you to be under the Regular Care of a Doctor for the Sickness or Injury causing your Disability in order to be eligible to receive payments from us.

MAY WE REQUIRE THAT INDIVIDUALS OTHER THAN THE DOCTOR PROVIDING YOUR REGULAR CARE EXAMINE OR INTERVIEW YOU?
We may require you to be examined by Doctor(s), other medical practitioner(s) or vocational expert(s) of our choice. Such examinations may include vocational testing and evaluations, or any other type of testing and evaluations we determine necessary to administer the terms and conditions of the Plan. We will pay for this examination. We can require an examination as often as it is reasonable to do so. In addition, we may require an interview with you by one of our authorized representatives.

WHEN WILL WE NOT COVER A DISABILITY?
We will not cover a Disability if it is due to:

- War, declared or not, or any act of war;
- Intentionally self-inflicted injuries or illness, while sane or insane;
- Your active participation in a riot;
- Your attempt to commit or your commission of a felony under federal or state law, or your being engaged in an illegal occupation or activity;
- An Injury arising out of, or in the course of, any work for wage or profit;
- A Sickness for which you are entitled to benefits under any Workers' Compensation law, unless you are a partner or sole proprietor not covered by this law;
- Active duty in the armed forces, military reserves or National Guard of any country or international authority, or in a civilian unit serving with such forces;
- Cosmetic or reconstructive surgery, except for complications arising from any such surgery, reconstructive surgery arising from congenital disease or anomaly resulting in a functional defect, or surgery necessary to correct a deformity caused by Sickness or Injury or arising from trauma, infection or other diseases of the involved part;
- An accident resulting from or caused by your operation of a motor vehicle while legally intoxicated according to the laws of the jurisdiction where the accident occurred; or
- An accident resulting from or caused by your voluntarily being under the influence of narcotics or any controlled substance, subject to the applicable laws in the state where the policy is issued for delivery, unless taken as prescribed by your Doctor.

No benefits are payable for any period of Disability during which you are legally incarcerated in a penal or correctional facility for a period of 30 or more consecutive days or for which you are not under the Regular Care of a Doctor.

If your professional or occupational license or your certification is suspended, revoked or surrendered, loss of your license or certification, by itself, does not mean you are Disabled.

HOW DO I CALCULATE MY STD BENEFIT?
Your STD Benefit will be equal to your NetGross Weekly Benefit, as determined below:

Step 1: Multiply your Pre-disability Earnings by the Benefit Percentage, with the result not to exceed the Maximum Weekly Benefit. This is your Gross Weekly Benefit.

Step 2: Subtract from your Gross Weekly Benefit your Other Income Amounts. This is the Net Weekly Benefit , but will not be less than the Minimum Weekly Benefit.

TOTAL DISABILITY BENEFIT: If you are working while Disabled and earning less than 20% of your Pre-disability Earnings, then the Other Income Amounts that we use to reduce your benefit will not include any of your Work Earnings.

WORK INCENTIVE BENEFIT: If you are working while Disabled and earning 20% or more of your Pre-disability Earnings, then the Other Income Amounts that we use to reduce your benefit will include Work Earnings only if your Gross Weekly Benefit and your Work Earnings exceed 100% of your Pre-disability Earnings.

WHAT IF YOUR WORK EARNINGS FLUCTUATE?
If your Work Earnings fluctuate, we may average amounts over a four (4) consecutive week period of time.

WHAT IF YOU ARE DISABLED FOR ONLY PART OF A WEEK?
Your weekly benefit from us is pro-rated. This means that if you are Disabled for only part of a week, you will receive a payment equal to 1/7th of a full weekly benefit for each day of the week you are Disabled.

WHAT ARE OTHER INCOME AMOUNTS?
These are weekly amounts, other than payments you are receiving from us, that include:

- Any benefits and awards, other than medical or death benefits, you receive or are eligible to receive under:
  - Workers' Compensation law;
  - Occupational disease or injury law; or
  - Any other similar federal or state act or law.

- Any disability income benefits you receive or are eligible to receive under:
  - Any governmental compulsory benefit act or law;
  - Any other group insurance plan with the Employer or with an association to the extent that such plan covers the same pre-disability income;
  - Any other group insurance plan with another employer, which you become insured under while you are Disabled under this Plan; or
  - Any governmental retirement system as a result of your job with the Employer.

- Any benefits under the United States Social Security Act, The Canada Pension Plan, The Quebec Pension Plan and includes any similar plan or act. Benefits include:
  - Disability benefits you, your Spouse, or your Children receive or are eligible to receive as a result of your Disability; or
  - Retirement benefits you, your Spouse or your Children receive because of your receipt of retirement benefits.

  If your Disability begins after your 70th birthday, and you were receiving Social Security retirement benefits before your Disability began, then we will not reduce our payments to you by these retirement benefits.

- Any payments you receive from the Employer as part of a termination or severance agreement.

- Any benefits you receive from the Employer's sick leave or formal salary continuation plan.

- Any benefits you receive from the Employer's Personal Time Off (PTO) plan which, when added to the amount of your Gross Weekly Benefit, exceeds 100% of your Pre-disability Earnings.

- Any Work Earnings.

- Any benefits from the Employer's Retirement Plan you:
  - Receive as disability benefits;
  - Voluntarily choose to receive as retirement benefits; or
  - Receive as retirement benefits once you reach the greater of age 62 or normal retirement age (as defined in the Employer's Retirement Plan).

- Any benefits for loss of time or lost wages you receive from an automobile liability insurance policy or the mandatory portion of a no-fault motor vehicle insurance plan.

- Any amounts you receive under any unemployment compensation law.

- Any amounts related to lost income you receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise for a Disability caused or contributed to by an act or omission of the third party.

  If the amount received from a third party does not specify the amount due to lost income, we will estimate the amount using a percentage of the amount received based on your Pre-disability Earnings, prorated to cover the period for which the judgment or settlement was made.

If you receive any of the Other Income Amounts in a lump sum payment, we will pro-rate the lump sum on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis according to its nature and purpose, but not beyond the end of your Maximum Payment Duration.

Other Income Amounts must be payable as a result of the same period of Disability as the one for which you are receiving a payment from us, except for retirement benefits and Work Earnings.

WHAT IF SUBTRACTING OTHER INCOME AMOUNTS RESULTS IN A ZERO PAYMENT TO YOU?
We will pay you a Minimum Weekly Benefit under this Plan, subject to any overpayments.

DO WE HAVE THE RIGHT TO ESTIMATE OTHER INCOME AMOUNTS?
We have the right to estimate the amount of disability benefits you may be eligible to receive under the first three bulleted items in the WHAT ARE OTHER INCOME AMOUNTS? provision. We can reduce our payments to you by this estimated amount if:

- You have not been awarded such benefits but have not been denied such benefits; or
- You have been denied such benefits and the denial is being appealed; or
- You are reapplying for such benefits.

We will not reduce our payments to you by these estimated amounts if:

- You apply (or reapply) for benefits and appeal your denial through all of the administrative levels we believe are necessary; and
- You sign our payment option form stating you will reimburse us any overpayment of benefits caused by an award.

If we reduce our payments to you by an estimated amount:

- Then we will adjust our payments to you when you give us proof of the amount awarded; or
- We will give you a lump sum refund of the estimated amount if you were denied benefits and have completed all appeals (or reapplications) we believe are necessary.

ARE YOU REQUIRED TO APPLY FOR OTHER INCOME AMOUNTS?

We will require you to apply for any Other Income Amounts that you may be eligible for as a result of the same period of Disability as the one you are claiming benefits for under this Plan. We may also require that you appeal a denial of your claim for these Other Income Amounts.

ARE YOU REQUIRED TO APPLY FOR SOCIAL SECURITY DISABILITY BENEFITS?
We will require you to apply for Disability benefits that may be available to you under the Social Security Act. If we disagree with the Social Security Administration's denial of your application, you will be required to follow the process set up by that agency to reconsider denials, and to continue in that process to the highest level of appeals. If denied again, you will be required to request a hearing. We will provide you with assistance in preparing for this hearing.

WHAT ARE NOT OTHER INCOME AMOUNTS?
We will not subtract from our payments to you any amounts you receive from the following:

- 401(k) plans;
- Profit sharing plans;
- Thrift plans;
- Tax sheltered annuities;
- Stock ownership plans;
- Credit disability insurance;
- Non-qualified plans of deferred compensation;
- Pension plans for partners;
- Military pension and military disability income plans;
- Disability benefits from the Veteran's Administration;
- A Retirement Plan from another employer;
- Individual retirement accounts (IRA);
- Informal salary continuation plan;
- Benefits from individual disability plans.

WHAT HAPPENS IF YOU RECEIVE A COST OF LIVING INCREASE TO ANY OF THE OTHER INCOME AMOUNTS?
Other than for increases in Work Earnings, once we have subtracted an Other Income Amount from your Gross STD Benefit, we will not reduce our payments to you due to a cost of living increase in that Other Income Amount.

WHEN WILL OUR PAYMENTS TO YOU STOP?
We will stop STD Benefit payments on the earliest of the following dates:

- The date you are no longer Disabled according to this Plan;
- The date you reach the end of the Maximum Payment Duration;
- The date your Work Earnings exceed 80% of your Pre-disability Earnings. If your Work Earnings fluctuate, we may average amounts over a four (4) consecutive week period of time instead of stopping our payments on the date your Work Earnings reach the earnings limit;
- The date you die;
- The date you fail to provide proof of continuing Disability;
- The date you cease to be under the Regular Care of a Doctor, or refuse to undergo, at our expense, an examination or testing by a Doctor or vocational, rehabilitation, or health assessment testing when we require such examination or testing;
- The date you refuse to receive medical treatment, including taking prescribed medicines, that your Doctor has recommended and that is generally acknowledged by Doctors to cure or improve the Sickness or Injury for which you are claiming benefits under the Plan so as to reduce its disabling effect;
- The date you refuse to make a good faith effort to adhere to necessary Wellness Programs, provided at our expense, that your Doctor has recommended and that are generally acknowledged by Doctors to cure or improve the Sickness or Injury for which you are claiming benefits under the Plan. We will work with your treating Doctor to determine the necessary Wellness Programs, if any, in accordance with generally accepted medical standards.
  Nonparticipation in a Wellness Program does not affect our determination of your Disability; however, failure to participate in a Wellness Program without Good Cause may result in the

termination of your benefit payments. We will give you 30 days prior written notice of our intent to apply this provision to terminate your benefits. During those 30 days you will have an opportunity to begin or resume reasonable efforts to adhere to the medically necessary Wellness Programs. We will not terminate your benefits if there is no reasonable basis for believing that you will be able to return to productive employment in your Regular Occupation or another Gainful Occupation on a full-time or part-time basis if you adhere to the recommended Wellness Programs.

- The date you refuse to try or attempt to work with the assistance of:
  - Modifications made to your work environment, functional job elements or work schedule; or
  - Adaptive equipment or devices;

  That a qualified Doctor has indicated will accommodate the limiting factors of the Sickness or Injury for which you are claiming benefits under the Plan and will enable you to perform the Material and Substantial Duties of an occupation from which you must be considered Disabled in order to receive STD Benefits under the Plan;
- If you reside outside the United States or Canada. We will consider you residing outside of these countries if you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of STD Benefits under the Plan.

WHAT HAPPENS IF YOU HAVE A TEMPORARY RECOVERY BUT YOU BECOME DISABLED AGAIN DUE TO THE SAME SICKNESS OR INJURY AS A PRIOR DISABILITY?

If you return to work and are no longer Disabled, and the same Sickness or Injury causes your Disability to occur again within 14 days of the date the prior Disability ended, we will resume our payments to you if you were continuously insured under the Plan for the period of your Temporary Recovery. You will not need to complete a new Elimination Period for this Disability.

Your current period of Disability will be subject to the same terms of the Plan that applied to your prior period of Disability.

If you become entitled to payments under any other group Short Term disability plan (including a plan with the Employer that became effective after your Disability began), you will not be eligible for payments under this Plan.

We will treat a Disability due to other causes as a new Disability, subject to all of the provisions of this Plan.

WHAT IF THE EMPLOYER CHANGES INSURANCE PLANS AND YOU ARE NOT IN ACTIVE EMPLOYMENT DUE TO SICKNESS OR INJURY ON THE EFFECTIVE DATE OF THIS PLAN?

Continuity of Coverage

We will cover you under this Plan if you were insured by the Prior Group STD Plan and the cost of your coverage under the Prior Group STD Plan was paid. However, the payments to you for a period of Disability that begins while you are insured under this Plan but before you satisfy the Active Employment requirement will be limited to the weekly amount the Prior Group STD Plan would have paid you had that plan stayed in effect. Our payments will be reduced by any amount the Prior Group STD Plan is responsible for paying.

Prior Group STD Plan means the group short term disability plan in effect with the Employer just before the effective date of this STD Plan.

SECTION 5: CLAIM INFORMATION

WHEN DO YOU NOTIFY US OF A CLAIM?

You need to notify us in writing of your claim within 30 days after the date your Disability begins. If you are not able to notify us within this time, then you need to notify us as soon as reasonably possible. Notice includes a notice you give, or which is given on your behalf, to us at our home office or to an authorized agent of ours.

WHEN DO YOU NEED TO GIVE US PROOF OF YOUR CLAIM?
Early proof of claim will allow us to make a timely claim decision. You need to send to our home office written proof (or telephonic or electronic proof, if we have agreed to accept such forms)] of your claim within the first 90 days after the Elimination Period ends. If you are unable to give us proof of your claim within this time, then you must give us proof of your claim within the next 12 months. If you do not have the legal capacity to make responsible decisions concerning yourself, then you may give us proof of your claim after this period.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE A CLAIM?
Within 15 days after we receive your notice of claim, we will send you a claim form, or you may get one from the Employer. If we do not give you a claim form within 15 days after giving notice of loss, then you should send written proof (or telephonic or electronic proof, if we have agreed to accept such forms)] of your claim to us, including the occurrence, character and extent of the loss for which the claim is made, without waiting for the form.

You and the Employer must fill out your claim form. Once you and the Employer have completed the claim form, give the claim form to the Doctor providing you Regular Care for the Sickness or Injury causing your Disability. The Doctor must fill out the physician section of the form. Please send the completed form to us or, if we have agreed to accept proof of your claim in a telephonic or electronic format, you may start the process by contacting us at 800-894-4532 within the time frames stated above].

WHAT AUTHORITY DO WE HAVE IN DETERMINING YOUR ELIGIBILITY FOR BENEFITS?
We have the authority to determine your eligibility for benefits and to interpret the terms of the Plan for the purpose of making benefit determinations.

WHAT INFORMATION DO YOU NEED TO INCLUDE IN YOUR PROOF OF CLAIM?
Your proof of claim must include:

- That you are under the Regular Care of a Doctor;
- The date your Disability began;
- The cause of your Disability as determined by objective medical tests and examinations acceptable to the medical community;
- The extent of your Disability, including restrictions and limitations;
- The name and address of all pharmacies, Hospital(s) or Institution(s) where you received Treatment, including all Doctors who prescribed medications or provided Regular Care;
- Documentation of your Pre-disability Earnings as well as earnings, income or benefits of any kind that you may be receiving while also receiving disability benefits under the Plan;
- Documentation that you have applied for all Other Income Amounts that you may be eligible for as a result of the same period of Disability for which you are claiming disability benefits under the Plan; and
- Tax returns, including all associated schedules and worksheets, and accountant's statements.

We may request that you send proof of continuing Disability and that you are under the Regular Care of a Doctor. We must receive this proof within 60 days of the date we ask for it. In some cases, we will require you to give us authorization to obtain additional medical and non-medical information as part of your proof of claim. We may temporarily suspend our payments to you if you do not cooperate or do not submit the appropriate information.

WHEN WILL YOU BEGIN TO RECEIVE YOUR BENEFIT PAYMENTS?
Once we approve your claim, you will begin to receive payments after you complete the Elimination Period. We will send you a payment not less frequently than monthly for any period for which we are liable.
If the claim is paid more than 30 days after the date we have approved your claim, the payment will be subject to simple interest at the rate of 10% per year beginning on the 31st day after we have approved the claim and ending on the day the claim is paid. We will send you a benefit payment for any period for which we are liable under the Plan. If the Policy or Plan is canceled, the cancellation will not affect a payable claim.

WHO DO WE MAKE BENEFIT PAYMENTS TO?

Unless otherwise specified in the Policy or Certificate, we will make all benefit payments to you, if living. Benefit payments that become due or if any amount for which we are liable remains unpaid after your death will be made to your estate. If there are legal impediments to payment of benefits that depend on the actions of parties other than us, we may hold further benefits due until such impediments are resolved and sufficient evidence of the same is provided. Legal impediments to payment may include, but are not limited to, the establishment of guardianships and conservatorships, or the appointment and qualification of trustees, executors and administrators, as applicable.

WHAT HAPPENS IF WE OVERPAY YOUR CLAIM?

We have the right to recover overpayments that occur due to:

- Fraud;
- An error we make in processing your claim; or
- Your receipt of Other Income Amounts for periods during which you received unreduced disability benefits under the Plan.

If we determine that we should have paid you a different benefit amount from the amount actually paid on your claim, we will adjust the benefit accordingly. If we determine that we overpaid your claim, then we require that you repay us in full. We will determine the method by which you will repay us. We reserve the right to apply our future payments that are determined to be due to you, including any applicable minimum benefits, toward any outstanding overpayment balances, until we are reimbursed in full. We have the right to recover overpayments from your eligible survivors or estate. We reserve the right to deduct from your claim payment any unpaid premium due for your coverage. We will not recover more money from you than the benefit amounts we paid to you. If the overpayment is due to your receipt of amounts from a third party by judgment, settlement or otherwise for a Disability caused or contributed to by an act or omission of the third party, you are obligated to repay us for the overpayment in full regardless of whether you have been fully compensated for your injuries.

WHAT IS THE PROCESS FOR NOTIFYING YOU OF OUR CLAIM DECISIONS?

We will send you written notice of our claim decision within 45 days after we receive due proof of your loss. If there are special circumstances that require more time, we will send you a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, we will send you written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days.

If we request additional information, you will have 45 days to respond to our request, and we will send written notice of our claim decision within 30 days after we receive your response.

If the claim is wholly or partly denied, our notice will include:

- Reasons for such denial;
- Reference to specific Plan provisions, rules or guidelines on which the denial was based;
- A description of the additional information needed to support your claim;
- Information concerning your right to request that we review our decision; and
- A description of our review procedures, and time limits, and notice to you of your right to bring a civil action.

DO YOU HAVE THE RIGHT TO REQUEST A REVIEW OF A DENIED CLAIM?

You may request us to review our denial of all or part of your claim. This request must be in writing and must be received by us no more than 180 days after you receive notice of our claim decision. As part of this review, you may:

- Send us written comments;
- Review any non-privileged information relating to your claim, upon request and free of charge; and
- Provide us with other information or proof in support of your claim.

We will review your claim promptly after receiving your request. We will advise you of the results of our review within 45 days after we receive your request, or within 90 days if there are special circumstances that

require more time. Our decision will be in writing and will include reference to specific Plan provisions, rules or guidelines on which the decision was based, and notice of your right to bring a civil action.

SECTION 6: ADDITIONS TO YOUR PLAN

All the defined terms, conditions, limitations and exclusions applicable to payment of disability benefits under the Plan also apply to the provisions appearing in Section 6, unless otherwise noted within the provisions.

STD REHABILITATION BENEFIT

HOW CAN OUR REHABILITATION BENEFIT ASSIST YOU?
If you are Disabled and receiving an STD Benefit from us, you may be eligible for our STD Rehabilitation Program services and incentives. The services offered by the Rehabilitation Program are available to assist you to return to work. They may include vocational testing, resume writing assistance, evaluation of job modifications or accommodations, job placement, or other services we find reasonably needed to assist you in returning to Active Employment either full-time or part-time.

A Rehabilitation Program proposal may be made by us, your Doctor or yourself. We will determine the extent to which Rehabilitation Program services may be provided. We will prepare a written program with input from you, your Doctor, your current Employer and/or your prospective Employer. Once we approve a program, you will be provided services according to the written program. We will pay for Rehabilitation Program services with the service provider(s), unless you and we agree to other arrangements.

The written Rehabilitation Program will describe:
- The goals of the program;
- What our responsibilities are;
- What your responsibilities are;
- What responsibilities are of any third party(ies) associated with this program;
- The expected dates of the services;
- The expected costs of the services; and
- The expected duration of the program.

We reserve the right to make the final decision concerning your eligibility to take part in a Rehabilitation Program and the type or amount of services you will be provided.
Nonparticipation in a Rehabilitation Program does not affect our determination of whether you are Disabled.

While we strongly encourage you to take advantage of the services provided by a Rehabilitation Program, participation in this program is strictly voluntary on your part. If you decline to actively participate in a rehabilitative program that we have approved, then you will not be eligible for any additional benefits that require participation in a Rehabilitation Program.

WILL I BE ELIGIBLE FOR ADDITIONAL BENEFITS IF I AM WORKING AS PART OF AN APPROVED STD REHABILITATION PROGRAM?
Yes. We will pay an additional STD Rehabilitation Program Benefit equal to 5% of your Gross Weekly Benefit, not to exceed a maximum of $100 per week, if you meet all of the following:
- You are Disabled;
- You are receiving an STD Benefit from us; and
- You are working as part of an approved Rehabilitation Program.

STD Rehabilitation Program Benefits are payable while you are participating in the approved Rehabilitation Program. STD Rehabilitation Program Benefits are payable in addition to your benefit for Disability and are not subject to any STD Plan provisions which would otherwise increase or reduce your weekly STD Benefit.

SECTION 7: DEFINITIONS

The following terms are used throughout the Certificate. Defined terms are capitalized throughout the Certificate. Other terms are defined in the PLAN HIGHLIGHTS section.

Active Employment means you are:

- Working for your Employer at their work site for earnings the Employer pays on a regular basis; and
- Performing the Material and Substantial Duties of your Regular Occupation.
  Active Employment includes normal non-work days such as vacation, weekends and holidays if you were working for your Employer at their work site for earnings the Employer pays on a regular basis on the last normal work day prior to a period of normal non-work days.

Your work site must be:

- The Employer's usual place of business;
- An alternative location if directed by the Employer; or
- A location to which your occupation requires you to travel.

Child or Children includes any of your children of a civil union, domestic partnership, marriage or other family or domestic relationship where required by law of the state where the Policy is issued.

Covered Pre-disability Earnings means the maximum amount of your Pre-disability Earnings for which you are insured under this Plan. This does not include amounts of your Pre-disability Earnings in excess of the amount calculated by dividing the Maximum Benefit by the Benefit Percentage.

Doctor means a person regularly performing tasks that are within the limits of the person's medical license, and:

- Who is licensed to practice medicine and prescribe and administer drugs or to perform surgery;
- With a Doctoral degree in Psychology (Ph.D. or Psy.D.) and whose primary practice is treating patients; or
- Who is a legally qualified medical practitioner according to the laws and regulations of the jurisdiction in which Regular Care is being given.

We will not recognize you, your Spouse, Children, parents, or siblings, or anyone who shares a significant business interest with you, as a Doctor for a claim you submit.

Elimination Period means a period of continuous days of Disability before benefits become payable. The Elimination Period begins on the first day of your Disability. Your Elimination Period appears in the PLAN HIGHLIGHTS.

Employee means a person who is a citizen or legal resident of the United States or Canada or Mexico in Active Employment with the Employer unless we advise you otherwise. This Plan excludes temporary and seasonal workers from coverage.

Employer means an individual, company, or corporation where you are in Active Employment, and includes any division, subsidiary, or affiliated company named in the Policy.

Evidence of Insurability means a statement of your medical history, which is provided at our expense and which we will use to assess if you will be approved for coverage.

Family or Medical Leave of Absence means a leave of absence for:

- The birth, adoption or foster care of a Child;
- The care of your Child, Spouse or parent who has a serious health condition; or
- Your own serious health condition;

As those terms are defined by the federal Family and Medical Leave Act of 1993 and any amendments, or by applicable state law.

Gainful Occupation means any occupation that your past training, education, or experience would allow you to perform or for which you can be trained.

Good Cause means we have made the determination that you are unable to perform such employment or responsibilities of the Rehabilitation or Wellness Program based on the medical opinions of a physician or qualified rehabilitation specialist approved by us. While we will consider the opinion of your Doctor in this decision, we reserve the right to make the final determination. In the case of conflicting opinions, an adverse determination would be subject to the provisions set out in the DO YOU HAVE THE RIGHT TO REQUEST A REVIEW OF A DENIED CLAIM? part of Section 5.

Gross Weekly Benefit means your weekly benefit amount before we subtract your weekly Other Income Amounts, including your weekly Work Earnings, subject to the Plan's Maximum Weekly Benefit .

Hospital or Institution means an accredited facility licensed to provide care and treatment for the condition causing you to be Disabled. The facility must be supervised by one or more physicians and operated under state and local laws. The facility must have 24-hour nursing services by registered graduate nurses and cannot be a rest home, convalescent home, home for the aged, or a facility primarily for custodial, educational, or rehabilitative care.

Injury means a bodily injury that occurs while you are insured and is the direct result of an accident and not related to any other cause. It does not include risk of Injury.

Layoff or Leave of Absence means the Employer has agreed in writing and in advance to a temporary absence from Active Employment for a specified period of time. Your normal vacation time or any period of Disability is not considered a temporary Layoff or Leave of Absence.

Material and Substantial Duties means duties that:

- Are normally required for the performance of the occupation; and
- Cannot be reasonably omitted or changed.

Maximum Payment Duration means the longest period of time for which STD Benefits are payable for any one continuous period of Disability, whether from one or more causes. Your STD Maximum Payment Duration is shown in the STD Coverage Highlights section of this Certificate. The STD Maximum Payment Duration begins at the end of the STD Elimination Period.

Net Weekly Benefit means the weekly payment amount after we subtract your weekly Other Income Amounts, including your weekly Work Earnings.

Occupational Sickness or Occupational Injury means a Sickness or Injury caused by or aggravated by any employment for pay or profit. This Plan does not cover an Occupational Sickness or Occupational Injury.

Own Job means the specific job you were regularly performing for the Employer immediately prior to the date you became Disabled, as evidenced by Employer documents including, but not limited to, a job description, performance reports, and/or management reports, and which was the source of your income from the Employer.

Plan means STD coverage under the Policy.

Plan Year means January 1st to December 31st.
Regular Care means:

- You personally visit a Doctor as often as is medically required to effectively manage and treat your disabling condition(s), according to generally accepted medical standards,but not if you remain Disabled after reaching your maximum point of recovery or if we determine it would be of no value to you; and
- You are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the Sickness or Injury causing your Disability must be given by a Doctor whose specialty or experience is appropriate.

Regular Occupation means the occupation, as it is performed nationally, that you are routinely performing when your Disability begins. Your Regular Occupation does not mean the job you are performing for a specific Employer or at a specific location.

Retirement Plan means a defined contribution plan or defined benefit plan, as defined in §402 of the Internal Revenue Code of 1986 and including future amendments to §402 affecting the definition. These are plans that provide retirement benefits to Employees and are not funded entirely by Employee contributions.

Disability benefits received from a Retirement Plan are benefits that are paid due to disability and which do not reduce the retirement benefit that would have been paid if the disability had not occurred.

Retirement benefits under a Retirement Plan are benefits that are paid based on the Employer's contribution to the Retirement Plan. Disability benefits that reduce the retirement benefit under the Retirement Plan will also be considered a retirement benefit.

Regardless of how the retirement funds from the Retirement Plan are distributed, for the purposes of figuring our payment to you, we consider Employee and Employer contributions to be distributed at the same time throughout your lifetime.

This Plan does not reduce payments you receive from us for your contributions to the Employer's Retirement Plan, or for amounts you rollover or transfer to an eligible Retirement Plan.

Sickness means an illness, disease, or complications of pregnancy. It also includes an Injury which occurs before you are insured. It does not include risk of Sickness.

Spouse means a person to whom you are legally married. It also includes any other person required to be covered as your Spouse under the civil union, domestic partnersip, marriage or other family relations laws, including case law, in the state where the Policy is issued.

STD Benefit means your weekly benefit payment, as calculated in the provision titled HOW DO I CALCULATE MY STD BENEFIT? in Section 4, SHORT TERM DISABILITY BENEFIT SPECIFICS.

Temporary Recovery means any time when we do not consider you to be Disabled. The days you are not Disabled will not count toward the Elimination Period.

Treatment means:

- Consulting with a Doctor;
- Receiving care or services from a Doctor or from other medical professionals a Doctor recommends you see;
- Taking prescribed medicines;
- Being prescribed medicines; or
- Receiving diagnostic measures.

Waiting Period is the number of days you must be in Active Employment in an Eligible Class before you may become covered under the Plan. Your Waiting Period appears in the PLAN HIGHLIGHTS.

Work Earnings means weekly income you earn or receive while Disabled from any form of employment. Work Earnings include earnings from your Rehabilitation Program, unless otherwise noted. We may require you to send us proof of your income. We will adjust our payments to you based on this information. As a part of the proof, we can require you to send us appropriate tax and financial records we believe we need to substantiate your income.

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TABLE OF CONTENTS

SUMMARY OF DENTAL PLAN BENEFITS 4
I. RENAISSANCE GROUP VISION PPO CERTIFICATE 10
II. DEFINITIONS 10
III. GENERAL ELIGIBILITY RULES 12
IV. BENEFITS 13
V. ACCESSING YOUR BENEFITS 14
VI. QUESTIONS AND ANSWERS 15
VII. COORDINATION OF BENEFITS 15
VIII. CLAIM DENIAL APPEALS 19
IX. TERMINATION OF COVERAGE 19
X. CONTINUATION OF COVERAGE 20
XI. GENERAL CONDITIONS 21

Important Cancellation Information – Please Read Section IX Entitled, “Termination of Coverage”

NOTE: This Group Vision Certificate should be read in conjunction with the Summary of Vision Plan Benefits that is provided with the Certificate. The Summary of Vision Plan Benefits lists the specific provisions of your group vision plan. Your group vision plan is a legal contract between the Policyholder and Renaissance Life & Health Insurance Company of America (“RLHICA”).

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company.

READ YOUR GROUP VISION CERTIFICATE CAREFULLY

IMPORTANT NOTICE

To obtain information or to make a complaint:

You may call Renaissance Life & Health Insurance Company of America's toll-free telephone number for information or to make a complaint at:

1-888-791-5995

You may also write to Renaissance Life & Health Insurance Company of America at:

Renaissance Life & Health
Insurance Company of America

P.O. Box 1596
Indianapolis, Indiana 46206-1596

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512)475-1771
Web :**http://www.tdi.texas.gov**
Email :**consumerprotection@tdi.texas.gov**

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact Renaissance Life & Health Insurance Company of America first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Renaissance Life & Health Insurance Company of America para informacion o para someter una queja al:

1-888-791-5995

Usted tambien puede escribir a Renaissance Life & Health Insurance Company of America:

Renaissance Life & Health Insurance Company of America

P.O. Box 1596
Indianapolis, Indiana 46206-1596

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512)475-1771
Web : **http://www.tdi.texas.gov**
Email :**consumerprotection@tdi.texas.gov**

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con Renaissance Life & Health Insurance Company of America primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Renaissance Life & Health Insurance Company of America
Summary of Vision Plan Benefits – Choice Plan
For MP0000356718 – ER Contrib Vision Plan 120 12-12-12

This Summary of Vision Plan Benefits should be read in conjunction with your Group Vision Certificate. Your Group Vision Certificate will provide you with additional information about your RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA (“RLHICA”) coverage, including information about exclusions and limitations.

Benefit Year - January 1 through December 31

Covered Services

RLHICA will provide vision care Benefits according to the Schedule listed below. This Summary lists the vision care Benefits to which Covered Persons of RLHICA are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. Administrative Services for the adjudication of claims and the payment of Benefits under this Plan will be provided by Vision Service Plan Insurance Company ("VSP"), using a VSP network of Providers. VSP is sometimes referred to as the claims administrator for this Plan. If Benefits are available for Out-of- Network Provider services, as indicated by the reimbursement provisions below, Benefits may be received from any licensed eye care provider whether an In-Network or Out-of-Network Provider. This Summary forms a part of the Certificate to which it is attached.

In-Network Providers are those Providers who have agreed to participate in the VSP Choice Network.

When Benefits are received from In-Network Providers, Benefits appearing in the Benefit column below are applicable subject to any applicable Copayments and other conditions, limitations and/or exclusions as stated below. When Benefits are received from Providers, the Covered Person is reimbursed for such Benefits according to the schedule in the Provider Benefit column below, less any applicable Copayment. The Covered Person pays the Provider the full fee at the time of service and submits an itemized bill to RLHICA’s claims administrator for reimbursement. Discounts do not apply for Benefits obtained from Out-of-Network Providers.

Copayment

Benefits received from In-Network Providers and Out-of-Network Providers require Copayments.

There shall be a Copayment of $10 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $10 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

Lens Options, if covered under this Certificate, may have a separate Copayment. Please refer to COVERED SERVICES AND MATERIALS, below.

BENEFITS – IN-NETWORK AND OUT-OF-NETWORK PROVIDERS

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
Eye Examination	Covered in full*	Up to $45.00*	Available once each calendar year**
Complete initial vision analysis: includes appropriate examination of visual functions and prescription of corrective eyewear where indicated. *Less any applicable Copayment. **Beginning with the first date of service.			

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
LENSES			Available once each calendar year**
Single Vision	Covered in full*	Up to $30.00*	
Lined Bifocal	Covered in full*	Up to $50.00*	
Lined Trifocal	Covered in full*	Up to $65.00*	
Lenticular	Covered in full*	Up to $100.00*	

Benefits for lenses are per complete set, not per lens.

*Less any applicable Copayment.
**Beginning with the first date of service.

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
Frames	Covered up to Plan Allowance*	Up to $70.00*	Available once each calendar year**

Benefits for lenses and frames include reimbursement for the following necessary professional services:

1. Prescribing and ordering proper lenses;
2. Assisting in frame selection;
3. Verifying accuracy of finished lenses;
4. Proper fitting and adjustments of frames;
5. Subsequent adjustments to frames to maintain comfort and efficiency;
6. Progress or follow-up work as necessary.

*Less any applicable Copayment.
**Beginning with the first date of service.

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
CONTACT LENSES			
Necessary			Available once each calendar year**
Professional Fees/ Materials	Covered in full*	Up to $210.00*	
Elective	Elective Contact Lens fitting and evaluation*** services are covered in full once each calendar year**, after a maximum $60.00 Copayment.		Available once each calendar year**
	Materials Up to $120.00	**Professional Fees/ Materials** Up to $105.00	

*Less any applicable Copayment.
**Beginning with the first date of service.

Necessary Contact Lenses are a Covered Services when specific benefit criteria are satisfied and when prescribed by Covered Person's Provider or Provider. Review and approval by RHLICA's claims administrator is not required for Covered Persons to be eligible for Necessary Contact Lenses.

Contact Lenses are provided in lieu of all other lens and frame benefits available herein.
When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again until the next calendar year.

COVERED SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT	FREQUENCY
LOW VISION			
Professional services for severe visual problems not correctable with regular lenses, including:			
Supplemental Testing (Includes evaluation, diagnosis and prescription of vision aids where indicated.)	Covered in full*	Up to $125.00	*
Supplemental Aids	75% of amount up to $1000.00*	75% of amount up to $1000.00*	*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years.

Low Vision benefits secured from Providers (if covered) are subject to the same time and Copayment provisions described above for Providers. The Covered Person should pay the Provider's full fee at the time of service. Covered Person will be reimbursed an amount not to exceed what would be paid to a Provider for the same services and/or materials.

THERE IS NO ASSURANCE THAT THE AMOUNT REIMBURSED WILL COVER 75% OF THE PROVIDER'S FULL FEE.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their Provider or by calling the Member Services Department at 1-800-877-7195.

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

NOT COVERED

There are no Benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (less than a ± .50 diopter power).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan that are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above stated allowances.
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where RLHICA or its claims administrator is required by law to pay.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.

BENEFITS – AFFILIATE PROVIDERS

GENERAL

Affiliate Providers are providers of Covered Services and materials who are not contracted as Providers but who have agreed to bill RLHICA's claims administrator directly for Covered Services provided pursuant to this Schedule. However, some Affiliate Providers may be unable to provide all Covered Services included in this Schedule. Covered Persons should discuss requested services with their Provider or contact the Member Services Department for details.

COPAYMENT

There shall be a Copayment of $10 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $10 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

Eye Examination	Covered in full*	Available once each calendar year**

Comprehensive examination of visual functions and prescription of corrective eyewear.

Spectacle Lenses

Single Vision, Lined Bifocal or Lined Trifocal	Covered in full*	Available once each calendar year**
Frames	Covered up to the Plan allowance*	Available once each calendar year**

CONTACT LENSES

Elective Contact Lenses (Materials Only)	Up to $120.00	Available once each calendar year**

The Elective Contact Lens fitting and evaluation services are covered in full once each calendar year, after a maximum $60.00 Copayment.

Necessary Contact Lenses	Up to $210.00*	Available once each calendar year**

Necessary Contact Lenses are a Covered Service when specific benefit criteria are satisfied and when prescribed by Covered Person's Provider. Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**Beginning with the first date of service.

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again until the next calendar year.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Up to $125.00-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of Affiliate Provider's fee up to $1000.00.

Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Covered Service when specific benefit criteria are satisfied and when prescribed by Covered Person's Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for Providers shall also apply to services rendered by Affiliate Providers.
2. Services from an Affiliate Provider are in lieu of services from a Provider or an Provider.
3. RLHICA's claims administrator is unable to require Affiliate Providers to adhere to its quality standards.
4. Where Affiliate Providers are located in membership retail environments, Covered Persons may be required to purchase a membership in such entities as a condition of obtaining Benefits.

Eligibility (Certificate Holder and Eligible Dependents) - All Full Time Eligible Employees of the Policyholder working at least 30 hours per week, retirees, members of an association or trust, and all individuals who are eligible for and elect Continuation Coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 or similar applicable state law. ("COBRA").

Also eligible are your Legal Spouse or Domestic Partner and your Children. Coverage for Children will terminate at the end of the calendar year of their 26th birthday.

Where two individuals are eligible under the same group and are legally married to each other, they will be enrolled under one application and will receive Benefits under a single Certificate without coordination of benefits under the RLHICA Policy.

Benefits will cease on the last day of the month in which your employment is terminated, subject to all applicable laws or regulations.

A Domestic Partner is defined as follows:

- each party is the sole Domestic Partner of the other;
- each party is at least 18 years of age or older and competent to enter into a contract in the state in which they reside;
- both parties currently share a common legal residence and have shared said residence for at least six months prior to application for Domestic Partner coverage;
- neither party is married to anyone or related to the other by adoption or blood to a degree of closeness that would otherwise bar marriage in the state in which they legally reside;
- both parties are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship in the indefinite future;
- both parties are jointly responsible for basic living expenses (basic living expenses are defined as the cost of basic food, shelter, and any other expenses of the common household - the partners need not contribute equally or jointly to the payment of these expenses as long as they agree that both are responsible for them); and
- neither party filed a Termination of Domestic Partnership within the preceding nine months.

I. RENAISSANCE GROUP VISION PPO CERTIFICATE

RLHICA issues this Renaissance Group Vision Certificate to you, the Certificate Holder. The Certificate is a summary of your vision benefits coverage. It reflects and is subject to the agreement between RLHICA and your employer or organization (the “Policyholder”).

The Benefits provided under This Plan may change if any state or federal laws change.

RLHICA agrees to provide Benefits as described in this Certificate.

All the provisions in the following pages, read in conjunction with the Summary of Vision Plan Benefits and all attachments and addendums, form a part of this document as fully as if they were stated over the signature below.

IN WITNESS WHEREOF, this Certificate is executed by an authorized officer of RLHICA.

Jeffrey Kolesar
Interim President and CEO

Home Office:

Renaissance Life & Health Insurance Company of America

Attn: Renaissance Administration
P.O. Box 1596
Indianapolis, IN 46206

Administrative Direct Line: **1-800-745-7509**
Customer Service Direct Line:
1-888-791-5995 (TTY users call 711)
Claim Service Direct Line: **1-800-877-7195**

II. DEFINITIONS

Additional Benefit Rider

Means a document, attached as a rider to this Certificate (when purchased by the Policyholder) which lists selected supplemental vision care services and vision care materials which a Covered Person is entitled to receive under this Certificate.

Adverse Benefit Determination

Means any denial, reduction or termination of the Benefits for which you filed a claim or a failure to provide or to make payment (in whole or in part) of the Benefits you sought, including any such determination based on eligibility, or a determination that the item or service for which Benefits are otherwise provided was not medically necessary or appropriate based on benefit criteria.

Assignments of Benefits

Means a written order signed by a Covered Person, eighteen (18) years of age or older, and included with each claim, directing RLHICA's claims administrator to pay available Benefits to a named Out-of-Network Provider.

Benefit Authorization

Means a process used to confirm eligibility of an individual named as a Covered Person and identifying those Benefits to which the Covered Person is entitled.

Benefit Year

Means the calendar year, unless your employer or organization elects the Policy Year to serve as the Benefit Year. The Benefit Year is specified in the Summary of Vision Plan Benefits Section.

Benefits

Means payment for Covered Services.

Certificate

Means this document. RLHICA will provide vision Benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the Policy. Changes to the Certificate may be set forth in the Summary of Vision Plan Benefits Section.

Certificate Holder

Means you, when your employer or organization certifies to RLHICA that you are eligible to receive Benefits under This Plan.

Children

Means your natural children, stepchildren, adopted children, foster children or children by virtue of legal guardianship during the waiting period for legal adoption or guardianship who are or meet one of the following:

- Your child(ren) who has not reached the end of the calendar year of their 25th birthday; or,
- You or your Legal Spouse's Child if, pursuant to a court decree or medical support order issued under Chapter 154 of the Texas Family Code (or enforceable by a court in the state of Texas), you or your Legal Spouse is financially responsible for the vision care of the Child; or
- You or your Legal Spouse's grandchild who is: (a) younger than 25 years of age; and (b) dependent on you or your Legal Spouse for federal income tax purposes at the time of application for coverage under this Policy (coverage cannot be terminated solely because the grandchild is no longer dependent on You or Your Legal Spouse for federal income tax purposes); or
- Your Child who has reached the end of the calendar year of his or her 25th birthday and is both (a) incapable of self-sustaining employment by reason of a mental retardation or physical disability and (b) chiefly dependent upon you for support and maintenance. In order to obtain coverage, you must notify RLHICA within 31 days of the date the Child reaches the Limiting Age. In the event that RLHICA denies a claim under this Policy for the reason that the child has attained the Limiting Age for dependent children, you have the burden of establishing that the Child continues to meet the two criteria specified above. If requested by RLHICA, you shall submit medical reports confirming that the Child meets the two criteria specified above. Such requests will not be made more frequently than annually.

Complaints and Grievances

Means disagreements regarding access to care, quality of care or treatment and services to be covered hereunder.

Confidential Information

Means all confidential materials concerning the medical, personal, financial and business affairs of Covered Persons acquired by RLHICA in the course of providing the Benefits hereunder.

Copayment

Means the dollar amount you must pay toward vision services or materials which are not fully covered, and which are payable at the time services are rendered or materials are ordered.

Covered Person

Means a Certificate Holder or Eligible Dependent (if dependent coverage is selected), who meets the eligibility criteria and on whose behalf premiums have been paid to RLHICA, and who is covered under this Certificate.

Covered Services

Means the unique vision care services and vision care materials selected for coverage by your employer or organization under This Plan. The Summary of Vision Plan Benefits Section lists your Covered Services.

Eligible Dependent

Means (a) your Legal Spouse; (b) your Child(ren); and (c) any other dependents who meet the criteria for eligibility set forth in the Summary of Vision Plan Benefits Section. If dependent coverage has been selected, it will be indicated in the Summary of Vision Plan Benefits Section.

In-Network Provider

Means a Provider who has entered into a contract to be part of the vision care network and to provide Covered Services to Covered Persons. A current list of In-Network providers will be made available to Certificate Holders.

Legal Spouse

Means a person who is any of the following: (a) your spouse through a marriage legally recognized by the State in which the Policy governing this Certificate was issued; (b) your partner through a civil union legally recognized by the State in which the Policy governing this Certificate was issued; or (c) your Domestic Partner so long as the requirements listed in the Summary of Vision Plan Benefits Section are met and proof that those requirements are met is provided to RLHICA at its request.

Limiting Age

Means the age at which a Child of yours is no longer eligible for Benefits under This Plan pursuant to the definition of Child above.

Open Enrollment Period

Means the period of time during which an eligible person as indicated in the Summary of Vision Plan Benefits Section may enroll or be enrolled to receive Benefits.

Out-of-Network-Provider

Means a Provider who has not entered into a contract to be part of the vision care network to provide Covered Services to Covered Persons.

Policy

Means the insurance contract for the provision of Benefits to you and your Eligible Dependents between RLHICA and your employer or organization. Policy includes, if applicable, the application, this Certificate and any appendices, supplements, riders, successor agreements or renewals now or hereafter executed.

Policy Year

Means the 12 month period beginning on the Effective Date of the Policy and each 12 month renewal period thereafter.

Provider

Means an optometrist, optician or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials in the state or jurisdiction in which vision care services are rendered or vision care materials are provided.

RLHICA

Means Renaissance Life & Health Insurance Company of America.

Summary of Vision Plan Benefits

Means a list of the specific provisions of This Plan and is a part of this Certificate.

This Plan

Means the vision coverage as provided for you and your Eligible Dependents pursuant to this Certificate.

Urgent Condition

Means a condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate care; or an unforeseen occurrence calling for immediate action.

III. GENERAL ELIGIBILITY RULES

A. You are not eligible for Benefits unless you are either currently enrolled in This Plan or currently listed as an Eligible Dependent.

B. Effective Date of Eligibility

1. **Initial Effective Date**: All Certificate Holders and Eligible Dependents on the Effective Date of the Policy are immediately eligible for Benefits.

2. **After the initial Effective Date:** For all Certificate Holders (and their Eligible Dependents) not associated with the employer or organization on the initial Effective Date of the Policy, eligibility for Benefits will begin, unless otherwise stated as follows:

a. **Newly hired or rehired employees:** Date for which employment compensation begins, or, if applicable, that date plus the number of days specified as a waiting period in the Summary of Vision Plan Benefits Section;

b. **Spouse:** Date of marriage, civil union or domestic partnership;

c. **Newborn:** Child's actual date of birth;

d. **Child subject to a medical support order or court decree:** Date of Policyholder’s receipt (or notice of) the medical support order or court decree;

e. **Foster children or guardianships:** Date the Child is placed in the foster home or with the Certificate Holder; at which time this Child will be covered on the same basis as a natural child;

f. **Adopted Children:** Date of birth, adoption, placement for adoption, or filing of the suit to seek adoption;

g. **Grandchild:** Date the Child becomes dependent on you or your Legal Spouse for federal income tax purposes;

h. **Stepchild:** Date that the Child’s natural parent becomes an Eligible Dependent;

i. **All others:** Date that RLHICA approves in writing the enrollment

or listing of those people, unless compelled by a court or administrative order to otherwise provide Benefits for a Child or Eligible Dependent.

Once eligible, you and your Eligible Dependents must enroll for coverage within 31 days from the date upon which you or your Eligible Dependents become eligible for Benefits under the terms of Section III B immediately above. You and your Eligible Dependents may properly enroll for coverage by completing all enrollment forms required by RLHICA and submitting such forms to your employer or organization. If you and your Eligible Dependents are not properly enrolled for coverage within 31 days from the date upon which you and your Eligible Dependents become eligible for Benefits, then you and/or your Eligible Dependents must wait until the next Open Enrollment Period to enroll.

C. Termination of Eligibility

Eligibility for Benefits will terminate for you and your Eligible Dependents under This Plan at the earlier of:

1. The termination of the Policy; or

2. The last day of the month for which payment has been made if the employer or organization fails to make the payments required by their Policy.

Your eligibility, and that of your Eligible Dependents, will also terminate if you cease to be a Certificate Holder as defined in the Summary of Vision Plan Benefits Section. An Eligible Dependent's eligibility also terminates upon lack of compliance with the eligibility requirements of the Policy.

IV. BENEFITS

COVERED SERVICES

RLHICA agrees to provide Benefits to you and your Eligible Dependents (if dependent coverage is selected) under the policies and procedures of RLHICA and under the terms and conditions of this Certificate, including, but not limited to, the categories of services, exclusions and limitations listed in the Summary of Vision Plan Benefits Section.

Unless otherwise specified in the Summary of Vision Plan Benefits Section, Covered Services will be subject to the following terms and conditions:

A. General

This Certificate provides Benefits for you and your Eligible Dependents, if dependent coverage is selected by the Policyholder.

B. Copayments for Covered Services

Any Copayments required under this Policy shall be the personal responsibility of you and your Eligible Dependents who are receiving Benefits. Copayments are to be paid at the time services are rendered or materials ordered. Amounts which exceed the Certificate allowances, annual maximum benefits or any other stated limitations are not considered Copayments, but are also the responsibility of you and your Eligible Dependents.

C. Obtaining Covered Services from In-Network Providers

To receive Covered Services from a In-Network Provider, You should select a In-Network Provider, schedule an appointment and inform the Provider's office that you are a Covered Person under this Certificate. The In-Network Provider will then obtain a Benefit Authorization prior to the time services are rendered or materials ordered. RLHICA's claims administrator shall provide a Benefit Authorization to the In-Network Provider. Each Benefit Authorization will contain an expiration date and must be used by you or your Eligible Dependents to obtain Benefits prior to the date the Benefit Authorization expires. RLHICA's claims administrator shall issue Benefit Authorizations in accordance with the latest eligibility information furnished by Policyholder and the past service utilization of you or your Eligible Dependents, if any. Any Benefit Authorization so issued shall constitute a certification to the In-Network Provider that payment will be made to the In-Network Provider, irrespective of a later loss of eligibility of you or your Eligible Dependents, as long as the services are rendered or materials provided prior to the Benefit Authorization expiration date. If you or your Eligible Dependents receive Covered Services from a In-Network Provider without a Benefit Authorization, any services or materials received from

the In-Network Provider will be treated as if they were obtained from a Out-of-Network Provider. You or your Eligible Dependents may obtain information on In-Network Providers through our website: www.RenaissanceFamily.com, the Member Service's toll-free number 1-800-877-7195 (TTY users call 711) or by written request.

D. Obtaining Covered Services from Out-of-Network Providers

If required by state law, or if purchased by the Policyholder, this Policy will provide Benefits for services and materials received from Out-of-Network Providers, based on the Out-of-Network Provider fee schedule. The Out-of-Network Provider may bill you or your Eligible Dependents for that Provider's standard rates, regardless of the amount of this Policy's Benefits. If you or your Eligible Dependents are eligible for and obtain Benefits from a Out-of-Network Provider, you or your Eligible Dependents remain liable for the Out-of-Network Provider's full fee. You or your Out-of-Network Providers may submit requests for reimbursement. RLHICA's claims administrator will pay available Benefits to you or your Eligible Dependents, or directly to Out-of-Network Providers when claims include a valid Assignment of Benefits. RLHICA may deny any claims received after one hundred and eighty (180) calendar days from the date services are rendered and/or materials provided.

E. Urgent Vision Care

When vision care is necessary for Urgent Conditions, you or your Eligible Dependents may obtain such care by contacting a In-Network Provider or a Out-of-Network Provider (if Out-of-Network benefits are available). Services for conditions of a medical nature are covered by RLHICA only under supplemental eyecare plans. If Policyholder purchases one of these plans, such coverage will be evidenced by an Additional Benefit Rider attached hereto. If Policyholder has not purchased one of these plans, then you or your Eligible Dependents are not covered by RLHICA for such care and should contact a physician under your medical insurance plan for care. For situations of a non-medical nature, such as lost, broken or stolen glasses, you may call the Member Service's toll-free number 1-800-877-7195 (TTY users call 711) for assistance. Reimbursement and eligibility are subject to the terms and conditions of this Certificate.

V. ACCESSING YOUR BENEFITS

To access your Benefits, follow these steps:

1. Please read this Certificate, including the Summary of Vision Plan Benefits Section carefully to become familiar with the Benefits and provisions of This Plan;

2. Make an appointment with your In-Network Provider and tell him or her that you have coverage with RLHICA and provide your ID number. If your Provider is not familiar with This Plan or has any questions regarding This Plan, have him or her contact us by calling the toll-free number, 1-800-877-7195 (TTY users call 711);

3. After receiving your treatment, your Provider's office staff will file the claim.

If you receive services from an Out-of-Network Provider, upon request, you will be furnished with such forms as are usually furnished for filing proofs of loss. If such forms are not furnished within 15 days after such request, you will be deemed to have complied with the requirements of This Plan as to proof of loss upon submitting, within the time frame for filing proofs of loss as described below, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Written proof of loss must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, RLHICA's claims administrator shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one (1) year from the time specified unless the claimant was legally incapacitated.

Claims, adjustment requests, and completed information requests should be mailed to:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

After receiving all required claim information, RLHICA's claims administrator will pay all Benefits due for Covered Services within 30 days of receipt of the claim, or notify you that the claim has been denied or deemed incomplete.

Payment for services rendered is sent to either (1) you, and it is your responsibility to make full payment to the Provider; or (2) directly to the Provider if you or your Eligible Dependent have executed an Assignment of Benefits in favor of the Provider who rendered Covered Services under This Plan.

If you file a claim for a Benefit that relates to a service that has already been rendered, and you receive notice of an Adverse Benefit Determination, RLHICA will notify you or your authorized representative of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. RLHICA's claims administrator may extend this period by up to 15 days if it determines that the extension is necessary due to matters out of its control.

If you have any questions about This Plan, please check with your employer, organization, or plan administrator or you may call the Member Services Department toll-free at 1-800-877-7195 (TTY users call 711).

VI. QUESTIONS AND ANSWERS

May I choose any Provider?

Yes, you are free to choose any Provider, as long as he or she is appropriately licensed to practice and provide vision services and supplies in the state or jurisdiction in which you receive care.

Will RLHICA send payment to the Provider or will I receive payment?

RLHICA's claims administrator will either send payment to you or directly to the Provider if you have executed an Assignment of Benefits for the Provider who rendered Covered Services.

How much of the vision bill do I pay?

If you choose a In-Network Provider, you are only responsible for applicable Copayments and anything not covered by the plan. For Covered Services provided by a Out-of-Network Provider, you will pay for the services in full and will be reimbursed up to the Out-of-Network plan allowances. Those Allowed Amounts are listed in the Summary of Vision Plan Benefits Section.

You are responsible for the Copayment shown on your explanation of benefits plus any charges for optional treatment or specific exclusions / limitations of This Plan.

Am I covered for all vision services?

No, the Summary of Vision Plan Benefits Section describes the vision services that are covered by This Plan. Please read them carefully. The exclusions and limitations govern these covered vision services.

What if my spouse is covered by another plan?

If you are covered by more than one vision Plan, your out-of-pocket costs may be reduced or eliminated. Please see Section VII Coordination of Benefits. It is important to tell your Provider about any other vision coverage so that claims are submitted properly.

VII. COORDINATION OF BENEFITS

COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

All of the Benefits under this Certificate, if applicable, will be subject to a Coordination of Benefits ("**COB**") provision that is designed to provide maximum coverage, but not result in payment of more than 100 percent of the total fee for a given treatment.

A. Applicability

1. This COB provision applies to This Plan when you or your Eligible Dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

2. If this COB provision applies, the order of benefit determination rules should be looked at first. These rules determine whether the Benefits of This Plan are determined before or after those of another Plan. The Benefits of This Plan:

a. Shall not be reduced when, under the order of benefit determination rules, This Plan determines its Benefits before another Plan; but

b. May be reduced when, under the order of benefits determination rules, another Plan determines its benefits first. The above reduction is described in Paragraph D. "Effect on the Benefits of This Plan."

B. DEFINITIONS

1. **"Allowable Expense"** means an expense covered under this Certificate when the item of expense is covered

at least in part by one or more Plans covering the person for whom the claim is made.

When a Plan provides payment for services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

2. **"Claim Determination Period"** means a calendar year during which Allowable Expenses are compared with total Benefits payable in the absence of COB, to determine whether overinsurance exists and how much each Plan will pay or provide. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

3. **"Plan"** is any of these which provides benefits or services for, vision care or treatment:

   a. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage;

   b. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

   Each contract or other arrangement for coverage under (a) or (b) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

4. **"Primary Plan/Secondary Plan:"** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

   When This Plan is a Primary Plan, its Benefits are determined before those of the other Plan and without considering the other Plan's benefits.

   When This Plan is a Secondary Plan, its Benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

   When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

5. **"This Plan"** means the vision coverage provided for you and your Eligible Dependents pursuant to this Certificate.

C. ORDER OF BENEFIT DETERMINATION RULES

1. **General.** When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its Benefits determined after those of the other Plan, unless:
   a. The other Plan has rules coordinating its benefits with those of This Plan; and

   b. Both those rules and This Plan's rules, in subparagraph (C)(2) below, require that This Plan's Benefits be determined before those of the other Plan.

2. **Rules.** This Plan determines its order of Benefits using the first of the following rules which applies:

   a. Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member, or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

      (i) Secondary to the Plan covering the person as a dependent and;

      (ii) Primary to the Plan covering the person as other than a dependent (*e.g.,* a retired employee), then the order of benefit

determination is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

b. Dependent Child/Parents not Divorced. Except as stated in subparagraph (C)(2)(c) below, when This Plan and another Plan cover the same Child as a dependent of different persons, called "parents:"

(i) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

(ii) If both parents have the same birthday, the benefits of the Plan which covered the parents longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in subparagraph (C)(2)(b)(i) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. Dependent Child/Parents Divorced. If two or more Plans cover a person as a dependent Child of divorced parents, benefits for the Child are determined in this order:

(i) First, the Plan of the parent with custody of the Child;

(ii) Then, the Plan of the spouse of the parent with custody of the Child;

(iii) Then, the Plan of the parent not having custody of the Child; and

(iv) Then, the Plan of the spouse of the parent not having custody of the Child.

If the other Plan does not have this subparagraph (C)(2)(c) and if, as a result, the Plans do not agree on the order of benefits, this subparagraph (C)(2)(c) shall be ignored.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This subparagraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the Plans covering the Child shall be subject to the order of benefit determination contained in subparagraph (C)(2)(b) above.

d. Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). 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 subparagraph (C)(2)(d) is ignored.

e. Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal

law (*i.e.*, COBRA) or state law also is covered under another Plan, the benefits of the Plan covering the person as employee, member, or subscriber (or that person's dependent) shall be determined before the benefits under the continuation coverage. 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 subparagraph (C)(2)(e) shall be ignored.

f. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

D. EFFECT ON THE BENEFITS OF THIS PLAN

1. When This Paragraph Applies. This Paragraph D. applies when, in accordance with Paragraph C. "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other Plans. In that event the Benefits of This Plan may be reduced under this Paragraph D. Such other Plan or Plans are referred to as "the other Plans" in subparagraph (D)(2) immediately below.

2. Reduction in This Plan's Benefits. The Benefits of This Plan will be reduced when the sum of:

a. The Benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

b. The Benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the Benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the Benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. RLHICA's claims administrator has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person subject in all events, to all provisions of applicable law. RLHICA's claims administrator need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give RLHICA's claims administrator any facts it needs to pay the claim.

F. FACILITY OF PAYMENT

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, RLHICA's claims administrator may pay that amount to the organization which made that payment.

That amount will then be treated as though it were a Benefit paid under This Plan. RLHICA's claims administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

G. RIGHT OF RECOVERY

If the amount of the payments made by RLHICA is more than it should have paid under this COB provision, it may recover the excess from one or more of the following:

1. The persons it has paid or for whom it has paid;

2. Insurance companies; or

3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

VIII. CLAIM DENIAL APPEALS

If you receive notice of an Adverse Benefit Determination, and if you think that RLHICA incorrectly denied all or part of your claim, you or your Provider should contact the Member Services Department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, 1-800-877-7195 (TTY users call 711) and speaking to a representative. You may also mail your inquiry to VSP, ATTN: Appeals Department P.O. Box 1596, Indianapolis, IN 46206 .

Initial Appeal: All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. You may review, during normal business hours, any documents held by RLHICA's claims administrator pertinent to the denial. You may also submit written comments or supporting documentation concerning the claim to assist in the review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to you within thirty (30) calendar days after receipt of the request for the appeal. Incomplete appeal information will suspend the 30 day response timeframe, until receipt of any additional necessary information.

The notice of a Claims Denial Appeals Procedure will meet the requirements described below under the heading "Manner and Content of Notice."

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent Policy provisions(s) on which the denial is based, the applicable review procedures for vision claims, including applicable time limits, and that you are entitled to access, free of charge, upon request, all documents, records and other information relevant to your claim. The notice will also contain a description of any additional materials necessary to complete your claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your claim has been completely reviewed according to this Claims Denial Appeals Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge.

Second Level Appeal

If you disagree with the response to the Initial Appeal of the denied claim, you have the right to a Second Level Appeal. A request for a Second Level Appeal must be submitted to RLHICA's claims administrator within sixty (60) calendar days after receipt of the response to the Initial Appeal. Communication of a final determination to you shall be provided within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. The communication to you shall include the specific reasons for the determination.

Other Remedies

When you have completed the appeals process provided for herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for your state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) [29 U.S.C. 1132(a)(1)(B)], you have the right to bring a civil action when all available levels of review, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Certificate and you disagree with the outcome of such appeals.

If you (a) need the assistance of a governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer, you may also contact the Consumer Protection Division of the Texas Insurance Department, P.O. Box 149104, Austin, Texas, 78714- 9104.

IX. TERMINATION OF COVERAGE

RLHICA must give your employer or organization at least 45 days' advance notice of cancellation, expiration, nonrenewal, or change in rates. In the event RLHICA chooses to terminate the Policy due to nonpayment of premium, RLHICA will give your employer or organization notice of the termination within 45 days after the premium due date. The effective date of such termination shall be the first day of the period for which the premium is due.

Your RLHICA coverage may be automatically terminated:

1. When your employer or organization advises RLHICA to terminate your coverage;

2. On the last day of the month for which your employer or organization has failed to pay RLHICA subject to the applicable Grace Period;

3. Or for any other reason stated in the Policy.

A person whose eligibility is terminated may be eligible to transfer to an individual direct payment contract with RLHICA. Please contact RLHICA to obtain further information.

X. CONTINUATION OF COVERAGE

A. Loss of Eligibility During Treatment

1. If you and/or an Eligible Dependent lose eligibility while receiving vision treatment, only those Covered Services received while you and/or your Eligible Dependent were eligible under the Policy will be payable.

2. Certain procedures begun before the loss of eligibility may be covered if the services were completed within a 90 day period measured from the date of termination. In those cases, RLHICA evaluates those services in progress to determine what portion may be paid by RLHICA. The difference between RLHICA's payment and the total fee for those procedures is your responsibility.

B. Continuation Coverage – COBRA

If your employer or organization is required to comply with provisions under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and your coverage would otherwise end, you and/or your covered Eligible Dependents may have the right under certain circumstances to continue coverage in the group health plans sponsored by your employer or organization, at your expense, beyond the time coverage would normally end.

COBRA continuation coverage may be available if your coverage or a covered Eligible Dependent's coverage would otherwise end because of one of the following COBRA qualifying events:

1. Voluntary or involuntary termination of employment for any reason other than your gross misconduct;

2. Reduction in the number of hours worked so that you are no longer an eligible employee under the terms of the group health plan;

3. Divorce or legal separation;

4. Death;

5. Loss of dependent status under the terms of the group health plan; or

6. You become entitled to Medicare (if applicable).

If you are called to active duty in the armed forces of the United States, you and your covered Eligible Dependents may also have continuation coverage rights under the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

If you believe you are entitled to continuation coverage either under COBRA or USERRA, you should contact your employer or organization to receive additional information about your rights and to learn more about the applicable procedures for applying for such continuation coverage.

C. Continuation Coverage – Death of Certificate Holder

Upon the death of the Certificate Holder, coverage for Eligible Dependents (if any) shall continue for a period of 90 days, subject to the termination provisions found in Section III and Section X of this Certificate.

D. Continuation Coverage – Eligible Dependents

Eligible Dependents may elect to continue coverage under this Certificate in the event of the divorce, retirement or death of the Certificate Holder. To elect coverage, Eligible Dependents should contact the Certificate Holder's employer or organization immediately following the occurrence of one of the above-mentioned events.

E. Continuation Coverage – Total Disability

In the event the Policy is terminated for any reason, the Benefits paid pursuant to the Policy shall continue for a period of 90 days in the event of total disability (on the date of such termination) of the Certificate Holder or an Eligible Dependent.

XI. GENERAL CONDITIONS

Change of Status

You must notify RLHICA through your employer or organization, of any event causing a change in the status of an Eligible Dependent. Events that can affect the status of an Eligible Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

Assignment

Benefits to you or your Eligible Dependent are for the personal benefit of you or your Eligible Dependent and cannot be transferred or assigned. You or your Eligible Dependent, however, may assign Benefits to the Provider who rendered Covered Services under This Plan. Benefits paid pursuant to such assignment shall discharge the obligation of RLHICA with respect to the amount of the Benefits so paid.

Right of Recovery

If you or your Eligible Dependent has a claim for damages or a right to recover damages from a third party or parties for any illness or injury for which Benefits are payable under this Certificate, RLHICA may have a right of recovery. Our right of recovery shall be limited to the recovery of any Benefits paid for identical covered medical expenses under this Certificate, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. Our right of recovery may include compromise settlements. You or your attorney must inform RLHI CA of any legal action or settlement agreement at least ten days prior to settlement or trial. RLHICA will then notify you of the amount it seeks to recover for Benefits paid. Our recovery may be reduced by the pro-rata share of your attorney's fees and expenses of litigation.

Obtaining and Releasing Information

While you are covered by RLHICA, you agree to provide RLHICA with any information it needs to process your claims and administer your Benefits. This includes allowing RLHICA to have access to your vision records.

Provider-Patient Relationship

You and your Eligible Dependents have the freedom to choose any Provider. Each Provider maintains the Provider-patient relationship with the patient and is solely responsible to the patient for vision advice and treatment and any resulting liability.

Late Claims Submission

Except as otherwise provided in this Certificate, RLHICA's claims administrator will not honor and no payment will be made for services, items or supplies if a claim for those services, items or supplies has not been received by RLHICA's claims administrator within one year from the date that the services, items or supplies were provided.

Change of Certificate or Policy

No agent has the authority to change any provisions in this Certificate or the provisions of the Policy on which it is based. No changes to this Certificate or the underlying Policy are valid unless approved in writing by an officer of RLHICA.

Note: This Certificate and the Policy are subject to change if, in the future, federal and state privacy laws and regulations require RLHICA or your employer or organization to comply with such laws and regulations. Should any such change to this Certificate or the Policy be necessary by law, you will receive written notice from RLHICA informing you of the reasons for any change to this Certificate or the Policy and the process by which you will receive an amended Certificate or the amended section of this Certificate.

Legal Actions

No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy, unless otherwise provided by applicable state law. No such action may be brought after the expiration of three years after the time written proof of loss is required to be given. This provision does not preclude the Policyholder or Certificate Holder from seeking a decision from a jury trial once all administrative appeals have been exhausted.

Representations

In the absence of fraud, all statements made by your employer or organization or by you or your Eligible Dependents, shall be deemed to be representations and not warranties. No such statement shall be used in defense to a claim under the Policy, unless it is contained in a written application.

ADDITIONAL BENEFIT RIDER

SUPPLEMENTAL PRIMARY EYECARE PLAN

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of Renaissance Life & Health Insurance Company of America ("RLHICA") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. Plan Benefits under the Supplemental Primary EyeCare Plan are available to Covered Persons only after all other benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan. This Rider forms a part of the Policy and Certificate of Coverage to which it is attached.

The Supplemental Primary EyeCare Plan is designed for the detection, treatment and management of ocular conditions and/or systemic conditions that produce ocular or visual symptoms. Under the Plan, Eyecare Professionals provide treatment and management of urgent and follow-up services. Primary EyeCare also involves management of conditions that require monitoring to prevent future vision loss.

The Eyecare Professional is responsible for advising and educating patients on matters of general health and prevention of ocular disease. If consultation, treatment, and/or referral are necessary, it is the responsibility of the Eyecare Professional, to manage and coordinate on behalf of the patient to assure appropriateness of follow-up services.

Covered Persons with the following symptoms and/or conditions (see DEFINITIONS, below) will be covered for certain Primary EyeCare services in accordance with the optometric scope of licensure in the Eyecare Professional's state.

SYMPTOMS

Examples of symptoms which may result in a patient seeking services on an urgent basis under the Primary EyeCare Plan include, but are not limited to:

- ocular discomfort or pain
- transient loss of vision
- flashes or floaters
- ocular trauma
- diplopia
- recent onset of eye muscle dysfunction
- ocular foreign body sensation
- pain in or around the eyes
- swollen lids
- red eyes

CONDITIONS

Examples of conditions which may require management under the Primary EyeCare Plan include, but are not limited to:

- ocular hypertension
- retinal nevus
- glaucoma
- cataract
- pink-eye
- macular degeneration
- corneal dystrophy
- corneal abrasion
- blepharitis
- sty

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated.

ELIGIBILITY

Covered Persons as defined in the Policy and Certificate are eligible for coverage when the Supplemental Primary EyeCare Plan is purchased.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated.

COPAYMENT

A Copayment amount of $10.00 shall be payable by the Covered Person at the time of each Supplemental Primary EyeCare office visit.

PLAN BENEFITS

SERVICE OR MATERIAL	IN-NETWORK PROVIDER BENEFIT	OUT-OF-NETWORK PROVIDER BENEFIT*
Eye Examination	Covered in full, less Copayment	Up to current Out-of-Network Schedule of Allowances
Consultation	Covered in full, less Copayment	Up to current Out-of-Network Schedule of Allowances
Urgent/Emergency Care	Covered in full, less Copayment	Up to current Out-of-Network Schedule of Allowances
Special Ophthalmological Services	Covered in full, less Copayment	Up to current Out-of-Network Schedule of Allowances
Eye and Ocular Adnexa Services	Covered in full, less Copayment	Up to current Out-of-Network Schedule of Allowances

***Services from an Out-of-Network provider are in lieu of services from an In-Network Provider. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full. RLHICA's claims administrator is unable to require Out-of-Network Providers to adhere to its quality standards.**

IN-NETWORK PROVIDER REFERRALS

The In-Network Provider will refer the Covered Person to another doctor under the following circumstances:

1. If the Covered Person requires additional services which are covered by the Primary EyeCare Plan but cannot be provided in the In-Network Provider's office, the Provider will refer the Covered Person to another In-Network Provider or to a physician under the Group's medical plan whose offices provide the necessary services.
2. If the Covered Person requires services beyond the scope of the Supplemental Primary EyeCare Plan, the In-Network Provider will refer the Covered Person to a physician under the Group's medical plan.

Referrals are intended to ensure that Covered Persons receive the appropriate level of care for their presenting condition. Covered Persons do not require a referral from an In-Network Provider in order to obtain Plan Benefits.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Primary EyeCare Plan is designed to cover Primary EyeCare services only. There is no coverage provided under the Policy for the following:

- Costs associated with securing materials such as lenses and frames.
- Orthoptics or vision training and any associated supplemental testing.
- Surgical or pathological treatment.
- Any eye examination, or any corrective eyewear required by an employer as a condition of employment.
- Medication.
- Pre- and post-operative services.
- Services and/or materials not indicated on this Rider as covered Plan Benefits.
- Frames, spectacle lenses, contact lenses or any other ophthalmic materials
- Surgery, and any pre- or post-operative services, except as an ocular adnexa service included herein.
- Treatment for any pathological conditions.
- Insulin or any medications or supplies of any type.
- Local, state and/or federal taxes, except where RLHICA or its vision administrator is required by law to pay.

DEFINITIONS

Blepharitis	Inflammation of the eyelids.
Cataract	A cloudiness of the lens of the eye obstructing vision.
Conjunctiva	The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eye.
Corneal Abrasion	Irritation of the transparent, outermost layer of the eye.
Corneal Dystrophy	A disorder involving nervous and muscular tissue of the transparent, outermost layer of the eye.
Diplopia	The observance by a person of seeing double images of an object
Eyecare Professional	Any duly licensed optometrist, ophthalmologist or other doctor of medicine (M.D.), or doctor of osteopathy (O.D.).
Eye Muscle Dysfunction	A disorder or weakness of the muscles that control the eye movement.
Flashes or Floaters	The observance by a person of seeing flashing lights and/or spots.
Glaucoma	A disease of the eye marked by increased pressure within the eye which causes damage to the optic disc and gradual loss of vision.
Macula	The small, sensitive area of the central retina, which provides vision for fine work and reading.
Macular Degeneration	An acquired degenerative disease which affects the central retina.
Ocular	Of or pertaining to the eye or the eyesight.
Ocular Conditions	Any condition, problem, or complaint relating to the eyes or eyesight.
Ocular Hypertension	Unusually high blood pressure within the eye.
Ocular Trauma	A forceful injury to the eye due to a foreign object.
Pink eye	An acute, highly contagious inflammation of the conjunctiva.
Retinal Nevus	A pigmented birthmark on the sensory membrane lining the eye that receives the image formed by the lens.
Systemic Condition	Any condition or problem relating to a person's general health.
Sty	An inflamed swelling of the fatty material at the margin of the eyelid.
Transient Loss of Vision	Temporary loss of vision.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION (For insurers declared insolvent or impaired on or after September 1, 2005)

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect Texas policyholders if their life or health insurance company fails. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not cover your policy in full or in part due to statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at that time **(irrespective of the policyholder's residency at policy issue)**
- Residents of other states, ONLY if the following conditions are met:
    1. The policyholder has a policy with a company domiciled in Texas;
    2. The policyholder's state of residence has a similar guaranty association; and
    3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $100,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $100,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, Texas 78730
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

NOTICE OF PRIVACY PRACTICES

Date of This Notice: July 20, 2021

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the privacy practices of Delta Dental Plan of Michigan, Inc., Delta Dental Plan of Ohio, Inc., Delta Dental Plan of Indiana, Inc., Delta Dental Plan of Arkansas, Inc., Delta Dental of Kentucky, Inc., Delta Dental Plan of New Mexico, Inc., Delta Dental of North Carolina, Delta Dental of Tennessee, Renaissance Life & Health Insurance Company of America, Renaissance Life & Health Insurance Company of New York (collectively, "we" or "us" or the "Plan"). These entities have designated themselves as a single affiliated covered entity for purposes of the privacy rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and each has agreed to abide by the terms of this Notice and may share protected health information with each other as necessary for treatment, payment or to carry out health care operations, or as otherwise permitted by law.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information" ("PHI"). Generally, PHI is individually identifiable health information, including demographic information, collected from you or received by a health care provider, a health care clearinghouse, a health plan or your employer on behalf of a group health plan that relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

We are required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are committed to protecting your health information.

We comply with the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. We maintain a breach reporting policy and have in place appropriate safeguards to track required disclosures and meet appropriate reporting obligations. We will notify you promptly in the event a breach occurs that may have compromised the security or privacy of your PHI. In addition, we comply with the "Minimum Necessary" requirements of HIPAA and the HITECH amendments. We also comply with all applicable laws relating to retention and destruction of your PHI.

For more information concerning this Notice please see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we may use or disclose your PHI.

For Treatment We may use or disclose your PHI to facilitate medical treatment or services by providers. We may disclose PHI about you to providers, including dentists, doctors, nurses, or technicians, who are involved in taking care of you. For example, we might disclose information about your prior dental X-ray to a dentist to determine if the prior X-ray affects your current treatment.

For Payment We may use or disclose PHI about you to obtain payment for your treatment and to conduct other payment related activities, such as determining eligibility for Plan benefits, obtaining customer payment for benefits, processing your claims, making coverage decisions, administering Plan benefits, and coordinating benefits.

For Health Care Operations We may use and disclose PHI about you for other Plan operations, including setting rates, conducting quality assessment and improvement activities, reviewing your treatment, obtaining legal and audit services, detecting fraud and abuse, business planning and other general administration activities. In accordance with the Genetic Information and Nondiscrimination Act of 2008, we are prohibited from using your genetic information for underwriting purposes.

To Business Associates We may contract with individuals or entities known as Business Associates to perform various functions or to provide certain types of services on the Plan's behalf. In order to perform these functions or provide these services, Business Associates may receive, create, maintain, use and/or disclose your PHI, but only if they agree in writing with the Plan to implement appropriate safeguards regarding your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide support services, such as utilization management, quality assessment, billing and collection or audit services, but only after the Business Associate enters into a Business Associate Agreement with the Plan.

Health-Related Benefits and Services We may use or disclose health information about you to communicate to you about health-related benefits and services. For example, we may communicate to you about health-related benefits and services that add value to, but are not part of, your health plan.

To Avert a Serious Threat to Health or Safety We may use and disclose PHI about you to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

Military and Veterans If you are a member of the armed forces, we may release PHI about you if required by military command authorities.

Worker's Compensation We may release PHI about you as necessary to comply with worker's compensation or similar programs.

Public Health Risks We may release PHI about you for public health activities, such as to prevent or control disease, injury or disability, or to report child abuse, domestic violence, or disease or infection exposure.

Health Oversight Activities We may release PHI to help health agencies during audits, investigations or inspections.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We also may disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement We may release PHI if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

To Plan Sponsor We may disclose your PHI to certain employees of the Plan Sponsor (i.e., the Company) for the purpose of administering the Plan. These employees will only use or disclose your PHI as necessary to perform Plan administrative functions or as otherwise required by HIPAA.

Disclosure to Others We may use or disclose your PHI to your family members and friends who are involved in your care or the payment for your care. We may also disclose PHI to an individual who has legal authority to make health care decisions on your behalf.

REQUIRED DISCLOSURES

The following is a description of disclosures of your PHI the Plan is required to make:

As Required By Law We will disclose PHI about you when required to do so by federal, state or local law. For example, we may disclose PHI when required by a court order in a litigation proceeding, such as a malpractice action.

Government Audits The Plan is required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with HIPAA.

Disclosures to You Upon your request, the Plan is required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits.

WRITTEN AUTHORIZATION

We will use or disclose your PHI only as described in this Notice**. It is not necessary for you to do anything to allow us to disclose your PHI as described here.** If you want us to use or disclose your PHI for another purpose, you must authorize us in writing to do so. For example, we may use your PHI for research purposes if you provide us with written authorization to do so. You may revoke your authorization in writing at any time. When we receive your revocation, it will be effective only for future uses and disclosures. It will not be effective for any PHI that we may have used or disclosed in reliance upon your written authorization. We will never sell your PHI or use it for marketing purposes without your express written authorization. We cannot condition treatment, payment, enrollment in a Health Plan, or eligibility for benefits on your agreement to sign an authorization.

ADDITIONAL INFORMATION REGARDING USES OR DISCLOSURES OF YOUR PHI

For additional information regarding the ways in which we are allowed or required to use of disclosure your PHI, please see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

YOUR RIGHTS REGARDING PHI THAT WE MAINTAIN

You have the following rights regarding PHI we maintain about you:

Your Right to Inspect and Copy Your PHI You have the right to inspect and copy your PHI. You must submit your request in writing and if you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request. A copy will be provided within 30 days of your request.

The Plan may deny your request to inspect and copy PHI in certain limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed by submitting a written request to the Contact Person listed below.

Your Right to Amend Incorrect or Incomplete Information If you believe that the PHI the Plan has about you is incorrect or incomplete, you may request that we change your PHI by submitting a written request. You also must provide a reason for your request. We are not required to amend your PHI but if we deny your request, we will provide you with information about our denial and how you can disagree with the denial within 60 days of your request.

Your Right to Request Restrictions on Disclosures to Health Plans. Where applicable, you may request that restrictions be placed on disclosures of your PHI.

Your Right to an Accounting of Disclosures We Have Made You may request an accounting of disclosures of your PHI that we have made, except for disclosures we made to you or pursuant to your written authorization, or that were made for treatment, payment or health care operations. You must submit your request in writing. Your request may specify a time period of up to six years prior to the date of your request. We will provide one list of disclosures to you per 12-month period free of charge; we may charge you for additional lists.

Your Right to Request Restrictions on Uses and Disclosures You have the right to request restrictions or limitations on the way that we use or disclose PHI. You must submit a request for such restrictions in writing, including the information you wish to limit, the scope of the limitation and the persons to whom the limits apply. We may deny your request.

Your Right to Request Confidential Communications Through a Reasonable Alternative Means or at an Alternative Location You may request that we direct confidential communications to you in an alternative manner (i.e., by facsimile or e-mail). You must submit your request in writing. We are not required to agree to your request, however we will accommodate your request if doing otherwise would place you in any danger.

Your Right to a Paper Copy of This Notice

To obtain a paper copy of this Notice or a more detailed explanation of these rights, send us a written request at the address listed below. You may also obtain a copy of this Notice at one of our websites:
www.deltadentalmi.com,
www.deltadentaloh.com,
www.deltadentalin.com,
www.deltadentalar.com
www.deltadentalky.com,
www.deltadentalnc.com,
www.deltadentalnm.com,
www.deltadentaltn.com, or
www.renaissancedental.com.

Your Right to Appoint a Personal Representative

Upon receipt of appropriate documentation appointing an individual as your personal representative, medical power of attorney or legal guardian, that individual will be permitted to act on your behalf and make decisions regarding your healthcare.

CHANGES TO THIS NOTICE

We may amend this Notice of Privacy Practices at any time in the future and make the new Notice provisions effective for all PHI that we maintain. We will advise you of any significant changes to the Notice. We are required by law to comply with the current version of this Notice.

COMPLAINTS

If you believe your privacy rights or rights to notification in the event of a breach of your PHI have been violated, you may file a complaint with us or with the Office of Civil Rights. Complaints about this Notice or about how we handle your PHI should be submitted in writing to the Contact Person listed below.

A complaint to the Office of Civil Rights should be sent to Office of Civil Rights, U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, 1-877-696-6775. You also may visit OCR's website at http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html for more information.

You will not be penalized, or in any other way retaliated against for filing a complaint with us or the Office of Civil Rights.

SEND ALL WRITTEN REQUESTS REGARDING THIS PRIVACY NOTICE TO:

Chief Privacy Officer
P.O. Box 30416
Lansing, MI 48909-7916
517-347-5451 (TTY users call 711)

Delta Dental is a registered trademark of Delta Dental Plans Association

FACTS WHAT DOES RENAISSANCE FAMILY OF COMPANIES DO WITH YOUR PERSONAL INFORMATION?

Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: ▪ Social Security Number and Insurance claim information ▪ Transaction history and Medical information ▪ Credit card payments and Employment information When you are *no longer* our customer, we continue to share your information as described in this notice.
Why?	All financial companies need to share members' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their members' personal information; the reasons Renaissance Family of Companies chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	**Does Renaissance Family of Companies share?**	**Can you limit this sharing?**
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	**Yes**	**No**
For our marketing purposes – to offer our products and services to you	**Yes**	**No**
For joint marketing with other financial companies	**No**	**We do not share**
For our affiliates' everyday business purposes – information about your transactions and experiences	**Yes**	**No**
For our affiliates' everyday business purposes – information about your creditworthiness	**No**	**We do not share**
For nonaffiliates to market to you	**No**	**We do not share**

For Privacy Concerns:	Call 517-347-5451 (TTY users call 711). All other questions must be answered by calling your general customer service number.

Who we are	
Who is providing this notice?	All of the members of the Renaissance Family of Companies listed as Affiliates in the Definitions section located on the back of this notice.

Delta Dental is a registered trademark of Delta Dental Plans Association

Page 2	
What we do	
How does Renaissance Family of Companies protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.
How does Renaissance Family of Companies collect my personal information?	We collect your personal information, for example: ▪ When you apply for insurance ▪ When you file an insurance claim ▪ When you give us your contact information ▪ When you use your credit or debit card ▪ When we pay your insurance claims
Why can't I limit all sharing?	Federal law gives you the right to limit only: ▪ Sharing for affiliates' everyday business purposes—information about your creditworthiness ▪ Affiliates from using your information to market to you ▪ Sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing.
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. ▪ *Our affiliates include companies with the Delta Dental name in Michigan, Ohio, Indiana, Kentucky, Tennessee, New Mexico, Arkansas and North Carolina; insurance companies such as Renaissance Life & Health Insurance Company of America and Renaissance Life & Health Insurance Company of New York.*
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ▪ *Renaissance Family of Companies does not share your personal information with nonaffiliates so they can market to you.*
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. ▪ *Renaissance Family of Companies does not jointly market with nonaffiliated financial companies.*
Other important information	
For customers in AZ, CA, CT, GA, IL, ME, MA, MN, MT, NV, NJ, NC, OH, OR and VA: To review your personal information, write to Privacy Officer, 4100 Okemos Road, Okemos, MI 48864. You must state your full name, address, policy number (if applicable) and the information you would like to see. We will tell you what information we have, and you may review and copy it at our office or ask that we mail a copy to you for a fee. If you think that personal information that we have about you is wrong, you may write to us. We will tell you what actions we take because of your letter. If you do not agree with our actions, you may send us a statement.	

Delta Dental is a registered trademark of Delta Dental Plans Association

YEARLY RENEWABLE
GROUP TERM LIFE AND ACCIDEN[illegible]H
AND DISMEMBERMENT (AD&D)[illegible]E
ACCELERATED DEATH BENEFIT
NON-PARTICIPATING POLICY
NON-CONTRIBUTORY AND CONTRIBUTORY

CERTIFICATE OF COVERAGE
COVER PAGE

POLICYHOLDER: ABC Company

GROUPNUMBER:G000000
POLICY NUMBER: CLASS A

POLICY EFFECTIVE DATE: JANUARY 1, 2020

POLICY ANNIVERSARY DATE: JANUARY 1

Renaissance Life & Health Insurance Company of America (referred to as "the Company," "We," "Us," or "Our") welcomes Your Employer as a Policyholder. "You" and "Your" as used in this Certificate of Coverage ("Certificate") means an Employee who is eligible for coverage under the Policy.

This is Your Certificate as long as You are eligible for coverage and You become insured. We certify that You are insured for the benefits described in this Certificate, subject to the provisions and requirements detailed in this Certificate. THIS CERTIFICATE MAY CONTAIN EXCLUSIONS, LIMITATIONS, REDUCTIONS IN COVERAGE, AND TERMINATION PROVISIONS. PLEASE READ YOUR CERTIFICATE CAREFULLY AND KEEP IT IN A SAFE PLACE.

We have written the Certificate in plain English. There are a few terms and provisions written as required by insurance law. If You have any questions about any of the terms and provisions, please contact Our Home Office. We will assist You in understanding Your benefits.

If the terms and provisions of the Certificate (issued to You) differ from the Policy (issued to the Policyholder), the Policy will govern however, benefits and rights under the Policy shall not be less than those stated in the Certificate. Contact the Policyholder if You wish to inspect a copy of the Policy. Your coverage may be canceled or changed in whole or in part under the terms and provisions of the Policy.

The Policy is delivered in and is governed by the laws of the state of the Policyholder and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. The Policy and this Certificate have been approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of the Policy or Certificate that on the provision's effective date is in conflict with Interstate Insurance Product Regulation Commission standards for Group Term Life and Accidental Death and Dismemberment insurance in effect on the date of the Commission's approval of the Policy and Certificate is hereby amended to conform to such standards as of the provision's effective date.

State Department of Insurance: Texas Department of Insurance
PO Box 149104
Austin, Texas 78714-9104
615-741-2218

The Death Benefit will be reduced if an Accelerated Death Benefit is paid. You should seek additional information from a personal tax advisor about the tax status of the Accelerated Death Benefit payment.

For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 A.M. and end at 12:00 midnight, local time, at the Policyholder's place of business in the state where the Policy is issued.

This Certificate of Coverage replaces any prior certificate issued under the Policy.

Renaissance Life & Health Insurance Company of America
225 S East Street, P.O. Box 1596
Indianapolis, Indiana 46206-1596
888-358-9484
www.renaissancefamily.com

TABLE OF CONTENTS

Your Certificate is divided into the following sections:

PLAN HIGHLIGHTS **4**
GENERAL INFORMATION **8**
WHAT IS THE CERTIFICATE OF COVERAGE? 8
TO WHAT INFORMATION DO WE HAVE ACCESS? 8
ELIGIBILITY FOR COVERAGE **9**
WHEN ARE YOU ELIGIBLE FOR COVERAGE? 9
EFFECTIVE DATES OF INSURANCE **10**
FILING A CLAIM **16**
WHEN DO YOU NOTIFY US OF A CLAIM? 16
WHEN DO YOU NEED TO GIVE US PROOF OF YOUR CLAIM? 16
HOW DO YOU FILE A CLAIM? 16
WHAT HAPPENS IN THE EVENT OF SUICIDE? 17
BENEFICIARY INFORMATION **18**
TERM LIFE FEATURES – ACCELERATED DEATH BENEFIT **19**
TERM LIFE FEATURES – WAIVER OF PREMIUM **21**
TERM LIFE FEATURES – CONTINUATION **22**
TERM LIFE FEATURE – CONVERSION **23**
POLICYHOLDER NOTICE **25**
ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE **26**
ACCIDENTAL DEATH AND DISMEMBERMENT PAYMENT 26
PLAN HIGHLIGHTS – AD&D INSURANCE **26**
Accidental Death & Dismemberment (AD&D) Insurance Definitions 27
Accidental Death & Dismemberment (AD&D) Insurance Additional Benefits 28
Benefit Payment Options 31
WHEN WILL WE NOT COVER AN ACCIDENTAL DEATH & DISMEMBERMENT LOSS? **32**
WHEN WILL THIS ACCIDENTAL DEATH & DISMEMBERMENT PLAN TERMINATE? **32**
GENERAL PROVISIONS **32**
GENERAL DEFINITIONS **33**

PLAN HIGHLIGHTS

This is a brief overview of Your benefits in the event of Your death or any other covered loss. These benefits are described further in the Certificate, along with other important information about Your coverage.

Defined terms are capitalized when used throughout the Certificate and can be located in the Definitions section of the Certificate or in some cases next to the specific benefit to which the Definition applies.

Policyholder: VRX Global

Eligible Class: Class A: All Full-time Active Employees

Employment Minimum Requirements:

Non-Contributory Insurance: 30 hours weekly
Contributory Insurance: 30 hours weekly

Waiting Period:

You are Active on the Policy Effective Date
You will be eligible for coverage the first of the month following 30 days of employment.

You become Active after the Policy Effective Date
You will be eligible for coverage the first of the month following 30 days of employment.

Employee Premium Contributions Required:

Group Term Life:	No
Accidental Death and Dismemberment:	No
Voluntary Group Term Life:	Yes
Voluntary Dependent Group Term Life:	Yes
Voluntary Accidental Death and Dismemberment:	Yes

Age Limit for Dependent Child: Under 26

If an Insured Person is eligible and applies for any amount of coverage in excess of the Guaranteed Issue Limit shown below, the Employee must furnish Evidence of Insurability, which is subject to Our approval.

Basic Group Term Life Plan			
Class A			
Benefit	**Principal Sum**	**Benefit Reduction Schedule/ Termination**	**Guaranteed Issue Limit**
Basic Employee Term Life	$100,000	Reduces to 65% at age 65 50% at age 70 Terminates at employee's Retirement Date with the Policyholder.	$100,000

Voluntary Group Term Life Plan			
Class A			
Benefit	**Principal Sum**	**Benefit Reduction Schedule /Termination**	**Guaranteed Issue Limit**
Voluntary Employee Term Life	The amount elected by You on Your enrollment form and approved by Us. Elected in $10,000 increments up to a maximum of $300,000 Not to exceed 5 times Base Annual Compensation Minimum: $10,000	Reduces to 65% at age 65 50% at age 70 Terminates at employee's Retirement Date with the Policyholder.	Under Age 70 $100,000 Age 70 and older $10,000
	The Guaranteed Issue Limit for Voluntary Employee Term Life coverage is in addition to the Guaranteed Issue Limit for Basic Term Life coverage.		
	You may increase Your Principal Sum by $10,000 during an Enrollment Period due to a Qualifying Event up to the Guaranteed Issue limit without providing Us Evidence of Insurability. Annual increases to Your Voluntary Term Life Insurance up to the Guaranteed Issue Limit may be requested in increments of $10,000 effective as of the Policy Anniversary. To be eligible for increases, the Employee must meet the Active Employment requirements set forth in the ELIGIBILITY FOR COVERAGE section before any increase in the amount of Your Voluntary Term Life Insurance will become effective.		

Voluntary Group Term Life Plan			
Class A			
Benefit	**Principal Sum**	**Benefit Reduction Schedule/ Termination**	**Guaranteed Issue Limit**
Voluntary Spouse Term Life	The amount elected by You on Your enrollment form and approved by Us. Elected in $5,000 increments up to a maximum of $150,000 not to exceed 50% of Your Voluntary Term Life amount. Minimum: $5,000	Reduces to 65% at age 65 50% at age 70 Terminates at Employee's Retirement Date with the Policyholder	Under Age 70 $20,000 Age 70 and older None
	Your Spouse's amount of life insurance will not be more than 50% of Your total amount of Group Term Life Insurance under this Certificate. Your Child's amount of life insurance will not be more than the lesser of the amount of insurance for which You are covered or $10,000.		

Voluntary Group Term Life Plan		
Class A		
Benefit	**Principal Sum**	**Benefit Reduction Schedule/ Termination**
Voluntary Child Term Life	6 months and over: $10,000 Birth to 6 months: $2,000	Child coverage does not reduce

Group Term Life Features	
Feature	**Benefit Feature Amount**
Accelerated Death Benefit For You	Minimum Benefit Amount: The lesser of 25% of the Death Benefit or $10,000 Maximum Benefit Amount: 75% or $300,000 Processing Fee: $250
Waiver of Premium For You	Basic Term Life Voluntary Term Life
Continuation of Term Life Insurance For You and Your Dependents	Basic Term Life Voluntary Term Life
Right to Convert For You and Your Dependents	Basic Term Life Voluntary Term Life

Basic Group Accidental Death & Dismemberment Plan		
Class A		
Benefit	**Principal Sum**	**Benefit Reduction Schedule/ Termination**
Basic Employee Accidental Death & Dismemberment	$100,000	Reduces to 65% at age 65 50% at age 70 Terminates at employee's Retirement Date with the Policyholder.

Voluntary Group Accidental Death & Dismemberment Plan		
Class A		
Benefit	**Principal Sum**	**Benefit Reduction Schedule/ Termination**
Employee Voluntary Accidental Death & Dismemberment	The amount elected by You on Your enrollment form and approved by Us. Elected in $10,000 increments up to a maximum of $300,000 Not to exceed 5 times Base Annual Compensation Minimum: $10,000	Reduces to 65% at age 65 50% at age 70 Terminates at employee's Retirement Date with the Policyholder.
	Annual increases to Your Employee Voluntary Accidental Death & Dismemberment Insurance up to the Guaranteed Issue Limit may be requested in increments of in $10,000 effective as of the Policy Anniversary Date. To be eligible for increases, You must meet the Active Employment requirements set forth in the ELIGIBILITY FOR COVERAGE section before any increase in the amount of Your Employee Voluntary Accidental Death & Dismemberment Insurance will become effective.	

Voluntary Group Accidental Death & Dismemberment Plan		
Class A		
Benefit	**Principal Sum**	**Benefit Reduction Schedule /Termination**
Spouse Voluntary Accidental Death & Dismemberment	The amount elected by You on Your enrollment form and approved by Us. Elected in $5,000 increments up to a maximum of $150,000 not to exceed 50% of Your Voluntary Term Life amount. Minimum: $5,000	Reduces to 65% at age 65 50% at age 70 Terminates at Employee's Retirement Date with the Policyholder

Voluntary Group Accidental Death & Dismemberment Plan		
Class A		
Benefit	**Principal Sum**	**Benefit Reduction Schedule /Termination**
Child Voluntary Accidental Death & Dismemberment	6 months and over: $10,000 Birth to 6 months: $2,000	Child coverage does not reduce

GENERAL INFORMATION

WHAT IS THE CERTIFICATE OF COVERAGE?

This Certificate is a Written statement prepared by Us and may include attachments. It tells You:
The coverage to which You may be entitled;
To whom We make payments; and
The limitations, exclusions, and requirements applying to This Plan.
It is the responsibility of the Policyholder to distribute the appropriate Certificate and any updates or other notices from Us to each Insured Person.

TO WHAT INFORMATION DO WE HAVE ACCESS?

The Policyholder will give us information about You including:

- If You are eligible for coverage;
- If Your amount of coverage changes, including salary change information;
- If Your coverage terminates; and
- Other information We may reasonably require.

The Policyholder's records that We believe have a bearing on coverage under This Plan are available for Our inspection at any reasonable time.

Clerical errors or omissions by the Policyholder, You, or Us will not:

- Terminate coverage which should otherwise be in effect;
- Continue coverage which should otherwise terminate;
- Create coverage which should not be in effect; or
- Change the amount of coverage that should otherwise be in effect.

WHAT IS THE INCONTESTABILITY PERIOD FOR YOUR COVERAGE?

Any statement You or the Policyholder makes to obtain coverage or an increase in coverage is a representation and not a warranty. No misrepresentation by You or the Policyholder will be used to reduce or deny a claim or to deny the validity of Your coverage or an increase in coverage unless:

- The misrepresentation is material to the risk accepted;
- Our coverage or increase in coverage would not have been approved if the truth had been known;
- Your misrepresentation is contained in a Written instrument signed by You; and
- You or Your Beneficiary, if applicable, have been given a copy of the Written instrument containing Your misrepresentation.

After Your coverage or increase in coverage under the Policy has been in effect for 2 continuous years during Your lifetime, We will not use a misrepresentation by You or by the Policyholder to:

- Reduce or deny a claim; or
- Deny the validity of Your coverage or increase in coverage;

unless it was a fraudulent misrepresentation made with actual intent to deceive, where permitted by applicable law in the state where the Policy was issued.

However, we have the right at any time to assert as a defense to a claim that You were not eligible to become covered because You did not meet the eligibility requirements in this Certificate, including, but not limited to, the requirements that You: (1) be in an Eligible Class; (2) submit and have approved Evidence of Insurability, if required; and (3) meet the Active Employment requirement.

WHAT CONSTITUTES THE ENTIRE CONTRACT?

Coverage is provided for eligible Employees under the Policy of group insurance between the Policyholder and Us. The Policy consists of:

- All Policy provisions and any amendments and/or attachments issued;
- The Policyholder’s application;
- Employees' signed Evidence of Insurability forms, if any; and
- The Certificate of Coverage.

HOW WILL WE HANDLE INSURANCE FRAUD?

We promise to focus on all means necessary to support fraud detection, investigation, and prosecution. It is a crime if You or the Policyholder knowingly, and with intent to injure, defraud or deceive Us, file a claim containing any false, incomplete or misleading information. These actions, as well as submission of false information, will result in denial of Your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

WHAT IF YOUR AGE OR OTHER DATA IS MISSTATED?

If Your age or other data on You is misstated, We have the right to make an equitable adjustment in the Premium or coverage due for You. The true facts will be used to determine if and for what amount coverage should have been provided for You.

DOES THE POLICYHOLDER ACT AS YOUR AGENT?

For all purposes of the Policy, the Policyholder acts on its own behalf or as Your agent. The Policyholder is not Our agent.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You can start legal action regarding Your claim 60 days after the date You sent us proof of claim. You have up to three years after the date of Your loss to start legal action, unless otherwise provided by law in the State of Policy Issue.

DOES THIS PLAN REPLACE OR AFFECT ANY REQUIREMENT FOR WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

This Plan does not replace or affect requirements for coverage by Workers' Compensation insurance.

ELIGIBILITY FOR COVERAGE

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

The Eligibility Date is the earliest date You are eligible for coverage under the Policy, when You have satisfied all requirements for coverage to begin, as required by the Policy:

- For an Employee in Active Employment who has completed any Waiting Period required by the Policyholder as of the Effective Date of the Policy; the Eligibility Date means the Effective Date of the Policy;
- For an Employee in Active Employment as of the Effective Date of the Policy who has not completed any Waiting Period required by the Policyholder, the Eligibility Date will be the date following the completion of the required Waiting Period; or
- For an Employee hired on or after the Effective Date of the Policy, the Eligibility Date will be the first date after the end of the Waiting Period, if any, required by the Policyholder.

If This Plan requires Employees to elect coverage under the Policy, the Eligibility Date will be the later of:

- The Employee's date of hire;
- The first date after any Waiting Period required by the Policyholder; or
- The approval by Us in Writing of any coverage for which You were required to provide Evidence of Insurability.

For Dependent coverage, this term means the date on which:

- You have newly acquired Dependents; or
- You are in a Class that includes Dependent coverage.

APPLICABLE TO EMPLOYEES
The term "Employee" is defined under the General Definitions section of this Certificate. Subject to the WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT ON THE DATE YOUR COVERAGE WOULD BE EFFECTIVE? section, each Employee in a class of Employees who may become insured under the Policy will become eligible on the latest of the following dates: (i) The Policy Effective Date; (ii) The date the Employee becomes a member of the class of Employees who may become insured; or (iii) the date the Employee satisfies the applicable Waiting Period specified in this Certificate.

If, after insurance of an Employee has ended, the Employee resumes Active Employment, the Waiting Period specified in this Certificate must again be satisfied before the Employee will again become eligible for insurance. However, if the Employee resumes Active Employment within three months after the Employee's insurance ended, previous Active Employment while in an Eligible Class of insurance under the Policy will apply toward the applicable Waiting Period.

For the purposes of the Policy, Employees of the company(ies) named on the Policyholder's application which are subsidiaries or affiliates of the Policyholder will be considered Employees of the Policyholder. If a company ceases to be a subsidiary or affiliate of the Policyholder, insurance under the Policy for the Employees of such company shall terminate on the date such company is no longer a subsidiary or affiliate of the Policyholder. Additional subsidiaries or affiliates of the Policyholder may be added after the Policy Effective Date via a Policy amendment. The effective dates for additional Employees of additional subsidiaries or affiliates must be approved by Us.

APPLICABLE TO DEPENDENTS (IF COVERED UNDER THIS CERTIFICATE)
If the Employee does not pay any part of the cost of Dependent coverage, a newly acquired Dependent is covered from the date he or she first becomes eligible.

If the Employee must pay part of the cost of Dependent coverage, and is already enrolled for Dependent coverage for Your initial Dependent, any newly acquired Dependent will be covered as of the date they are first eligible.

However, if the Employee was previously eligible to enroll for Dependent coverage and waived coverage or failed to enroll, We will not cover any Dependents until You submit Evidence of Insurability on Your Dependent, We approve that proof in Writing and the Employee makes any additional required payments.

Exception: We will postpone the Eligibility Date of a Dependent's, other than a newborn Child's, coverage if, on that date, he or she is confined to a Hospital or other health care facility or home confined, or unable to perform two or more Activities of Daily Living. In that case, We will postpone the Eligibility Date of his or her coverage until the day after the date of his or her discharge from such facility or his or her home confinement ends, or he or she no longer requires assistance with two or more Activities of Daily Living.

If a Dependent was covered under a prior plan at transfer and elected coverage under This Plan, this language will not apply to the amount of coverage that was in force with the prior plan.

PROOF OF FAMILY MEMBER ELIGIBILITY: We have the right to require proof of any fact relating to a person's qualifications to be a covered Dependent. All such proof must be satisfactory to Us.

EFFECTIVE DATES OF INSURANCE

WHEN DOES YOUR COVERAGE BECOME EFFECTIVE?
Your coverage will be effective on the date determined as follows:

NON-CONTRIBUTORY INSURANCE (THE POLICYHOLDER PAYS ALL PREMIUM.)
You will be insured under the Policy on the day You become eligible according to the records on file with Us.

Any change in the amounts of insurance as shown in the Plan Highlights shall become effective on the first day of the Policy Month coincident with or next following the date of change of Your classification, provided You are then in Active Employment; if You are not then in Active Employment, such change shall become effective on the day You return to Active Employment.

If You are not in Active Employment on the day Your insurance would otherwise begin, You will be insured on the day You return to Active Employment, except as otherwise provided in the ELIGIBILITY FOR COVERAGE section of the Policy.

CONTRIBUTORY INSURANCE (YOU PAY SOME OR ALL OF THE PREMIUM.)

To enroll, You must submit to Us a group enrollment form, and if We require it, a health information form. The Policyholder will provide instructions to You about this process.

If You enroll for insurance on or before the day You become eligible, You will be insured up to the Guaranteed Issue Limit on the day of your Eligibility Date.

If You enroll for insurance within 31 after the day You become eligible, You will be insured up to the Guaranteed Issue Limit on the day You enroll.

If You enroll more than 31 days after the day You become eligible, You are a late applicant. You will not be insured until the first day of the calendar month after We approve Your Evidence of Insurability provided to Us on a health information form. We may require You to have a medical exam at Our expense. We will either approve or decline insurance for You based on the medical information We obtain in the health information form and in the medical exam, if any was performed.

Any change in the amounts of insurance as shown in the Plan Highlights will become effective on the first day of the Policy Month coincident with or next following the date of the change , provided You are then in Active Employment. If You are not then in Active Employment, such change will become effective on the day You return to Active Employment.

To enroll for Dependent insurance, You must submit to Us an enrollment form listing each of the Dependents to be insured, and if We require it, complete the health information section of the enrollment form for each of the Dependents to be insured.

A Dependent will be insured on the latest of the following dates:

1. On the day the Dependent becomes eligible, if You enroll for Dependents' insurance on or before the day You first have a Dependent who is eligible; or
2. On the day You enroll the Dependent, if You enroll for Dependents' insurance within 31 days after the day You first have a Dependent who is eligible; or
3. The day Your insurance begins; or
4. For newborn Children the first day of the Age Limit for newborn Children as shown in the Plan Highlights.

If You enroll for Dependent insurance more than 31 days after the day the Dependent becomes eligible, Your Dependent will not be insured until the first day of the calendar month after We approve the Dependent's Evidence of Insurability provided to Us on a health information form. We may require the Dependent to have a medical exam at Our expense. We will either approve or decline insurance for the Dependent based on the medical information We obtain in the health information form and in the medical exam, if any was performed.

[**Guaranteed Issue Limit – Base Annual Compensation (BAC)**
If You apply for an amount of insurance above the Guaranteed Issue Limit, or for any subsequent increase in the amount of insurance due to an increase in the Base Annual Compensation (BAC) which is greater than 10%, You will not be insured until the first day of the calendar month after We approve Your Evidence of Insurability provided to Us on a health information form. We may require You to have a medical exam at Our expense. We will either approve or decline the increase in insurance based on the medical information We obtain in the health information form and in the medical exam, if any was performed.

WHEN IS EVIDENCE OF INSURABILITY REQUIRED?

You will need to provide Evidence of Insurability to us with Your application if You:

- Apply for coverage more than 31 days after the date You or Your Dependents are first eligible to apply or if required during an Enrollment Period; or
- Voluntarily terminate Your coverage and want to reapply for coverage; or
- Apply for an amount of coverage for which We require Evidence of Insurability, as noted in the PLAN HIGHLIGHTS section.

You must apply for coverage in Writing through the Policyholder and use an enrollment form that is satisfactory to Us. Coverage for amounts of insurance subject to such Evidence of Insurability will become effective on the 1st day of the month coinciding with or next following the date We approve Your Evidence of Insurability.
Your insurance will not go into effect on a date You are not in Active Employment because of a Sickness or Injury. Your insurance will go into effect after You have been in Active Employment for one full day in an Eligible Class, as shown on the PLAN HIGHLIGHTS section.

WHEN CAN YOUR COVERAGE UNDER THIS PLAN CHANGE?

For changes in This Plan, Your earnings, or Your class - Coverage changes become effective on the later of:

- The first of the month coinciding with or next following the date of the change; or
- The first of the month coinciding with or next following the date We approve Your Evidence of Insurability, if You are required to provide it.
- For Voluntary Life and AD&D Insurance coverage, This Plan's next Anniversary Date.

Increases in coverage due to changes in This Plan, Your earnings, or Your class are also subject to the terms of Active Employment.

Enrollment Period means a period of 31 days during which You may apply, in Writing, to change Your insurance under the Policy due to the occurrence of a Qualifying Event during the term of the Policy.

Re-enrollment Period means a period of time set by the Policyholder and Us during which You may apply, in Writing, for insurance under the Policy, or change Your insurance under the Policy if You are currently enrolled.

Qualifying Event means:

1. Marriage;
2. The birth, adoption or placement for adoption of a Child;
3. Divorce, legal separation or annulment;
4. The death of a Dependent; or
5. A change in Your or Your Dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your Dependent to gain or lose eligibility for insurance.

You may increase Your life insurance coverage at the time of a Qualifying Event without providing Evidence of Insurability in the amount indicated on the Plan Highlights.

If You are currently enrolled for coverage and do not re-enroll for coverage during a Re-enrollment Period, You will continue to be insured for the same coverage as previously enrolled. If You are not currently enrolled for coverage and do not enroll for coverage during the Re-enrollment Period, then You will not be eligible to enroll for coverage under the Policy until the next Re-enrollment Period.

If You apply to change Your coverage at any time other than during a Re-enrollment Period, We will need to approve Your Evidence of Insurability before any increase in coverage can become effective. In this instance, Your increase in coverage will become effective on the date We approve Your Evidence of Insurability.

If You are currently enrolled for coverage and do not re-enroll for coverage during a Re-enrollment Period, You will continued to be insured for the same coverage as previously enrolled.

Increases in coverage due to a change in Your coverage elections are also subject to the terms of the provision titled "WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT ON THE DATE YOUR COVERAGE WOULD BE EFFECTIVE?" provision.

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT ON THE DATE YOUR COVERAGE WOULD BE EFFECTIVE?

If the date You are first eligible is not a regularly scheduled work day because it falls on:

1. A holiday;
2. A vacation day;
3. A non-scheduled work day;
4. A day during an approved leave of absence not due to sickness or injury, lasting 90 days or less; or
5. A day during a period of absence that is less than 7 days in duration;

And if:

1. You are fully capable of performing the major duties of Your Regular Occupation for the Policyholder for the minimum number of hours of an Employee in Your Eligible Class in the Plan Highlights section on the Eligibility Date; and
2. You were performing the major duties of Your Regular Occupation and working the minimum number of hours of an Employee in Your Eligible Class on Your last regularly scheduled work day;

Then Your coverage will start on the Eligibility Date. However, any increases of coverage for which You must elect and pay all or part of the cost, will not start if You are on an approved leave, layoff or absence.

Delayed Eligibility: If You are not in Active Employment as a result of sickness or injury, We will postpone coverage for an otherwise covered loss for any condition that prevents You from being in Active Employment. The coverage will be postponed until You return to Active Employment working the minimum number of hours of an Employee in Your Eligible Class and performing the duties of Your Regular Occupation.

WHEN DOES YOUR COVERAGE UNDER THIS PLAN END?

Your coverage under This Plan will end on the earliest of the following:

1. Your coverage under the Policy ends when the first of the following events occurs:
   a. The Policy ceases;
   b. Premium payments for Your coverage cease;
   c. The date insurance for the class under which You are eligible ends;
   d. Upon the Your Written request;
   e. The date You attain the termination age shown in the PLAN HIGHLIGHTS section;
   f. The date Your employment in the classes of Employees eligible under the Policy ends; or
   g. The date on which Your maximum number of months or weeks of continued insurance as provided below ends.
2. A Dependent's insurance ends when the first of the following events occurs:
   a. The Policy ceases;
   b. Premium payments for the coverage of the Dependent ceases;
   c. Your coverage under the Policy ends; or
   d. The Dependent is no longer a Dependent eligible for coverage.

   The amount of Your coverage and Your Dependent's coverage will be that in force on the day before You stopped Active Employment. However, this provision is subject to any reduction in the amount of coverage due to You or Your Dependent's attainment of a specific age, as specified in the Plan Highlights.

WHAT HAPPENS TO YOUR COVERAGE IF YOU ARE ON A FAMILY OR MEDICAL LEAVE OF ABSENCE?

If you are on a Family or Medical Leave of Absence, your coverage will be governed by the Employer's Human Resource policy on Family or Medical Leaves of Absence.

We will continue your coverage if the following conditions are met:

- Premiums for the cost of your continued coverage are paid; and
- Your leave is approved in advance and in writing by the Employer.

Your coverage will continue for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993, and any amendments; or
- The leave period required by applicable state law.

While you are on an approved Family or Medical Leave of Absence, Your coverage amount will be based on the amount of coverage in force for You just prior to the date your Leave of Absence started to determine any Benefit payments to You.

If you return to Active Employment at the end of the approved Family or Medical Leave of Absence, your coverage will continue under the Policy. If you do not return to Active Employment at the end of the Family or Medical Leave of Absence, your coverage will end in accordance with WHEN DOES YOUR COVERAGE UNDER THIS PLAN END? provision.

If your coverage does not continue during a Family or Medical Leave of Absence, then when you return to Active Employment:

- You will not have to meet a new Waiting Period, including a Waiting Period for coverage of a Pre-existing Condition; and
- You will not have to give us Evidence of Insurability to reinstate the coverage you had in effect before your leave began.

WHAT HAPPENS TO YOUR COVERAGE IF YOU ARE ON A MILITARY SERVICES LEAVE OF ABSENCE?

We will allow your coverage to continue, for up to 4 weeks in a 12 month period, if you enter the military service of the United States. While you are on a Military Services Leave of Absence, the premium must be paid according to the terms specified in the Policy to keep the insurance in force. Changes such as revisions to coverage because of age, class, or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective for you until you have returned to work from Military Services Leave of Absence for one full day.

All other terms and conditions of the Policy will remain in force during this continuation period. Your continued coverage will cease on the earliest of the following dates:

- The date the Policy terminates; or
- The date ending the last period for which any required premium was paid; or
- 4 weeks from the date your continued coverage began.

If you return to Active Employment at the end of the Military Services Leave of Absence, your coverage will continue under the Policy. If you do not return to Active Employment at the end of the Military Services Leave of Absence, your coverage will end in accordance with WHEN DOES YOUR COVERAGE UNDER THIS PLAN END? provision.

WHAT HAPPENS TO YOUR COVERAGE IF YOU ARE ON A SABBATICAL AND OR IF YOUR LEAVE IS DUE TO A LAY-OFF?

We will allow your coverage to continue, for up to 12 months for a sabbatical leave and for up to 4 weeks in a 12 month period while you are on lay-off. The premium must be paid according to the terms specified in the Policy to keep the insurance in force. Changes such as revisions to coverage because of age, class, or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective for you until you have returned to work from lay-off or sabbatical for one full day.

While you are on lay-off or sabbatical, Your coverage amount will be based on the amount of coverage in force for You just prior to the date your lay-off or sabbatical started to determine any Benefit payments to You.

If you return to Active Employment at the end of the lay-off or sabbatical, your coverage will continue under the Policy. If you do not return to Active Employment at the end of lay-off or sabbatical, your coverage will end in accordance with WHEN DOES YOUR COVERAGE UNDER THIS PLAN END? provision.

If your coverage does not continue during a lay-off or sabbatical, then when you return to Active Employment:

- You will not have to meet a new Waiting Period, including a Waiting Period for coverage of a Pre-existing Condition; and
- You will not have to give us Evidence of Insurability to reinstate the coverage you had in effect before your leave began.

WHAT IF YOU ARE REHIRED BY THE POLICYHOLDER WITHIN THE SAME YEAR YOUR EMPLOYMENT TERMINATED?

If You are rehired by the Policyholder and Actively Employed within three months of Your employment termination date, then You will be insured for the same benefits and class of coverage that were in effect for You on the date Your employment terminated.

If your Termination of Employment was a result of Sickness or Injury, we will postpone coverage for an otherwise covered loss for any condition that resulted in your Termination. The coverage will be postponed until You:

1. Complete one full day of Active Employment, working the minimum number of hours of an Employee in Your Eligible Class, with the capacity to do so for one full week; and,
2. Do not miss a day of work due to the same condition for one week.

WHEN WILL INDIVIDUAL COVERAGE BE REINSTATED?

If Your and Your Dependent coverage ends due to Your employment termination and You are rehired to an Eligible Class within 90 days from the date Your employment terminated, Your and Your Dependent coverage may be reinstated if reinstatement is requested within 31 days from the date You again become eligible for coverage.

If You Converted coverage for You and Your Insured Dependents when Your employment terminated, the amount of Guaranteed Issue coverage available to You and any eligible Dependents upon Your reinstatement will be reduced by the amount of coverage that was ported or converted.

If Your insurance ends, You should refer to the following sections of the Policy regarding the rights that are available upon termination:

1. "Employee Right to Convert" provision;
2. "Employee Continuation of Basic and Voluntary and Dependent Term Life Insurance During Disability" provision; and
3. "Employee Continuation of Basic and Voluntary and Dependent Term Life Insurance due to Termination of Employment" provision.

If a Dependent's insurance ends, the Dependent should refer to the "Dependent Right to Convert" provision.

If the Policy ceases, Written notice of this shall be given to all Employees as soon as reasonably possible. The Policyholder is responsible for giving notice. The Written notice shall include information regarding Employee rights to conversion and other rights, if any, as provided in the Policy. If notice of the conversion right is not given on a timely basis, the Employee's right to convert shall be extended as described in the "Employee Right to Convert" provision.

FILING A CLAIM

WHEN DO YOU NOTIFY US OF A CLAIM?

Subject to the terms of this Certificate, We will pay the benefit Proceeds for a covered loss as shown in the Plan Highlights.

NOTICE OF CLAIM: Written notice of intent to file a claim under the Policy must be sent to Us within 20 days of the date of the loss. This Notice should include the name of the insured and the Policy number. For details and to request a claim form kit, You can contact Us at 888-358-9484 or www.renaissancefamily.com.

WHEN DO YOU NEED TO GIVE US PROOF OF YOUR CLAIM?

PROOF OF LOSS: Early proof of a claim will allow us to make a timely claim decision. You should send Written Proof of Loss to Our Home Office within 90 days of the loss. We will not void or reduce Your claim if We do not receive Notice and Proof of Loss within the required time. In that case, Notice and Proof of Loss must be sent as soon as reasonably possible.

Proof of Loss for a death claim will consist of a certified copy of the death certificate of the insured, or other lawful evidence providing equivalent information, and proof of the claimant's interest in the Proceeds. When We receive the claim form and Proof of Loss, We will review the Proof of Loss and if We approve the claim, We will pay the Proceeds to the Beneficiary subject to the terms of the Policy. If the Employee is not alive at the death of the Dependent, payment will be made to the Appropriate Payee.

For all other claims, Proof of Loss may include itemized bills as part of claim processing.

HOW DO YOU FILE A CLAIM?

CLAIM FORMS: We will furnish a claims form kit within 15 days of receipt of Notice of Claim. The process for completing and submitting the claim form will be explained in the claim form kit. If We do not furnish the forms on time, We will accept a Written notice and adequate proof of death that is the basis of the claim as Proof of Loss. Interest shall accrue on the death Benefit and be payable from the date of death. Interest shall accrue at the rate or rates applicable to the Policy for funds left on deposit or, if We have not established a rate for funds left on deposit, at the Two Year Treasury Constant Maturity Rate as published by the Federal Reserve.

Additional interest shall accrue at a rate of 10% annually beginning with the date that is 31 calendar days from the latest of items to the date the claim is paid,

- the date that due Proof of Loss following death is received by Us;
- the date We receive sufficient information to determine Our liability, the extent of the liability, and the appropriate payee legally entitled to the proceeds; and
- the date that legal impediments to payment of proceeds that depend on the action of parties other than Us are resolved and sufficient evidence of the same is provided to Us.

We will send You a benefit payment for any period for which We are liable under This Plan. If the Policy or Plan is canceled, the cancellation will not affect a payable claim.

TO WHOM DO WE MAKE BENEFIT PAYMENTS?

Unless otherwise specified in the Policy or Certificate, We will make all benefit payments to You, if living. Benefit payments that become due after Your death will be made to Your Beneficiaries.

APPLICABLE TO INSURANCE ON EMPLOYEES

The Loss of Life Proceeds are payable to Your Beneficiary, except as otherwise provided. No Proceeds will be paid until We have received Proof of Loss as set forth in the FILING A CLAIM section of this Certificate. You may name one or more Beneficiaries and You may designate the proportion of the Proceeds each named Beneficiary should receive. If there is a part of the insurance for which there is no named beneficiary living after Your death, payment will be made in a lump sum or sums to any of the following survivors in the following order of priority: Your (a) Spouse; (b) any children; (c) father or mother; or (d) any brother or sister. If none survives, that part will be paid in a lump sum payment to Your estate.

APPLICABLE TO INSURANCE ON DEPENDENTS

The Beneficiary of the Dependent's life insurance will be You. No benefits will be paid until We have received Proof of Loss as set forth in the Dependent Term Life Insurance provision of this Certificate. If You are not living at the time such Dependent dies, or die within one week of the Dependent, payment will be made: (a) In the case of a Spouse's death, to such Spouse's estate; and (b) In the case of a Child's death, to any of the following survivors, as We determine to be appropriate: the Child's (i) father or mother, or (ii) any brother or sister. If none survives, payment will be made to the Child's estate.

OPTIONAL MODES OF SETTLEMENT: As an alternative to having the life benefit paid in a single lump sum check, You may elect to have all or any part of the insurance for loss of life paid out to the Beneficiary in installments or in any other way that may be agreed to by Us. To make such an election, You must give Us Written notice in a form satisfactory to Us. You have the right to change such election. The terms of payment will be in accord with those offered by Us for the insurance at the time election is made.

After Your death , the Beneficiary:

1. May make such election if You had not done so;
2. May name person(s) to receive any amount which, if no person(s) were so named, would go to the Beneficiary's estate; and
3. Will have the right to change the person(s) name in accordance with the BENEFICIARY INFORMATION section of this Certificate.

WHAT HAPPENS IF WE OVERPAY YOUR CLAIM?

We have the right to recover overpayments that occur due to:

- Fraud;
- An error We make in processing Your claim; or
- If We determine that We should have paid You a different benefit amount from the amount actually paid on Your claim, We will adjust the benefit accordingly. If We determine that We overpaid Your claim, then We require that You repay us in full. We will determine the method by which You will repay us. We reserve the right to apply our future payments to You toward any outstanding overpayment balances. We have the right to recover overpayments from Your eligible survivors or estate. We reserve the right to deduct from Your claim payment any unpaid Premium due for Your coverage. We will not recover more money from You than the benefit amounts We paid to You.
- If We determine that We were overpaid Premium for Your coverage, We will refund the Premium to You.

WHAT HAPPENS IN THE EVENT OF SUICIDE?

Until You or Your Dependent have been insured under the Policy and any predecessor Policy for a continuous period of two years, no Proceeds will be paid for death which is caused or contributed to by suicide or any other intentionally self-inflicted injury, while sane or insane. Our liability will be limited to the return to the Appropriate Payee the amount of Premiums paid by You and the return to the Policyholder of all Premiums, if any, paid by the Policyholder for Your or Your Dependent's insurance.

Until any increase in the amount of Your or Your Dependent's insurance for which Evidence of Insurability is required has been in effect for a continuous period of two years, no Proceeds will be paid for death which is caused or contributed to by suicide or any other intentionally self-inflicted injury. Our liability will be limited to the amount of insurance that was in effect before the increase. We will return to the Appropriate Payee any Premiums paid by You for the increase and to the Policyholder any Premiums paid by the Policyholder for the increase in Your or Your Dependent's insurance.

APPEAL PROCEDURE

If Your claim has been denied in whole or in part, You or Your Beneficiary may request a review of the decision. You or Your Beneficiary must file a written request for appeal within 90days from the date of the notice of denial of Your claim. The right to appeal the denial may be forfeited if this deadline is not met.

Along with a written request for a review, You or Your Beneficiary should submit any additional information You believe should be considered during the review.

Upon request, We will provide You or Your Beneficiary with copies of documents, records and other information relevant to your claim, free of charge.

We will review the claim and respond with a final determination within 60 days. If We need additional time to decide the appeal, We may extend the review by 30 days. If we need such an extension, We will inform You or Your Beneficiary in writing: (1) that We need an extension, (2) why We need the extension, (3) what additional information We may need to complete the review, and (4) when You or Your Beneficiary can expect a decision. We will notify You or Your Beneficiary of the extension before the expiration of the initial 60-day period. In no event will the total period for review of the appeal exceed 90 days.

NOTIFICATION OF APPEAL DECISION

We will notify You or Your beneficiary, in writing, of Our final decision. If the claim is denied on appeal, the notice will include the following:

1. The specific reasons for the denial;
2. A reference to the specific provision(s) on which the decision for denial was based;
3. A statement regarding Your right, upon request and without charge, to a copy of documents, records and other information relevant to the claim; and, if applicable,
4. A statement regarding Your right to bring a civil action under Section 502(a) of ERISA following a denial on appeal.

BENEFICIARY INFORMATION

If You name two or more Beneficiaries:

1. Two or more surviving beneficiaries will share equally, unless You provide for unequal shares;
2. If You provide for unequal shares, and two or more Beneficiaries survive, We will pay each surviving Beneficiary his or her designated share, unless You provide otherwise. We will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries; and
3. If only one Beneficiary survives, We will pay the total Death Benefit to that Beneficiary, unless You provide otherwise.

You may name or change the Beneficiary at any time without the consent of a Beneficiary, if the right to do so has not been assigned. However, if an irrevocable beneficiary has been designated, such a Beneficiary cannot be changed without the consent of the irrevocable beneficiary. Once received by Us, the designation will take effect as of the date You signed the designation unless You have indicated a different date. Until the designation is received, We will not be liable for any action taken in good faith contrary to directions contained in the designation.

You may name or change Beneficiaries by providing Written notice to Us, or by submitting the change request electronically using the system provided by the Policyholder. We have the right to refuse to record any designation that does not comply with Our rules and regulations. All designations are subject to the terms and conditions of this Certificate.

Subject to the limitations stated in this Certificate, the designation of a Beneficiary in the application for a conversion policy will be treated as a request to name or change the Beneficiaries to the extent of the amount of insurance being converted.

If there is a part of the insurance for the loss of Your life for which there is no named beneficiary living at Your death, that part will be paid in a lump sum to the Appropriate Payee.

Any payment We make in good faith shall discharge Our liability to the extent of such payment.

TERM LIFE FEATURES – ACCELERATED DEATH BENEFIT

Only Employees are eligible for this Accelerated Death Benefit.

THIS COVERAGE PROVIDES AN ACCELERATED BENEFIT PROVISION. RECEIPT OF THIS ACCELERATED BENEFIT WILL REDUCE THE DEATH BENEFIT, MAY BE TAXABLE AND MAY AFFECT ELIGIBILITY FOR TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS. INSURED EMPLOYEES SHOULD SEEK ASSISTANCE FROM THEIR PERSONAL TAX ADVISOR.

BENEFIT AMOUNT FOR THE ACCELERATED DEATH BENEFIT: The amount of the Accelerated Death Benefit for which You may apply is based on the amount of Group Term Life insurance for which You are insured on the day before You apply for the benefit subject to the minimum and maximum amounts as shown in the Plan Highlights, less any reductions under the terms of the Policy or Certificate scheduled to apply within the next 12 months.

ACCELERATED DEATH BENEFIT DEFINITIONS:

ACCELERATED DEATH BENEFIT means the benefit payable if You are certified as Terminally Ill.

CERTIFIED or **CERTIFICATION** refers to a Written statement, made by a Physician on a form provided by Us, as to Your Terminal Illness.

DISCOUNT AMOUNT means the amount of the Accelerated Death Benefit which is available to You and is discounted to the present value in 6 months from the date this benefit is paid, using the Discount Rate. A detailed statement of the method of computing the amount of the Accelerated Death Benefit is available from Us on request.

DISCOUNT RATE means the greater of:

1. The then current yield on the 90-day Treasury Bills available at the date of application for an Accelerated Death Benefit; or
2. The Moody's Corporate Bond Yield Averages-Monthly Average Corporate published by Moody's Investors Service, Inc., or successor thereto, for the calendar month ending two months before the date of application for an Accelerated Death Benefit.

TERMINALLY ILL or **TERMINAL ILLNESS** refers to an illness or physical condition that is certified by a Physician to reasonably be expected to result in death in 12 months or less.

PAYMENT CONDITIONS: This benefit is payable if You are Certified as Terminally Ill. In order for this benefit to be paid: (a) We must receive a Written request; and (b) We must receive from any assignee or irrevocable beneficiary his or her signed acknowledgement and agreement to payment of this benefit.

We may, at Our option, confirm the terminal diagnosis with a second medical exam performed at Our expense. In the event that the second medical exam conflicts with the initial certification, we would refer the two findings to a third medical provider at Our expense and mutually agreed upon by the Insured and Us for a final determination within 14 days.

If You die after You elect to receive an Accelerated Death Benefit but before any such benefits are received, the election shall be cancelled and the Proceeds will be paid pursuant to the terms of this Certificate.

PAYMENT OF THE ACCELERATED DEATH BENEFIT: If We approve Your application for this benefit, We pay the amount You have elected, less the: (1) present value discount; and (2) processing fee. We pay this benefit to You immediately upon due Written proof of benefit eligibility in one lump sum. This payment is subject to all of the other terms of the Certificate. The Accelerated Death Benefit is payable and can be utilized only one time and cannot exceed the Maximum Benefit as shown in the Plan Highlights. If any index used in determining interest or expense charges for the Accelerated Death Benefit, We will use an appropriate substitute index subject to the approval of the Interstate Insurance Product Regulation Commission.

PROCESSING FEE: A fee in the amount shown in the PLAN HIGHLIGHTS will be required for the administrative cost of evaluating and processing Your application for this benefit. This fee is deducted from the amount of the Accelerated Death Benefit paid to You.

EFFECT OF ACCELERATED DEATH BENEFIT: If You become eligible for, and elect to receive this benefit, the following will result:

1. The Death Benefit used to determine Proceeds will be reduced by the amount of Death Benefit accelerated. The reduced amount of insurance will be subject to all Policy provisions dealing with changes in the amount of insurance and reductions or termination for age or retirement. The amount of the Death Benefit accelerated plus the remaining Death Benefit will not exceed the amount that would have been paid as a Death Benefit in the absence of this coverage;
2. Any amount of insurance that would otherwise be continued under a waiver of Premium provision will be reduced by the amount of the Death Benefit accelerated. Conversion privileges will still be available for the reduced amount of insurance that remains in force after acceleration;
3. THE PREMIUM AMOUNT DUE FOR THE EMPLOYEE LIFE INSURANCE BENEFIT WILL REMAIN THE SAME AFTER THE DEATH BENEFIT IS ACCELERATED.

Any Accidental Death and Dismemberment benefit provision will not be affected by payment of the Accelerated Death Benefit.

Upon a request for an Accelerated Death Benefit and upon payment of an Accelerated Death Benefit, We will provide a statement to You and any assignee of record and any irrevocable beneficiary of record demonstrating the effect of the acceleration on the Death Benefit and the Premium.

The acceleration of part of a Death Benefit shall not impact other Dependent coverage under this Certificate whether or not the Dependent coverage is based on a percentage of the Death Benefit.

TERMINATION OF AN ACCELERATED DEATH BENEFIT: This Accelerated Death Benefit coverage will terminate on the first of the following:

1. The date of termination of the Policy;
2. The date You are no longer an insured Employee;
3. The date Your coverage under this Certificate terminates;
4. The date of payment of the Accelerated Death Benefit; or
5. Upon Your Written request.

Such termination shall not prejudice the payment of benefits for any Qualifying Event that occurred while the Accelerated Death Benefit was in force.

EXCEPTIONS: The Accelerated Death Benefit will not be available if the Terminal Illness is due to any intentionally self-inflicted injury or suicide attempt. The Accelerated Death Benefit will not be available if:

1. You are required by a health care facility to use the Accelerated Death Benefit as a condition of admission to such facility or for providing any care in such facility or to continue a government benefit or entitlement; or
2. You have previously received an Accelerated Death Benefit under this Certificate.

TERM LIFE FEATURES – WAIVER OF PREMIUM

If, while insured and prior to age 60, You become Totally Disabled for a continuous period of at least nine months, Your Group Term Life insurance will be extended under this Certificate. When Your insurance is extended, no Premium will be due for such insurance. Premium will continue to be due for Dependent insurance, if any. No additional benefits, such as Accidental Death and Dismemberment (AD&D) Benefits, will be extended under this benefit.

For purposes of this WAIVER OF PREMIUM section, "Total Disability" or "Totally Disabled" means that due to injury or disease, You are unable to perform the material duties of Your regular job and You are not able to perform for remuneration or profit any work for which You are reasonably fitted by training, education and experience. Total disability will be deemed to have ended if You do any work for which You are reasonably fitted by training, education and experience.

If Your coverage terminates, You are Totally Disabled and until You have been approved by Us for this Waiver of Premium benefit, You must exercise Your right to continue insurance under the Employee Continuation of Basic and Voluntary and Dependent Term Life Insurance During Disability provision of this Certificate or the Employee Right to Convert to an individual Policy. You must remain insured under such continuation provision, or individual Policy until We approve this Waiver of Premium benefit.

If We approve You for this Waiver of Premium benefit, Your coverage under the continuation provision, conversion policy will be cancelled by Us, any Premium paid under the continuation provision, conversion policy will be refunded to the Policyholder or You (whoever paid the Premium), and Your Group Term Life insurance will be once again extended under this Certificate. In no event will We be liable to pay a Death Benefit under more than one of the waiver, conversion, or continuation provisions of this Certificate.

If You die while eligible for this Waiver of Premium benefit and after Your insurance has been converted, but before You have been approved by Us for this Waiver of Premium benefit, any amount paid under the individual Policy will be deducted from the Proceeds due under this Certificate, and Premiums paid under the individual Policy will be paid to the Beneficiary of that Policy on return of that Policy to Us; and any Premiums paid under a continuation provision will be refunded to the Policyholder, if paid by the Policyholder, and to the Beneficiary designated by You under this Certificate, if paid by You.

Your claim including written notice and proof by way of Your Statement and attending Physician's statement stating that Disability began prior to age 60 and while You were insured and the Disability has existed continuously for nine months must be given to Us at Our Home Office within 12 months from the date You become Totally Disabled. We may, at Our option, confirm this Waiver of Premium benefit eligibility with a second or third medical opinion performed at Our expense. The second medical opinion may include a physical examination by a Physician designated by Us. In the case of conflicting opinions, eligibility for this Waiver of Premium benefit will be determined by a third medical opinion, which may include a physical examination that is provided by a Physician that is mutually acceptable to You and Us.

The claim with written notice and proof must be given to Us during Your lifetime and during the period of Total Disability. Failure to give such notice will not invalidate or reduce any claim if such notice and proof was given as soon as reasonably possible, and, in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. We will send You written notice advising whether You have been approved for the Waiver of Premium benefit and, if approved, the amount of the Premium being waived. Premium payments need to be paid by You and upon submission of satisfactory proof, any Premium paid for Your coverage after the date Disability began will be refunded. However, no Premium due more than one year before satisfactory proof is received will be waived. We may require satisfactory proof of continued Total Disability at reasonable intervals, but not more often than once per year.

If You die while Premiums are being waived, the Premiums waived under this provision will not be deducted from the Proceeds, but the amount of insurance will be reduced by any conversion benefit payable under the "Employee Right to Convert," or any continuation provisions of this Certificate.

No Premium due more than one year before proof is received will be waived. An otherwise valid claim will not be reduced or denied if it was not reasonably possible to furnish such notice and proof within such time, provided such notice and proof were provided as soon as was reasonably possible.

While Your insurance is extended under this provision, You will be covered for the amount of life insurance for which You were insured just before ceasing Active Employment due to Total Disability. This amount is subject to reduction, if any, as shown in the Plan Highlights.

Your insurance will end when You: (a) Cease to be Disabled; (b) Fail to give required proof as set forth above; (c) Fail to submit to a health exam required by Us; (d) Attain age 65; or (e) attain Your Retirement Date. When this insurance ends, You will have the same conversion rights as those described under the "Employee Right to Convert" and continuation of insurance rights as those described under "Employee Continuation of Basic and Voluntary and Dependent Term Life Insurance During Disability" sections of this Certificate, unless You become insured again under the Policy.

Termination of this Certificate will not affect an otherwise valid claim arising from Total Disability which began before such termination.

TERM LIFE FEATURES – CONTINUATION

EMPLOYEE CONTINUATION OF TERM LIFE INSURANCE DURING TOTAL DISABILITY OR TERMINATION OF EMPLOYMENT

REQUESTING CONTINUATION

If Your employment and Group Term Life insurance is terminated while You are Totally Disabled, or because You are no longer employed by the Policyholder, then You will have the option to continue such insurance, including insured Dependent Term Life Insurance, if any, without having to provide Evidence of Insurability, for up to 12 months from the date of termination, by applying for continuation of insurance, and paying the Premiums directly to Us for the continuation on the same basis as Premiums were paid on the day before Total Disability, provided that You meet the applicable requirements below.

For purposes of this CONTINUATION section, "Total Disability" or "Totally Disabled" means that due to injury or disease, You are unable to perform the material duties of Your regular job and You are not able to perform for remuneration or profit any work for which You are reasonably fitted by training, education and experience. Total disability will be deemed to have ended if You do any work for which You are reasonably fitted by training, education and experience.

For Continuation of Basic, Voluntary and Dependent Term Life Insurance During Total Disability, You must:

1. Pay the first Premium for the continuation of insurance: (a) within 31 days after the date Your insurance is terminated under the Policy, or (b) within any extended period of time to exercise continuation provided below;
2. Provide Written notice and proof to Us at Our Home Office that You were Totally Disabled on the date insurance terminated. Proof that covered Total Disability lasted until death must be given to Us within one year after death occurs. We have the right to have Our medical representative examine You when necessary.

For Continuation of Basic, Voluntary and Dependent Term Life Insurance During Termination of Employment, You must:

1. Pay the first Premium for the continuation of insurance: (a) within 31 days after the date Your insurance is terminated under the Policy if notice is given to You by the Policyholder at least 15 days before termination; or (b) within any extended period of time to exercise continuation provided below;
2. Be insured under this Certificate for at least 6 consecutive months prior to the date Your insurance terminated under this Certificate;
3. Keep this Certificate in force;

4. Be under age 70; and
5. Be a citizen or resident of the United States; and
6. Not be receiving a waiver of Premium benefit under this Certificate.

CONTINUATION OF INSURANCE

Continuation of insurance will be for the amount and types of life insurance, including Dependent life insurance, if any, for which You were insured on the day before Your insurance would otherwise terminate under the Policy; subject to all applicable provisions under this Certificate, including reductions due to age. The Dependent Term Life Insurance, if any, can only be continued when Your term life insurance is continued. No additional benefits, such as Accidental Death and Dismemberment (AD&D) Benefits, may be continued under this provision.

We will bill You for the insurance Premiums. If the Premium is not paid on or before its due date, the insurance will enter a 31 day grace period. If the Premium due is not paid by the end of the grace period, the insurance will terminate as of the Premium due date. Nothing in this section will impair or be deemed to impair Our right to change Premium rates in accordance with the provisions of the Policy.

If You or Your covered Dependent(s) die(s) during the 31 day grace period, Proceeds will be payable under the terms of the Policy, provided that insurance would not have terminated for other reasons prior to the date of death.

RIGHT TO CONVERT DURING CONTINUATION OF INSURANCE

You and Your covered Dependents will have the right to exercise the Right to Convert at any time while insured under these continuation of insurance provisions. We will give You a notice of Your and Your covered Dependents' right to exercise the Right to Convert within 15 days before termination of Your and Your covered Dependents' continuation insurance. If notice is so given, then the Conversion Period will be 31 days after the date the continuation insurance terminates.

If You are not given notice of the right to exercise the Right to Convert at least 15 days before the termination of the continuation insurance, then the Conversion Period will expire on the later of 16 days after You are given such notice or 31 days after the insurance ended, but in no event shall the Right to Convert extend beyond 91 days after the insurance ends.

If You die during the period to elect continuation of life insurance, We will pay Your beneficiary Proceeds calculated using the amount of life insurance for which You were insured on the day before insurance terminated, subject to all applicable provisions under this Certificate, upon receipt of Proof of Loss establishing that You died during the continuation period. If Your covered Dependent dies during the continuation period, We will pay Your Proceeds in accordance with the terms of this Certificate. If You are not alive at the death of the covered Dependent, payment will be made in accordance with the terms of this Certificate. The Dependent Right to Convert provision describes the conversion rights available to all other covered Dependents.

This option to continue Employee and Dependent term life insurance, if any, is in addition to Your Right to Convert to an individual Policy. However, any amount of insurance converted will no longer be eligible for continuation under this continuation of insurance provision. In no event will We be liable to pay a Death Benefit under more than one of the conversion and continuation provisions of this Certificate.

TERM LIFE FEATURE – CONVERSION

EMPLOYEE RIGHT TO CONVERT

Right to Convert means the right to buy an individual policy of life insurance during the Conversion Period set forth below without submitting Evidence of Insurability. The individual conversion policy may be on any one of the life insurance forms that We customarily make available for purposes of conversion, except for term insurance.

You have a Right to Convert the life insurance in force on Your life and on the lives of Your Dependents then covered under this Certificate (if any) on the date ("Employee Conversion Date") Your life insurance under this Certificate ends or is reduced for any reason other than failure to make the required Premium payment.

If You have a Right to Convert, the maximum amount that can be converted is the amount of the Basic term life insurance, including any Voluntary term life insurance that ended or was reduced. Any additional insurance such as Accidental Death and Dismemberment (AD&D) insurance is not available for conversion. The amount which can be converted is reduced by the amount of life insurance for which You may be or may become eligible under any group policy issued or reinstated by Us or another insurer within 31 days after the date Your insurance ended or was reduced. If the amount of life insurance that terminated is below the standard minimum that We offer or make available for purposes of conversion, the entire amount must be converted.

Conversion Period and Notice of Right to Convert When the Employee's Insurance Ends or is Reduced:
In order to exercise the Right to Convert, You must apply to Us in Writing for an individual policy of insurance and pay Us the first Premium for the individual policy of insurance within the Conversion Period set forth below.

The Policyholder must give You notice of the Right to Convert at least 15 days before a termination or reduction in the amount of insurance. If notice is so given, then the Conversion Period will be 31 days after the Employee Conversion Date.

If You are not given notice of the Right to Convert at least 15 days before a termination or reduction in the amount of insurance, then the Conversion Period will expire at the later of 16 days after the notice of the Right to Convert is given or 31 days after the Employee Conversion Date.

But in no event will the right to convert extend beyond 91 days after the Employee Conversion Date.

Full compliance with the notice requirements will be satisfied by Written notice that is:

1. Given to You by the Policyholder; or
2. Mailed to You by the Policyholder to Your last known address.

If the Right to Convert is exercised, the individual policy of life insurance will become effective on the day after the Conversion Period ends.

The Premium payable will be based on the rates in use by Us on the date the individual conversion policy takes effect. The rates will be those applicable to the form and amount of the policy chosen, the attained age used at issue, and the class of risk under this Certificate.

During the Conversion Period, Your life insurance will continue under the terms of this Certificate. If an Employee with the Right to Convert dies during the Conversion Period provided above, We will pay Proceeds calculated using the maximum amount of life insurance You had a Right to Convert. Such amount will be paid to the beneficiary named under this Certificate. If You had applied for and paid Premium for a conversion policy, the Premiums paid for the conversion policy shall be refunded.

The right to elect to continue insurance under this Certificate under the Employee Continuation of Basic and Voluntary and Dependent Term Life Insurance due to Termination of Employment or During Disability provisions of this Certificate is in addition to Your Right to Convert, not in lieu of the Right to Convert. However, any amount converted will no longer be continued under this Certificate.

In no event will We be liable to pay Proceeds under more than one of the conversion and continuation provisions of this Certificate.

DEPENDENT RIGHT TO CONVERT
Right to Convert means the right to buy an individual policy of life insurance during the Conversion Period set forth below without submitting Evidence of Insurability. The individual conversion policy may be on any one of the life insurance forms that We customarily make available, except for term insurance.

A Spouse insured under this Certificate has the Right to Convert the life insurance in force on his or her life on the date (the "Spouse Conversion Date") insurance terminates because:
1. The insured Employee dies. In such case, the Spouse also has the Right to Convert any life insurance then in force on the lives of any Children then covered under this Certificate; or
2. The insured Employee and Spouse divorce or annul their marriage or terminate their domestic partnership.

A Child insured under this Certificate has the Right to Convert the life insurance in force on his or her life on the date such Child's insurance terminates because he or she has reached the Age Limit under this Certificate (the "Child Conversion Date").

You may have the Right to Convert Dependent life insurance under other circumstances as set forth in the "Employee Right to Convert" provision of this Certificate.

If a Dependent has a Right to Convert, the maximum amount that can be converted is the amount of the life insurance, including Voluntary insurance, if any, but excluding any other additional insurance such as Accidental Death and Dismemberment (AD&D) insurance, that ended or was reduced. If the amount of life insurance that terminated is below the standard minimum that We offer or make available for purposes of conversion, the entire amount must be converted.

Conversion Period When Dependent Insurance Ends or is Reduced:
In order to exercise the Right to Convert, the Dependent with the Right to Convert must apply to Us in Writing for an individual policy of insurance and pay Us the first Premium for the individual Policy of insurance within the Conversion Period set forth below.

If the Right to Convert is exercised, the individual policy of life insurance will become effective on the day after the Conversion Period ends.

The Premium payable will be based on the rates in use by Us on the date the individual conversion policy takes effect. The rates will be those applicable to the form and amount of the policy chosen, the Insured Person's then attained age, and the class of risk under the Policy.

During the Conversion Period provided above, the Dependent's life insurance will continue under the terms of this Certificate. If a Dependent with the Right to Convert dies during the Conversion Period provided above, We will pay Proceeds calculated using the maximum amount of life insurance the Dependent had a Right to Convert. If the Dependent had applied for and paid Premium for a conversion policy, the Premiums paid for the conversion policy shall be refunded. In no event will We be liable to pay a Death Benefit under both this Certificate and the conversion policy.

POLICYHOLDER NOTICE

The Policyholder must give You notice of the right to:
1. Continue term life insurance; and
2. Convert term life insurance.

Notice must be provided to You at least 15 days before the termination of Your insurance. If notice is so given, the rights will remain in effect for 31 days after the date Your insurance terminated.

If You are not given notice of Your rights at least 15 days before the termination of Your insurance, then the rights will expire on the later of 16 days after You are given such notice or 31 days after the insurance ended, but in no event shall the rights extend beyond 91 days after the insurance ends.

Full compliance with this provision will be satisfied by Written notice that is:
1. Given to You by the Policyholder; or
2. Mailed to You by the Policyholder at Your last known address.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

ACCIDENTAL DEATH AND DISMEMBERMENT PAYMENT

If You or Your Dependent suffer a Loss described below, We will pay the amount of insurance that applies. You, or Your beneficiary, must give Us proof that:

1. Injury occurred while the insurance was in force under this section of this Certificate;
2. The loss was due to an Injury independent of all other causes; and
3. The loss occurred within 365 days after the Injury.

In paying Accidental Death and Dismemberment (AD&D) benefits, We will consider only losses sustained while insured under this section of this Certificate. We will pay no more than the full amount shown in the Plan Highlights below for losses resulting from any one Injury.

PLAN HIGHLIGHTS – AD&D INSURANCE

ACCIDENTAL DEATH AND DISMEMBERMENT PLAN HIGHLIGHTS	
Base Benefits	**Principal Sum Benefit Percentage** Percentage (%) of the Accidental Death and Dismemberment Principal Sum up to the Maximum Amount or Duration Allowed. Unless otherwise specified, the Principal Sum is based on the Insured Person who incurred the injury. **Benefit Limitations** In addition to Limitations and Exclusions included under the Certificate.
Loss of Life ("Principal Sum")	100% of the Basic Term Life Insurance applicable to the Insured Person who incurred the Injury.
Seatbelt	10% of the Principal Sum up to $10,000
Airbag	10% of the Principal Sum up to $10,000

ENHANCED BENEFITS ACCIDENTAL DEATH AND DISMEMBERMENT PLAN HIGHLIGHTS	
Enhanced Benefits The Base and Enhanced Benefits combined will be limited to no more than 150% of the Loss of Life ("Principal Sum") amount.	**Principal Sum Benefit Percentage** Percentage (%) of the Accidental Death and Dismemberment Principal Sum up to the Maximum Amount or Duration Allowed. Unless otherwise specified, the Principal Sum is based on the Insured Person. **Benefit Limitations** In addition to Limitations and Exclusions included under the Certificate.
Loss of both hands or both feet	100% of the Principal Sum
Loss of sight of both eyes	100% of the Principal Sum
Loss of one hand and sight of one eye	100% of the Principal Sum

Loss of one foot and sight of one eye	100% of the Principal Sum
Loss of one hand	50% of the Principal Sum
Loss of one foot	50% of the Principal Sum
Loss of one arm	50% of the Principal Sum
Loss of one leg	50% of the Principal Sum
Loss of sight of one eye	50% of the Principal Sum
Loss of speech	50% of the Principal Sum
Loss of hearing	50% of the Principal Sum
Loss of thumb and index finger of the same hand	25% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Paraplegia	50% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Triplegia	50% of the Principal Sum
Uniplegia	50% of the Principal Sum
Common Carrier Hazard Benefit	10% of Your Principal Sum
Repatriation Benefit	The lesser of the amount of the repatriation cost; 10% of the Principal Sum on that Insured Person; or $10,000
Coma	Lesser of: 1. 5% of the Principal Sum; or 2. $5,000
Child Care Benefit	3% of Your Principal Sum up to $2,500 per year for 4 years The Child Care Benefit is not payable beyond the date the Child reaches age 13.
Education Benefit For Qualified Children	5% of Your Principal Sum up to $2,500 per year for 4 years The Qualified Children Education Benefit is not payable beyond the date the Child reaches age 26 Per Qualified Child per school year, not to exceed 4 school years per Qualified Child.
Spouse Training Benefit	Lesser of: 1. Expense incurred for the training which includes tuition charged and the cost of materials needed, but does not include room and board cost; 2. 10% of Your Principal Sum; or 3. $2,500.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE DEFINITIONS

COMA means a state of deep and total unconsciousness from which the comatose person cannot be aroused for a continuous period of at least 90 days.

HEMIPLEGIA means total and permanent Paralysis (as defined below) of upper and lower Limbs on one side of the body.

INJURY means bodily injury resulting from an accident, independent of disease, illness, acting as an organ donor, or complications of pregnancy and not related to any other cause.

INPATIENT means a person confined in a Hospital, for whom at least one day's room and board charge is made by the Hospital as a result of an Injury.

LIMB means an entire arm or an entire leg.

LOSS means any loss of use or loss of appendage due to an Injury and covered under This Plan.

LOSS OF ARM means severance at or above the elbow.

LOSS OF FOOT means severance at or above the ankle but below the knee.

LOSS OF HAND means severance at or above the wrist but below the elbow.

LOSS OF HEARING means total and irrecoverable hearing impairment in both ears that continues for a period of at least 180 days and cannot be corrected by medical or surgical treatment.

LOSS OF LEG means severance at or above the knee.

LOSS OF SIGHT means permanent and uncorrectable vision impairment that continues for 180 days and is not correctible by medical or surgical treatment or artificial means. The visual acuity must be 20/200 or worse in the eye and the field of vision must be less than 20 degrees.

LOSS OF SPEECH means the total and irrecoverable loss of audible communication that continues for a specified period of time, not to exceed 180 days, following the date of loss.

LOSS OF THUMB AND INDEX FINGER means the actual, complete and permanent severance through or above the metacarpophalangeal joints.

PARAPLEGIA means total and permanent Paralysis of both lower Limbs.

PARALYSIS means permanent impairment and loss of the ability to voluntarily move or to have sensation in any Limb. Paralysis must be the result of an Injury and without the severance of a Limb.

QUADRIPLEGIA means total and permanent Paralysis of both upper and lower Limbs.

REGULAR CARE means:

1. You personally visit a Physician as often as is medically required to effectively manage and treat Your condition(s), according to generally accepted medical standards; and
2. You are receiving appropriate treatment and care, according to generally accepted medical standards.

SICKNESS means a diagnosed illness, disease or pregnancy.

SPEECH means the power of audible expression.

TREATMENT means: Consulting with a Physician; Receiving care or services from a Physician or from another medical professional a Physician recommends; Taking prescribed medicines as prescribed; and receiving diagnostic measures.

TRIPLEGIA means total and permanent Paralysis of three Limbs.

UNIPLEGIA means total and permanent Paralysis of one Limb.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE ADDITIONAL BENEFITS

SEAT BELT AND AIR BAG BENEFIT

These benefits apply to all Insured Persons.

SEAT BELT BENEFIT: We will pay a Seat Belt Benefit if a Loss of Life benefit is payable under this AD&D insurance and the loss of Your or Your covered Dependent's life results from Injuries sustained while driving or riding in a Private Passenger Car if Your or Your Dependent's Seat Belt was properly functioning and fastened. The investigating officer must certify the correct position of the Seat Belt. A copy of the police report must be submitted with the claim.

The amount of the Seat Belt Benefit is as shown in the AD&D Plan Highlights.

A benefit is not payable under this provision if You or Your Dependent are the driver of the Private Passenger Car and You or Your Dependent do not hold a current and valid driver's license at the time of the accident.

AIR BAG BENEFIT: We will pay an Air Bag Benefit if a Seat Belt Benefit is payable for the loss of Your or your Dependent's life and the Private Passenger Car is:

1. Equipped with a single Air Bag and the deceased person was the driver; or
2. Equipped with an Air Bag for both the driver and for the front passenger seat and the deceased person was the driver or front seat passenger; or
3. Equipped with an Air Bag for the driver seat, for the front passenger seat and for all rear passenger seats and the deceased person was the driver, front seat passenger or rear seat passenger; and
4. The police report or other evidence establishes that the Air Bag in the seat the deceased person was occupying inflated properly upon impact.

The amount of the Air Bag Benefit is as shown in the AD&D Plan Highlights.

DEFINITIONS APPLICABLE TO SEAT BELT AND AIR BAG BENEFIT

AIR BAG means, for the purposes of this AD&D Benefit, a supplemental restraint system that inflates for added protection to the head and chest areas. The Air Bag must meet published federal safety standards.

PRIVATE PASSENGER CAR means, for the purposes of this AD&D Benefit, any validly registered four-wheel private car, four-wheel drive vehicle, sports-utility vehicle, pick-up truck, or mini-van. It does not include any commercially licensed car, any private car being used for commercial purposes, or any vehicle used for recreational or professional racing.

SEAT BELT means, for the purposes of this AD&D Benefit, any restraint device, which meets published federal safety standards, has been installed by the car manufacturer and has not been altered after such installation.

DEPENDENT SPOUSE TRAINING BENEFIT

This benefit applies to You for Your covered Spouse.

We will pay a Dependent Spouse Training Benefit to Your Spouse if the Spouse:

1. Is an Insured Person under this Certificate on the date You died as a result of an Injury and a Loss of Life benefit is payable for You under this AD&D insurance; and
2. Enrolls in a postsecondary institution, professional or trade school training program:
   a. For the purpose of obtaining an independent source of support and maintenance; and
   b. Within 24 months of the date of Your death.

The Dependent Spouse Training Benefit payable is as shown in the AD&D Plan Highlights.

QUALIFIED CHILDREN EDUCATION BENEFIT

This benefit applies to You or Your covered Spouse.

We will pay a yearly education benefit to each of Your Qualified Children if:

1. You died as the result of an Injury and a Loss of Life benefit is payable under this AD&D insurance;
2. You die within 90 days after the date of the accident causing the accidental bodily Injury;
3. Proof is given to Us that the Child is a Qualified Child (as defined below); and
4. The Qualified Child continues to be enrolled on a Full-Time Basis in an accredited post-secondary institution of higher learning.

The amount of the Qualified Child Education Benefit is as shown in the AD&D Plan Highlights.

This Qualified Children Education Benefit is payable in addition to any other benefits provided under this Certificate. We will not pay more than one Qualified Children Education Benefit per Qualified Child during any one school year.

The Qualified Child Education Benefit will terminate for each Qualified Child on the earliest of the following dates:
1. The date the Qualified Child fails to furnish proof of enrollment as required by Us;
2. The date the Qualified Child no longer qualifies as a Dependent Child for any reason except Your death; or
3. The date on which the maximum number of years this Qualified Children Education Benefit, as shown in the AD&D Plan Highlights, has been paid.

The following terms are defined for the purposes of this Qualified Children Education Benefit:

QUALIFIED CHILD OR CHILDREN means any of Your unmarried Children under the age of 26 who, on the date of Your death as a result of an Injury, was either:
1. Enrolled on a Full-Time Basis in an accredited post-secondary institution of higher learning; or
2. At the 12th grade level and enrolls on a Full-Time Basis in an accredited post-secondary institution of higher learning within 365 days following the date of Your death.

FULL-TIME BASIS means full-time as defined by the accredited post-secondary institution of higher learning being attended by the Qualified Child.

CHILD CARE EXPENSE BENEFIT
This benefit applies to You.

We will pay a Child Care Expense Benefit if:
1. You and Your Child are insured under this Certificate; and
2. You died as the result of an Injury and a Loss of Life benefit is payable for You under this AD&D insurance.

This benefit will be paid on behalf of any insured Child under the age of 13 or any insured Child age 13 or older who needs ongoing Personal Care Assistance (as defined below), who is receiving child care from a licensed child care provider at the time of Your death, or within 90 days of Your death. Personal Care Assistance means assistance with bathing, dressing, hair care, and other personal needs in the Child's place of residence. Payment will be made to the insured Child's parent or legal guardian.

The amount of the Child Care Expense Benefit is as shown in the AD&D Plan Highlights.

This Child Care Expense Benefit is payable each year for each Child who qualifies for Child Care Expense Benefits. No more than the maximum number of years specified in the AD&D Plan Highlights will be payable for each insured Child.

To receive this benefit, the Child's parent or legal guardian must provide Written proof satisfactory to Us that he or she has incurred expenses that entitle him or her to the Child Care Expenses Benefit. Expenses must be charged by a child care provider who is licensed to provide such services in the jurisdiction in which the services are provided.

The Child Care Expense Benefit will end on the earlier of the following:
1. The date the Child is no longer receiving child care from a licensed child care provider;
2. The date the maximum number of Child Care Expense Benefits have been paid;
3. The date the Child reaches 13 years of age unless the Child needs ongoing Personal Care Assistance.

REPATRIATION BENEFIT
This benefit applies to all Insured Persons.

We will pay a Repatriation Benefit if all of the following requirements are met:
1. You or Your covered Dependent died as the result of an Injury and a Loss of Life benefit is payable for You or Your covered Dependent under this AD&D insurance;
2. Your or Your covered Dependent's death occurs more than 100 miles from Your or Your covered Dependent's primary place of residence; and
3. Expense is incurred for the transportation of Your body or Your covered Dependent's body to a mortuary near the primary place of residence.

The amount of the Repatriation Benefit is as shown in the AD&D Plan Highlights.

The Repatriation Benefit is payable subject to satisfactory Written proof of the incurred transportation expense.

COMMON CARRIER HAZARD BENEFIT
This benefit applies to all Insured Persons.

We will pay a Common Carrier Hazard Benefit amount for a loss that is the result of a Common Carrier Hazard, provided You or Your covered Dependent died as the result of an Injury and a Loss of Life benefit is payable under this AD&D insurance.

Common Carrier Hazard means:
1. Riding, boarding or deboarding as a passenger (not as a pilot or crew member):
   a. Any air, land or water conveyance that is licensed for the transportation of passengers for hire, excluding an aircraft owned, operated, chartered or leased by or for the Policyholder; or
   b. As a fee paying passenger of any transport type aircraft operated by the Military Airlift Command (MAC) of the United States or by a similar air transport service of any duly constituted government authority recognized by the government of the United States; or
2. A parachute jump from an aircraft as described in item 1. above in order to save oneself; or
3. Being struck by an aircraft as described in item 1. above.

The amount of the Common Carrier Hazard Benefit payable is as shown in the AD&D Plan Highlights.

TO WHOM AD&D INSURANCE BENEFITS ARE PAYABLE

Benefits are payable to You with these exceptions:
1. Benefits payable to You that are unpaid after Your death or become payable on account of Your death will be paid to Your beneficiary or beneficiaries.
2. Benefits for any covered Dependent Loss are payable to You. If You are not living at the time the benefits are payable, benefits for a Dependent's Loss are payable to the Dependent who suffered the Loss. If that Dependent is not living, the benefits will be paid to the Appropriate Payee.
3. The Dependent Spouse Training Benefit will be paid to:
   a. Your Spouse, if living or
   b. The estate of Your Spouse.
4. The Qualified Children Education Benefit and the Child Care Expense Benefit will be paid to the person who, or agency that, has assumed the main support of the Children.

BENEFIT PAYMENT OPTIONS

Depending on the benefits listed on Your Plan Highlights, one or more of the following options will be available to You at the time You submit Your claim:

Benefit payments will be made in one lump sum no later than 30 days after proof of the Insured Person's Loss has been submitted and approved by Us.

Benefit payments will be made in a series of pre-defined equal distributions beginning 30 days after proof of the Insured Person's Loss has been submitted and approved by Us.

Benefit payments will be made as a monthly benefit beginning 30 days after proof of the Insured Person's Loss has been submitted and approved by Us until the later of the date the Insured Person would have reached age 65 or for 20 years.

WHEN WILL WE NOT COVER AN ACCIDENTAL DEATH & DISMEMBERMENT LOSS?

We will not cover an Accidental Death & Dismemberment Loss if it is caused or contributed to by:

1. Suicide or attempted suicide, whether sane or insane;
2. Mental disorder;
3. Sickness of any kind or medical or surgical treatment for such sickness;
4. Intentionally self-inflicted Injury, or any attempt to inflict such Injury;
5. War, whether declared or not, or an act of war;
6. Taking part in, or as a result of taking part in, commission of a felony or attempted felony;
7. Driving a Motor Vehicle (defined as any vehicle powered by an engine) if, at the time of driving, the Insured Person had a blood alcohol level greater than the legal limit, or was under the influence of a narcotic not administered on the advice of a Physician;
8. Voluntary use of any controlled substance unless taken as prescribed by a Physician (This is defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments.);
9. Travel or flight in or descent from any kind of aircraft as a pilot or crew member, operated by or for the Policyholder, a subsidiary of the Policyholder, or an affiliate of the Policyholder as a passenger or in an aircraft not intended for the transportation of passengers;
10. Any bacterial or viral infection. However, this does not include:
    a. A pyogenic infection resulting from an accidental cut or wound; or
    b. A bacterial infection resulting from accidental ingestion of a contaminated substance;
11. Voluntarily participating in any riot or insurrection; or
12. An accident that occurs while the Insured Person is serving on full-time active duty for more than 30 days in any armed forces, or units auxiliary thereto. However, this does not include Reserve or National Guard active duty for training.

WHEN WILL THIS ACCIDENTAL DEATH & DISMEMBERMENT PLAN TERMINATE?

This Accidental Death & Dismemberment Plan will terminate at the end of the earliest of:

1. Upon written request from You, unless prohibited by federal or state law or the Policyholder's Plan;
2. The date Your group term life insurance coverage ends under this Certificate;
3. The end of the period for which the last Premium has been paid for You, in accordance with the provisions of the Certificate;
4. The date the Policy ends; or
5. The date You cease to be an in an eligible class under the Certificate.

GENERAL PROVISIONS

ASSIGNMENTS BY THE POLICYHOLDER: We will not be bound by any assignment of this Certificate by the Policyholder: (a) unless it is in Writing; and (b) until it is filed at Our Home Office. We are not responsible for the validity of any assignment.

ASSIGNMENTS BY YOU: You have the right to assign all of Your rights concerning this life insurance coverage, including the right to designate the Beneficiary and the privilege of converting to a policy of individual life insurance upon termination of coverage under this Certificate, by filing an appropriate Written assignment with Us. No assignment shall be binding on Us until a signed copy is received by Our Home Office. We are not responsible for the validity of any assignment. Unless otherwise specified, the assignment shall take effect on the date the notice of assignment is signed, subject to any payments made or actions taken by Us prior to receipt of this notice. The right of any Beneficiary to receive the Death Benefit under the Policy shall be subject and subordinate to the rights of any assignee.

TERMINATION OR CHANGE OF POLICY:

1. We may terminate this Policy for non-payment of Premium as set forth in the "Grace Period" provision.
2. By giving advance written notice to the Policyholder of at least 60 days, We may terminate or change this Policy on any Premium due date for any reason, including but not limited to the following reasons:
    a. For Non-Contributory Insurance, there is less than 100% eligible Employee participation;
    b. For Contributory Insurance, there is less than 75% eligible Employee participation;
    c. For Voluntary Insurance, there is less than 20% eligible Employee participation;
    d. The Policyholder does not promptly provide Us with information that is reasonably required;
    e. The Policyholder fails to perform any of its obligations that relate to this Policy; or
    f. Fewer than 10 Employees are insured under this Policy.
3. Provided We receive at least a 31-day advance written notice, the Policyholder may terminate this Policy. In this case, the Policy will end on the later of:
    a. The date stated in the written notice; or
    b. The date that is 31 days after We receive the written notice;

Unless otherwise set forth in this Policy, We have the right on any Premium due date to change the Premium rates for the insurance under this Policy. Policyholder is responsible for notifying Employees of changes in the Premium rates for coverage under this Policy.

The consent of an Employee or other person referred to in this Policy is not required to terminate, amend, modify or change this Policy.

If We accept Premium after Policy termination date, such acceptance shall not act to reinstate the Policy. We shall refund any unearned Premium.

This Policy may be changed in whole or in part. Only an officer of Ours can approve a change. The approval must be in writing and endorsed on or attached to this Policy. Any rider, endorsement or amendment added to the Policy after the date of issue that diminishes rights, benefits or coverage in the Policy shall require signed acceptance by the Policyholder. A copy of the rider, endorsement or amendment will be provided to the Certificate holder for attachment to the Certificate if the change affects the Certificate. A rider, endorsement or amendment shall not affect the insurance provided under the Certificate until the effective date of the change, unless retroactivity is required by the Interstate Insurance Product Regulation Commission. No other person, including any agent, may change this Policy or waive any part of it. We shall only make changes that are consistent with Interstate Insurance Product Regulation Commission standards.

You must give Us advance notice of a request to change the Policy or a Plan under the Policy. At any time, We may change any or all of the Policy's provisions by mutual agreement with You.

TERM OF COVERAGE; RENEWAL OF POLICY: This Policy is issued for an initial term of coverage starting on the Policy Effective Date shown on the first page of this Policy and ending on the next following Policy Anniversary Date. Provided that Premiums have been paid in full to the Policy Anniversary Date, this Policy may be renewed on each Policy Anniversary Date for a successive one-year renewal period, subject to all of the provisions of this Policy, including our right to terminate this Policy as set herein.

PROOF OF AGE: We have the right to require satisfactory proof of age.

GENERAL DEFINITIONS

The following defined terms appear with their initial letters capitalized.

ACTIVE EMPLOYMENT: This term means You are:

- Working for the Policyholder at their work site for earnings the Policyholder pays on a regular basis; and
- Performing the material and substantial duties of Your Regular Occupation.

Active Employment includes normal non-work days such as vacation, weekends and holidays if You were working for the Policyholder at their work site for earnings the Policyholder pays on a regular basis on the last normal work day prior to a period of normal non-work days, provided the Employee was in Active Employment on the Employee's immediately preceding scheduled work day and the Employee:

1. Is not Hospital Confined on such day;
2. Is not Disabled due to an injury or sickness; or
3. Is not a Retiree (Life Insurance only).

Your work site must be:
- The Policyholder's usual place of business;
- An alternative location if directed by the Policyholder; or
- A location to which Your occupation requires You to travel.

ACTIVITIES OF DAILY LIVING: This term means the ability to independently perform the following, with or without equipment or adaptive devices:
- **BATHING:** wash in a tub or shower; or take a sponge bath; and towel dry.
- **DRESSING:** put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and fasten or unfasten them.
- **TOILETING:** get to and from and on and off the toilet; to maintain personal hygiene; and care for clothes.
- **TRANSFERRING:** move in and out of a chair or bed.
- **CONTINENCE:** control bowel and bladder function; or, in the event of incontinence, maintain personal hygiene.
- **EATING:** get food into the body by any means once it has been prepared and made available.

APPROPRIATE PAYEE: This term refers to the person or entity identified as the party eligible to receive funds returned or paid by Us.

BASE ANNUAL COMPENSATION ("BAC")**:** This term means Your base gross annual income from the Policyholder. BAC includes Your total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. The insurance benefits payable to a beneficiary, or as an Accelerated Death Benefit to You, will be calculated using the lesser of Your actual BAC and the BAC last reported to Us by the Policyholder. It is the responsibility of the Policyholder to report to Us on a timely basis any increase or decrease in Your BAC.

BENEFICIARY means the person or entity You choose to receive Your life insurance benefits at Your death in accordance with the "Who Do We Make Benefit Payments To?" section of the Certificate. You may not designate Your Employer as Your Beneficiary.

CONTRIBUTORY OR CONTRIBUTORY INSURANCE: This term means insurance for which the Policyholder requires You to make full or partial Premium contribution. The Plan Highlights show whether Your specific coverage is Contributory Insurance. With regard to Contributory Insurance, the maximum amount that You may be required to contribute to the cost of such insurance shall not exceed the Premium charged for the amounts of such insurance.

DEATH BENEFIT: This term means the insurance amount payable under this Certificate at the death of the Insured Person. It does not include any amount payable under the Accidental Death and Dismemberment insurance, if any, under this Certificate.

DEPENDENT: This term means any of those described below who are not eligible for insurance under this Certificate as an Employee (defined below):
1. Your lawful Spouse and any other person required to be covered as Your Spouse by the Policyholder or under the civil union, domestic partnership, marriage or other family or domestic relations laws, including the case law, of any applicable State law ("Spouse").

2. Your unmarried child or children within the Age Limit shown in the Plan Highlights and dependent upon You for support and maintenance. This includes a stepchild, a legally adopted child, a child in the process of adoption by You and any other children required to be covered as provided in the civil union, domestic partnership, marriage or other family or domestic relations laws of applicable State law ("Child" or "Children").

   Incapacitated Child: The Age Limit provision shown in the Plan Highlights will not apply to an unmarried Dependent Child who:
   a. Is incapable of self-sustaining employment because of a mental or physical Disability;
   b. Became so incapable prior to attainment of the age at which Dependent Child coverage would otherwise terminate; and
   c. Is chiefly dependent upon the You for support and maintenance, while Your coverage under this Certificate remains in force and the Dependent Child remains in such condition.

   The Age Limit provision shown in the Plan Highlights will be waived only if You have within 60 days after such Dependent Child's attainment of the termination age submitted proof to Us of such Dependent Child's Disability.

   Insurance will continue while such Dependent Child remains incapable of self-sustaining employment because of the Disability and continues to meet the definition of Dependent except for the Age Limit shown in the Plan Highlights. If at the end of the continuation period the Dependent Child is no longer eligible for insurance under this Certificate, the Dependent has the right to exercise the Dependent Right to Convert.

   Leave of Absence from School: We will continue the insurance coverage for a Dependent Child within the above Age Limit shown in the Plan Highlights who takes a leave of absence from school due to illness for period of up to 12 months from the last day of attendance in school. The medical necessity of a leave of absence from school must be certified to by the Child's duly licensed attending Physician.

   A Dependent is not a person who is:
   - Also insured as an Employee of the Policyholder;
   - Also insured as a Dependent of another Employee of the Policyholder; or
   - On active military duty of any country or international authority.

   Active military duty does not include weekend or summer training for the National Guard or Reserves of the United States.

DISABILITY OR DISABLED: This term means that due to an injury or sickness You are unable to perform the material duties of Your regular job and are unable to perform any other job for which You are fit by education, training or experience. Material duties mean the sets of tasks or skills generally required by employers from those engaged in an occupation. We will consider one material duty of Your regular job to be the ability to work for the Policyholder on a full-time basis as required in the Policy.

ELIGIBLE CLASS: This term means a group of Employees who have met the criteria selected by the Policyholder for eligibility for coverage under the Policy.

ELIMINATION PERIOD means a period of continuous days of Disability before benefits become payable. The Elimination Period begins on the first day of your Disability.

EMPLOYEE: This term means an individual in Active Employment whose principal employment is with the Policyholder for a minimum of 30 hours per week, and who is reported as an Employee on the Policyholder's records for Social Security and withholding tax purposes. Persons employed by subsidiaries or affiliates of the Policyholder will be considered Employees of the Policyholder.

EVIDENCE OF INSURABILITY: This term means a statement of medical history, which is provided at Our expense and which We will use to assess if a person will be approved for coverage.

GUARANTEED ISSUE LIMIT: This term means the insurance amount for which an Employee or Dependent may be insured without submitting Evidence of Insurability.

HOME OFFICE: This term means Our Home Office at P.O. Box 1596 Indianapolis, Indiana 46206-1596.

HOSPITAL: This term means a facility supervised by one or more Physicians and operated under state and local laws. It must have 24-hour nursing service by registered graduate nurses. It may specialize in treating alcoholism, drug addiction, chemical dependency, or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged.

HOSPITAL CONFINEMENT OR HOSPITAL CONFINED: This term means staying in a Hospital as a registered inpatient for 24 hours a day.

INSURED PERSON: This term means each person insured under this Certificate and includes You and/or Your Dependent(s) as defined in this Certificate.

MILITARY LEAVE OF ABSENCE: This term means a leave of absence that:

1. is subject to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), and any amendments to it;
2. is taken in accord with Your Policyholder's leave policy and the federal USERRA law; and
3. does not exceed the period required by that law.

NON-CONTRIBUTORY INSURANCE: This term means insurance for which the Policyholder does not require Premium contributions from the insured Employee. The Plan Highlights shows whether the specific insurance is non-contributory insurance. The Policyholder shall not require You to contribute to the cost of noncontributory insurance, except where necessary for the Policyholder to comply with applicable tax law.

PHYSICIAN: This term means a duly licensed practitioner, acting within the scope of his or her license, who is recognized by the law of the state in which diagnosis is received. The Physician may not be You or a member of Your immediate family.

POLICY ANNIVERSARY DATE: This term means the date specified on the face page of the Policy.

POLICY MONTH: The first Policy Month begins on the Policy Effective Date shown on the first page of the Policy. Subsequent Policy Months will begin on the same day of each subsequent calendar month.

PREMIUM(S): This term means the amount the Policyholder or You shall pay to Us for the insurance provided under the Policy.

PRINCIPAL SUM: This term means the life insurance amount payable under this Certificate at the death of the Insured Person. It is the base amount used to determine additional amounts payable under the Accidental Death and Dismemberment insurance, if any, under the Policy.

PROCEEDS: Subject to the terms of the Policy, Proceeds become payable when a loss occurs while this Certificate is in force. The Proceeds are equal to:

1. The benefit amount shown on the Plan Highlights; less
2. Any Premium owed to Us by the Policyholder or You.

PROOF OF LOSS: This term means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this Certificate. The Proof of Loss shall establish:

1. The nature and the extent of the loss or condition;
2. Our obligation to pay the claim; and
3. The claimant's right to receive payment.

RETIREMENT DATE: This term means the first of the following to occur:

1. The date You are eligible for retirement benefits under:
   a. Any plan of a federal, state, county, municipal, or other retirement system for which You are eligible as a result of employment with the Policyholder:
   b. Any plan the Policyholder sponsors; or
   c. Any plan for which the Policyholder:
      i. Makes contribution; or
      ii. Has made contributions; or

2. The date You are eligible for disability benefits under the United States Social Security Act or any similar plan or act.

However, if You are in Active Employment and receiving retirement benefits under the United States Social Security Act or any similar plan or act, You will not be considered retired.

THIS PLAN: This term means the specific coverage and benefits as provided for You and/or Your covered Dependents pursuant to this Certificate.

VOLUNTARY INSURANCE: This term refers to Contributory Insurance where You pay all of the Premium.

WAITING PERIOD: This term means the number of days You must be in Active Employment in an Eligible Class before You may become covered under THIS Plan. Your Waiting Period appears in the PLAN HIGHLIGHTS.

WRITTEN OR WRITING: This term means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

AGENDA ITEM NO. _____

AGENDA ITEM SUMMARY FORM

PROPOSED MEETING DATE: August 7, 2024
PREPARED BY: Tracey Vasquez, Director
DEPARTMENT: Human Resources

AGENDA ITEM DESCRIPTION:

Consideration, discussion, and possible action on the insurance policies for health benefits for FY 2024-2025 between the City of Manor and United Healthcare Insurance Company.

BACKGROUND/SUMMARY:

On July 3, 2024, City Council approved the selection of United Healthcare Insurance Company as the health benefits provider and directed staff to negotiate the terms with the insurance provider. As part of the process for United Healthcare to issue the policy, the City will need to submit an application. The attached policy is provided for the City Council's consideration.

LEGAL REVIEW: Yes, Veronica Rivera, Assistant City Attorney
FISCAL IMPACT:
PRESENTATION: No
ATTACHMENTS: Yes

- Policy for health benefits

STAFF RECOMMENDATION:

Staff recommends City Council approve the health benefit insurance policy for FY 2024-2025 between the City of Manor and United Healthcare Insurance Company and authorize the City Manager to execute the application, policy and other documents needed by United Healthcare Insurance Company to provide the health insurance benefits.

CITY COUNCIL: **Recommend Approval** **Disapproval** **None**

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Certificate of Coverage

For

the Plan DQ6U

of

City of Manor

Group Number: 935966

Effective Date: September 1, 2024

Table of Contents

Schedule of Benefits 1
How Do You Access Benefits? 1
Does Prior Authorization Apply? 1
Care Management 2
Special Note Regarding Medicare 2
What Will You Pay for Covered Health Care Services? 3
Additional Benefits Required By Texas Law 31
Allowed Amounts 34
Provider Network 37
Network Transplant Providers 37
Health Care Services from Out-of-Network Providers Paid as Network Benefits 38
Limitations on Selection of Providers 38
Certificate of Coverage 1
What Is the Certificate of Coverage? 1
Can This Certificate Change? 1
Other Information You Should Have 1
Introduction to Your Certificate 2
What Are Defined Terms? 2
How Do You Use This Document? 2
How Do You Contact Us? 2
Your Responsibilities 3
Eligibility, Enrollment, and Required Contributions 3
Be Aware the Policy Does Not Pay for All Health Care Services 3
Decide What Services You Should Receive 3
Choose Your Physician 3
Obtain Prior Authorization 3
Pay Your Share 4
Pay the Cost of Excluded Services 4
Show Your ID Card 4
File Claims with Complete and Accurate Information 4
Use Your Prior Health Care Coverage 4
Our Responsibilities 5
Determine Benefits 5
Pay for Our Portion of the Cost of Covered Health Care Services 5
Pay Network Providers 5
Pay for Covered Health Care Services Provided by Out-of-Network Providers 5
Review and Determine Benefits in Accordance with our Reimbursement Policies 5
Offer Health Education Services to You 6
Certificate of Coverage Table of Contents 7
Section 1: Covered Health Care Services 8
When Are Benefits Available for Covered Health Care Services? 8
1. Ambulance Services 8
2. Cellular and Gene Therapy 9
3. Clinical Trials 9
4. Congenital Heart Disease (CHD) Surgeries 11
5. Dental Services - Accident Only 11
6. Diabetes Services 12
7. Durable Medical Equipment (DME), Orthotics and Supplies 13
8. Emergency Health Care Services - Outpatient 14

9. Enteral Nutrition 14
10. Fertility Preservation for Iatrogenic Infertility 14
11. Gender Dysphoria 15
12. Habilitative Services 15
13. Hearing Aids 16
14. Home Health Care 17
15. Hospice Care 17
16. Hospital - Inpatient Stay 17
17. Lab, X-Ray and Diagnostic - Outpatient 17
18. Major Diagnostic and Imaging - Outpatient 18
19. Mental Health Care and Substance-Related and Addictive Disorders Services 19
20. Ostomy Supplies 20
21. Pharmaceutical Products - Outpatient 20
22. Physician Fees for Surgical and Medical Services 21
23. Physician's Office Services - Sickness and Injury 21
24. Pregnancy - Maternity Services 21
25. Preimplantation Genetic Testing (PGT) and Related Services 22
26. Preventive Care Services 22
27. Prosthetic Devices 23
28. Reconstructive Procedures 23
29. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment 24
30. Scopic Procedures - Outpatient Diagnostic and Therapeutic 25
31. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services 25
32. Surgery - Outpatient 26
33. Temporomandibular Joint (TMJ) Services 26
34. Therapeutic Treatments - Outpatient 27
35. Transplantation Services 27
36. Urgent Care Center Services 28
37. Urinary Catheters 28
38. Virtual Care Services 28
Additional Benefits Required By Texas Law 28
39. Acquired Brain Injury 28
40. Developmental Delay Services 30
41. Human Papillomavirus, Cervical Cancer and Ovarian Cancer Screenings 30
42. Osteoporosis Detection and Prevention 31
43. Speech and Hearing Services 31
44. Telehealth, Telemedicine and Teledentistry Services 31

Section 2: Exclusions and Limitations 32

How Do We Use Headings in this Section? 32
We Do Not Pay Benefits for Exclusions 32
Where Are Benefit Limitations Shown? 32
A. Alternative Treatments 32
B. Dental 32
C. Devices, Appliances and Prosthetics 33
D. Drugs 34
E. Experimental or Investigational or Unproven Services 35
F. Foot Care 35
G. Gender Dysphoria 36
H. Medical Supplies and Equipment 36
I. Mental Health Care and Substance-Related and Addictive Disorders 37
J. Nutrition 37
K. Personal Care, Comfort or Convenience 38
L. Physical Appearance 39
M. Procedures and Treatments 39

N. Providers 40
O. Reproduction 41
P. Services Provided under another Plan 41
Q. Transplants....42
R. Travel....42
S. Types of Care 42
T. Vision and Hearing....43
U. All Other Exclusions 43
Section 3: When Coverage Begins 45
How Do You Enroll?....45
What If You Are Hospitalized When Your Coverage Begins?....45
What If You Are Eligible for Medicare? 45
Who Is Eligible for Coverage?....45
Eligible Person 45
Dependent....45
When Do You Enroll and When Does Coverage Begin? 46
Initial Enrollment Period 46
Open Enrollment Period....46
New Eligible Persons 46
Adding New Dependents 46
Special Enrollment Period....47
Section 4: When Coverage Ends 49
General Information about When Coverage Ends 49
What Events End Your Coverage? 49
Fraud or Intentional Misrepresentation of a Material Fact....50
Coverage for a Disabled Dependent Child....50
Extended Coverage for Total Disability....50
Continuation of Coverage 50
Continuation of Coverage under State Law 51
Qualifying Events for State Continuation Coverage Due to Reasons other than Severance of the Family Relationship 51
Notification Requirements, Election Period and Premium Payment for State Continuation Coverage Due to Reasons Other than Severance of the Family Relationship....51
Terminating Events for State Continuation Coverage Due to Reasons Other than Severance of the Family Relationship....51
Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship....52
Notification Requirements, Election Period and Premium Payment for State Continuation Coverage Due to Severance of the Family Relationship 52
Termination Events for State Continuation Coverage Due to Severance of the Family Relationship....52
Section 5: How to File a Claim 53
How Are Covered Health Care Services from Network Providers Paid? 53
How Are Covered Health Care Services from an Out-of-Network Provider Paid?....53
Required Information....53
Payment of Benefits 53
Section 6: Questions, Complaints and Appeals....55
What if You Have a Question?....55
What if You Have a Complaint? 55
How Do You Appeal a Claim Decision?....55
Post-service Claims 55
Pre-service Requests for Benefits....55
Prior Authorization....55
How to Request an Appeal 56
Adverse Determinations....56

Notice of Adverse Determinations....56
Procedures for Appealing an Adverse Determination....57
Retrospective Review....57
Urgent Appeals that Require Immediate Action....57
Expedited Appeals for Denial of Emergency Care, Continued Hospitalization, Prescription Drugs, or Intravenous Infusions....58
Federal External Review Program....58
Standard External Review....59
Expedited External Review....59
Section 7: Coordination of Benefits....61
Benefits When You Have Coverage under More than One Plan....61
When Does Coordination of Benefits Apply?....61
Definitions....61
What Are the Rules for Determining the Order of Benefit Payments?....62
Effect on the Benefits of This Plan....65
Right to Receive and Release Needed Information....66
Payments Made....66
Does This Plan Have the Right of Recovery?....66
How Are Benefits Paid When This Plan is Secondary to Medicare?....66
Section 8: General Legal Provisions....67
What Is Your Relationship with Us?....67
What Is Our Relationship with Providers and Groups?....67
What Is Your Relationship with Providers and Groups?....67
Notice....68
Statements by Group or Subscriber....68
Do We Pay Incentives to Providers?....68
Do We Receive Rebates and Other Payments?....69
Who Interprets Benefits and Other Provisions under the Policy?....69
Who Provides Administrative Services?....69
Amendments to the Policy....69
How Do We Use Information and Records?....70
Do We Require Examination of Covered Persons?....70
Is Workers' Compensation Affected?....70
How Are Benefits Paid When You Are Medicare Eligible?....70
Subrogation and Reimbursement....71
Subrogation....71
Reimbursement....71
When Do We Receive Refunds of Overpayments?....73
Is There a Limitation of Action?....74
Continuity of Care....74
What Is the Entire Policy?....74
Section 9: Defined Terms....75
Section 10: Consolidated Appropriations Act Summary....90
No Surprises Act....90
Balance Billing....90
Determination of Our Payment to the Out-of-Network Provider:....90
Continuity of Care....90
Provider Directories....91
Notice of Certain Mandatory Benefits....92
Disclosure of Provider Status Notice....95
Preferred Provider Health Benefit Plan Notice....96

Section 6: Questions, Complaints and Appeals 97
What if You Have a Question? 97
What if You Have a Complaint? 97
How Do You Appeal a Claim Decision? 97
Post-service Claims 97
Pre-service Requests for Benefits 97
Pre-Authorization 97
How to Request an Appeal 98
Complaint Appeal Procedures 98
Filing Complaints with the Texas Department of Insurance 99
Adverse Determinations 99
Notice of Adverse Determinations 99
Procedures for Appealing an Adverse Determination 100
Retrospective Review 100
Urgent Appeals that Require Immediate Action 100
Expedited Appeals for Denial of Emergency Care, Continued Hospitalization, Prescription Drugs, or Intravenous Infusions 101
Federal External Review Program 101
Standard External Review 102
Expedited External Review 103

Amendments, Riders and Notices (As Applicable)

Outpatient Prescription Drug Rider
One Pass Select Rider
Real Appeal Rider
UnitedHealthcare Rewards Rider
Virtual Behavioral Health Therapy and Coaching Rider
Language Assistance Services
Notice of Non-Discrimination
Important Notices

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

How Do You Access Benefits?

You can choose to receive Designated Network Benefits, Network Benefits or Out-of-Network Benefits. In some instances, enhanced Designated Network Benefits are available when you see a Designated Provider. These Benefits appear under the Designated Network headings shown throughout the *Schedule of Benefits* table below. In limited instances noted in this *Schedule of Benefits*, you must see a Network Transplant Provider to obtain Benefits for certain complex Covered Health Care Services.

Designated Network Benefits apply to Covered Health Care Services that are provided by a provider or facility that has been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Care Services as shown in the *Schedule of Benefits* table below.

Network Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Care Physician in order to obtain Network Benefits.

Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

Covered Health Care Services provided at certain Network facilities by an out-of-Network Physician, when not Emergency Health Care Services, will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*. For these Covered Health Care Services, "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Ground and Air Ambulance transport provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Group, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?

We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you unless they qualify for an exemption from prior authorization requirements as described in *TIC §4201.651 - §4201.659*.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to put in place the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Care Services.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Limits are calculated on a calendar year basis.

When Benefit limits apply, the limit stated refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. Any amount that you pay for Covered Health Care Services that is applied to the Designated Network Annual Deductible will be applied to the Network Annual Deductible. Any amount you pay for Covered Health Care Services that is applied to the Network Annual Deductible will be applied to the Designated Network Annual Deductible.	***Designated Network and Network*** $750 per Covered Person, not to exceed $1,500 for all Covered Persons in a family. ***Out-of-Network*** $5,000 per Covered Person, not to exceed $10,000 for all Covered Persons in a family.
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits*, including Covered Health Care Services provided under the *Outpatient Prescription Drug Rider*. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits*	***Designated Network and Network*** $4,000 per Covered Person, not to exceed $8,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible. ***Out-of-Network*** $10,000 per Covered Person, not to exceed $20,000 for all Covered

Payment Term And Description	Amounts
table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts, when applicable. Any amount that you pay for Covered Health Care Services that is applied to the Designated Network Out-of-Pocket Limit will be applied to the Network Out-of-Pocket Limit. Any amount you pay for Covered Health Care Services that is applied to the Network Out-of-Pocket Limit will be applied to the Designated Network Out-of-Pocket Limit.	Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.
Co-payment	
Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Co-payment. • The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	
Co-insurance	
Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500.			
Emergency Ambulance Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	***Network*** *Ground Ambulance* 20% *Air Ambulance* 20% ***Out-of-Network*** Same as Network	 Yes Yes Same as Network	 Yes Yes Same as Network
Non-Emergency Ambulance Ground or Air Ambulance, as appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	***Network*** *Ground Ambulance* 20% *Air Ambulance* 20%	 Yes Yes	 Yes Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network *Ground Ambulance* 50% *Air Ambulance* Same as Network	 Yes Same as Network	 Yes Same as Network
2. Cellular and Gene Therapy			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
For Network Benefits, Cellular or Gene Therapy services must be received from a Network Transplant Provider.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
3. Clinical Trials			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
increase will not exceed $500.			
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
4. Congenital Heart Disease (CHD) Surgeries			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount, however, the amount of the increase will not exceed $500. **It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	***Network*** 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 50%	Yes	Yes
5. Dental Services - Accident Only			
	Network 20% ***Out-of-Network*** Same as Network	Yes Same as Network	Yes Same as Network
6. Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500.			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of DME are not	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies.* Benefits for podiatric appliances are limited to two pairs of therapeutic footwear per year for the prevention of complications associated with diabetes.	the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider*.		
7. Durable Medical Equipment (DME), Orthotics and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500.			
Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums, which are limited to a single purchase (including repair/replacement) every three years. To receive Network Benefits, you must obtain the DME or orthotic from a Network vendor or from the	***Network*** 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
prescribing Network Physician.	***Out-of-Network*** 50%	Yes	Yes
8. Emergency Health Care Services - Outpatient			
Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission or as soon as reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of*	***Network*** 20% after you pay $500 per visit.	Yes	No

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Benefits.	***Out-of-Network*** Same as Network	Same as Network	Same as Network
9. Enteral Nutrition			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
10. Fertility Preservation for Iatrogenic Infertility			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500.			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
11. Gender Dysphoria			
Prior Authorization Requirement for Surgical Treatment For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for an Inpatient Stay. **It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may**			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
be available to you and are designed to achieve the best outcomes for you. **Prior Authorization Requirement for Non-Surgical Treatment** Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*			
Limits for voice modification therapy and/or voice lessons will be the same as, and combined with outpatient speech therapy limits as described under *Habilitative Services and Rehabilitation Services - Outpatient Therapy and Manipulative Treatment*.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Rider*.		
12. Habilitative Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization before admission, we recommend at least five business days, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient*	***Network*** *Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule*		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Rehabilitation Services.	*of Benefits.*		
Outpatient therapies: • Physical therapy. • Occupational therapy. • Manipulative Treatment. • Speech therapy. • Post-cochlear implant aural therapy. • Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.* Limits for physical, speech and occupational therapy do not apply when provided to a child for the treatment of Autism Spectrum Disorders or when provided in accordance with an individualized family service plan issued by the *Texas Interagency Council on Early Childhood Intervention* under Chapter 73 of the *Texas Human Resource Code*. Visit limits do not apply if the primary diagnosis is for a Mental Illness.	*Outpatient* $25 per visit	Yes	No
	Out-of-Network *Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	each Covered Health Care Service category in this *Schedule of Benefits.*		
	Outpatient 50%	Yes	Yes
13. Hearing Aids			
Benefits are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	***Network*** 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
14. Home Health Care			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before receiving services, we recommend at least five business days or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500.			
Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a Network Provider.	***Network*** 20%	Yes	Yes
	Out-of-Network		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	50%	Yes	Yes
15. Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before admission for an Inpatient Stay in a hospice facility, we recommend at least five business days or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500. In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
16. Hospital - Inpatient Stay			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization before admission, we recommend at least five business days, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
17. Lab, X-Ray and Diagnostic -			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for Genetic Testing, sleep studies,stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization before scheduled services are received, we recommend at least five business days. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500.			
Lab Testing - Outpatient	***Network***		
	None	Yes	No
	Out-of-Network		
	50%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient	***Network***		
	None	Yes	No
	Out-of-Network		
	50%	Yes	Yes
18. Major Diagnostic and Imaging - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology, you must obtain prior authorization before scheduled services are received, we recommend at least five business days, or for non-scheduled services we recommend at least one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500.			
	Network		
	20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 50%	Yes	Yes
19. Mental Health Care and Substance-Related and Addictive Disorders Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization before admission, we recommend at least five business days, or as soon as is reasonably possible for non-scheduled admissions. In addition, for Out-of-Network Benefits, you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).* If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500.			
	Network *Inpatient* 20% *Outpatient* *Office Visits* $25 per visit *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive*	Yes Yes	Yes No

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Outpatient Treatment 20% *Intensive Behavioral Therapy* 10% ***Out-of-Network*** *Inpatient* 50% *Outpatient* *Office Visits* 50% *All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment* 50% *Intensive Behavioral Therapy* 50%	Yes Yes Yes Yes Yes Yes Yes	Yes No Yes Yes Yes Yes
20. Ostomy Supplies			
	Network 20% ***Out-of-Network*** 50%	Yes Yes	Yes Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
21. Pharmaceutical Products - Outpatient			
	Network 20% ***Out-of-Network*** 50%	 Yes Yes	 Yes Yes
22. Physician Fees for Surgical and Medical Services			
Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will apply the same cost sharing (Co-payment, Co-insurance and applicable deductible) as if those services were provided by a Network provider; however, Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	***Designated Network*** 20% ***Network*** 20% ***Out-of-Network*** 50%	 Yes Yes Yes	 Yes Yes Yes
23. Physician's Office Services - Sickness and Injury			
	Designated Network **For Covered Persons under the age of 19:** None per visit for a	 Yes	 No

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Primary Care Physician office visit or $25 per visit for a Specialist office visit **For Covered Persons age 19 and older:** $25 per visit for a Primary Care Physician office visit or $25 per visit for a Specialist office visit ***Network*** **For Covered Persons under the age of 19:** None per visit for a Primary Care Physician office visit or $50 per visit for a Specialist office visit	Yes Yes	No No
No deductible is applicable to necessary diagnostic follow-up care relating to the screening test for hearing loss of a Dependent child. Except for the Designated Network Benefit level for Primary Care Physician office visits, Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office: • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures -*			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Outpatient Diagnostic and Therapeutic. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*. **Note:** When a test is performed or a sample is drawn in the Physician's office, lab, radiology/X-ray, or other diagnostic analysis or testing whether performed in or out of the Physician's office will apply additional cost sharing as described above. No deductible is applicable to necessary diagnostic follow-up care relating to the screening test for hearing loss of a Dependent child. Additional cost sharing (Co-payments/Co-insurance and any deductible), will not apply to the following Covered Health Care Services from a Primary Care Physician as described in the *Certificate of Coverage* when performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures -*			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Outpatient Diagnostic and Therapeutic. • Outpatient surgery procedures described under *Surgery - Outpatient.* **Note:** When a test is performed or a sample is drawn in the Physician's office, lab, radiology/X-Ray, or other diagnostic analysis or testing performed outside of the Physician's office is not included in the exception of additional cost-sharing described above.	**For Covered Persons age 19 and older:** $25 per visit for a Primary Care Physician office visit or $50 per visit for a Specialist office visit ***Out-of-Network*** 50%	Yes Yes	No Yes
24. Pregnancy - Maternity Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500.			
	Network		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. ***Out-of-Network*** Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
25. Preimplantation Genetic Testing (PGT) and Related Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500.			
Benefit limits for related services will be the same as, and combined with, those stated under *Fertility Preservation for Iatrogenic Infertility*. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the *Outpatient Prescription Drug Rider*.	***Network*** 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
26. Preventive Care Services			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining a breast pump. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500.			
Physician office services	***Network***		
	None	No	No
	Out-of-Network		
	50%	Yes	Yes
Lab, X-ray or other preventive tests	***Network***		
	None	No	No
	Out-of-Network		
	50%	Yes	Yes
Breast pumps	***Network***		
	None	No	No
	Out-of-Network		
	50%	Yes	Yes
27. Prosthetic Devices			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500.			
Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the	***Network*** 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
same manner as a purchase. Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998*.	***Out-of-Network*** 50%	Yes	Yes
28. Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before a scheduled reconstructive procedure is performed, we recommend at least five business days, or for non-scheduled procedures we recommend at least one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
29. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Limited per year as follows:	***Network***		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
• 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 Manipulative Treatments. • 20 visits of speech therapy. • 20 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. Limits for physical, speech and occupational therapy do not apply when provided to a child for the treatment of Autism Spectrum Disorders or when provided in accordance with an individualized family service plan issued by the *Texas Interagency Council on Early Childhood Intervention* under Chapter 73 of the *Texas Human Resource Code*.	\$25 per visit ***Out-of-Network*** 50%	Yes Yes	No Yes
30. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	Network 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 50%	Yes	Yes
31. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization before admission, we recommend at least five business days, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
Limited to 60 days per year.	***Network*** 20% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
32. Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery, you must obtain prior authorization before scheduled services are received, we recommend at least five business days, or for non-scheduled services we recommend at least one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500.			
	Network 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 50%	Yes	Yes
33. Temporomandibular Joint (TMJ) Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before TMJ services are performed during an Inpatient Stay in a Hospital, we recommend at least five business days. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
34. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization for the following outpatient therapeutic services before scheduled services are received, we recommend at least five business days, or for non-scheduled services we recommend at least one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	will not exceed $500.		
	Network 20% ***Out-of-Network*** 50%	 Yes Yes	 Yes Yes
35. Transplantation Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount; however, the amount of the increase will not exceed $500. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.			
For Network Benefits, transplantation services must be received from a Network Transplant Provider. We do not require that cornea transplants be received from a Network Transplant Provider in order for you to receive Network Benefits.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
36. Urgent Care Center Services			
Co-payment/Co-insurance and any deductible for the following services	***Network***		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
also apply when the Covered Health Care Service is performed at an Urgent Care Center: • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.	$50 per visit ***Out-of-Network*** 50%	Yes Yes	No Yes
37. Urinary Catheters			
	Network 20% ***Out-of-Network*** 50%	Yes Yes	Yes Yes
38. Virtual Care Services			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.	***Network*** *Urgent Care* None	Yes	No
	Out-of-Network 50%	Yes	Yes
Additional Benefits Required By Texas Law			
39. Acquired Brain Injury			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*			
Hospital - Inpatient Stay and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
Outpatient Post-Acute Care, Transitional Services and Rehabilitative Services	***Network*** $25 per visit	Yes	No
	Out-of-Network		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	50%	Yes	Yes
40. Developmental Delay Services			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*. ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
41. Human Papillomavirus, Cervical Cancer and Ovarian Cancer Screenings			
	Network None ***Out-of-Network*** 50%	 Yes Yes	 No Yes
42. Osteoporosis Detection and Prevention			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule*		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate,* Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	of Benefits.		
43. Speech and Hearing Services			
Benefits are paid at the same level as Benefits for any other Covered Health Care Services, except that the Benefit limit for *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* does not apply to speech and hearing services. Benefits for the purchase or fitting of hearing aids are not provided under this Covered Health Care Service category, but are instead provided under the *Hearing Aids* category in this *Schedule of Benefits.*	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
44. Telehealth, Telemedicine and Teledentistry Services			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.* ***Out-of-Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		

Allowed Amounts

Allowed Amounts are the amount determined to be payable for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Out-of-Network Benefits, except as described below, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount we will pay for Allowed Amounts.
    - For Covered Health Care Services that are ***Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians****,* you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *Certificate*.
    - For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below****,* you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate.*
    - For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *Certificate.*
    - For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance, or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Certificate*.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law, as described in the *Certificate*.

Designated Network Benefits and Network Benefits

Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Designated Network and Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Care Services, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment, or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

Out-of-Network Benefits

When Covered Health Care Services are received from an out-of-Network provider as described below, Allowed Amounts are determined as follows:

- **For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians** when such services are either Ancillary Services, or non-

Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Ac*t with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the Allowed Amount is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement.*
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

Except in cases of Emergency, when the participation of an assistant surgeon in a surgical procedure is Medically Necessary, the Allowed Amount for the Covered Health Care Services provided by an out-of-Network assistant surgeon will be the lesser of the assistant surgeon's billed charges or 14% to 16% of the Allowed Amount calculated for an out-of-Network surgeon to provide the surgical services indicated on the claim from the assistant surgeon. An assistant surgeon means a licensed practitioner, including a Physician's assistant, surgical assistant, registered nurse, or nurse practitioner, who is licensed by the *Texas Board of Physician Assistant Examiners, Texas Board of Medical Examiners,* or *Texas Board of Nursing,* and meets the Hospital or Alternate Facility's credentialing criteria for a first assistant.

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *Certificate*.

- **For Emergency Health Care Services provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement.*
  - The reimbursement rate as determined by state law.
  - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
  - The amount determined by *Independent Dispute Resolution (IDR).*

  IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance, or deductible which is based on the Recognized Amount as defined in the *Certificate.*
- **For Air Ambulance transportation provided by an out-of-Network provider**, the Allowed Amount is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement.*
  - The reimbursement rate as determined by state law.
  - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.

- The amount determined by *Independent Dispute Resolution (IDR).*

IMPORTANT NOTICE: You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance, or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Certificate.*

- **For Emergency ground ambulance transportation provided by an out-of-Network provider**, the Allowed Amount, which includes mileage, is a rate agreed upon by the out-of-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

  IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

When Covered Health Care Services are received from an out-of-Network provider, except as described above, Allowed Amounts are determined based on either of the following:

- Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates, or subcontractors.
- If rates have not been negotiated, then one of the following amounts:
  - Allowed Amounts are determined based on 100% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
    - 50% of *CMS* for the same or similar freestanding laboratory service.
    - 45% of *CMS* for the same or similar Durable Medical Equipment from a freestanding supplier, or *CMS* competitive bid rates.
    - 70% of *CMS* for the same or similar physical therapy service from a freestanding provider.
  - When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third -party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location, and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
    - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
    - When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service

- When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically put in place within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here. This includes non-Ancillary Services when notice and consent is satisfied as described under section *2799B-2(d) of the Public Health Service Act.*

Provider Network

We arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to choose your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at www.myuhc.com or the telephone number on your ID card to request a copy. If you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly by us prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing (Co-payment, Co-insurance and applicable deductible) that would be no greater than if the service had been provided from a Network provider.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits. However, if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network providers contract with us to provide only certain Covered Health Care Services, but not all Covered Health Care Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for help.

Network Transplant Providers

If you have a medical condition that we believe needs special services, such as transplant services or cellular and gene therapy for which expertise is limited, we will help you select a Network Transplant Provider which may be inside or outside your Service Area. If you are required to travel to obtain such

Covered Health Care Services from a Network Transplant Provider, you may be eligible for reimbursement of certain travel expenses.

You or your Network Physician must notify us of special service needs (such as transplants or cellular and gene therapy) that might warrant services by a Network Transplant Provider. If you do not notify us in advance, and if you receive services from an out-of-Network facility (regardless of whether it is a Network Transplant Provider) or other out-of-Network provider, Network Benefits will not be paid. Out-of-Network Benefits may be available if the special needs services you receive are Covered Health Care Services for which Benefits are provided under the Policy.

Health Care Services from Out-of-Network Providers Paid as Network Benefits

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through an out-of-Network provider.

When Covered Health Care Services are rendered to a Covered Person by an out-of-Network provider because there was not a Network provider reasonably available, we will:

- Pay the claim, at a minimum, at the usual, reasonable or customary charge for the Covered Health Care Service, less any applicable Co-insurance, Co-payment or Annual Deductible amount.
- If the claim is subject to the claim dispute resolution process in *Chapter 1467* of the *Texas Insurance Code*, pay the claim at the usual and customary rate as described under *Allowed Amounts* for the Covered Health Care Service, less any applicable Co-insurance, Co-payment or Annual Deductible amount.
- Pay the claim at the Network Benefit Co-insurance level.
- In addition to any amount that would have been credited had the provider been a Network provider, credit any out-of-pocket amounts you paid to the out-of-Network provider for charges for Covered Health Care Services that were beyond the Allowed Amount toward the Annual Deductible and Out-of-Pocket Limit applicable to Network services.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you do not use the selected Network Physician, Covered Health Care Services will be paid as Out-of-Network Benefits.

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-3408

1-800-357-1371

UnitedHealthcare Insurance Company

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

UnitedHealthcare Insurance Company
To get information or file a complaint with your insurance company or HMO:

Call: Appeals at 1-866-842-9268
Toll-free: Austin 1-800-424-6480
Dallas 1-800-458-5653
Houston 1-800-548-1078
San Antonio 1-800-842-0174
Online: www.uhc.com
Email: nasc_oldsmar_admin@uhc.com
Mail: 185 Asylum Street, Hartford, Connecticut 06103-3408

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC CO-CP, Texas Department of Insurance,
P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de sucompañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

UnitedHealthcare of Texas, Inc.

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Appeals al 866-842-9268

Teléfono gratuito: Austin 1-800-424-6480
Dallas 1-800-458-5653
Houston 1-800-548-1078

Houston 1-800-548-1078

San Antonio 1-800-842-0174

En línea: www.uhc.com

Correo electrónico: nasc_oldsmar_admin@uhc.com

Dirección postal: 185 Asylum Street, Hartford, Connecticut 06103-3408

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: Consumer Protection, MC CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

Certificate of Coverage

UnitedHealthcare Insurance Company

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Group. The *Certificate* describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Group's *Application* and payment of the required Policy Charges.

In addition to this *Certificate,* the Policy includes:

- The *Schedule of Benefits*.
- The Group's *Application*.
- Riders, including the *Outpatient Prescription Drug Rider*.
- Amendments.

You can review the Policy at the Group's office during regular business hours.

Can This Certificate Change?

We may, from time to time, change this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When this happens we will send you a new *Certificate*, Rider or Amendment.

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends*.

We are delivering the Policy in Texas. The Policy is subject to the laws of the state of Texas and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Texas law governs the Policy.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Introduction to Your Certificate

This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

How Do You Use This Document?

Read your entire *Certificate* and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *Certificate* at www.myuhc.com.

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *Certificate* and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

If there is a conflict between this *Certificate* and any summaries provided to you by the Group, this *Certificate* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact Us?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Eligibility, Enrollment, and Required Contributions

Benefits are available to you once you are enrolled for coverage under the Policy. The Group will apply the eligibility rules.

- Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:
  - Your enrollment must be in accordance with the rules of the Policy issued to your Group, including the eligibility rules.
  - You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms*.
- You continue to receive Benefits as long as you continue to qualify as a Subscriber or Dependent as defined in *Section 9: Defined Terms* and meet the eligibility rules noted in the Policy which includes this *Certificate* and the Group *Application.*
- Your Benefits are no longer available as described in *Section 4: When Coverage Ends.*

Your Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy. If you have questions about this, contact your Group.

Be Aware the Policy Does Not Pay for All Health Care Services

The Policy does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Physician. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver your care. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization unless they qualify for an exemption from prior authorization requirements as described in *TIC §4201.651 - §4201.659*. However, if you choose to receive Covered Health Care Services from an out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Your Physician or health care provider may request a renewal of an existing prior authorization at least 60 days before the date the prior authorization expires. Further, if the request is received before the existing prior authorization expires, we, if practicable, will review and issue a determination before the existing prior authorization expires.

Pay Your Share

You must meet any applicable deductible and pay a Co-payment and/or Co-insurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Benefits*.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Policy's exclusions.

Show Your ID Card

You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from us or assigning Benefits directly to that provider. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health care services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under the Policy for all other Covered Health Care Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether the Policy will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the authority to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may assign this authority to other persons or entities that may provide administrative services for the Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Care Services

We pay Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Care Services Provided by Out-of-Network Providers

In accordance with any state prompt pay requirements, we pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We adjudicate claims consistent with industry standards. We develop our reimbursement policy guidelines, as we determine, generally in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with

Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at www.myuhc.com or the telephone number on your ID card.

We may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, we will use a comparable methodology(ies). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable methodology.

Offer Health Education Services to You

We may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but we recommend that you discuss them with your Physician.

Certificate of Coverage Table of Contents

Section 1: Covered Health Care Services 8
Section 2: Exclusions and Limitations.....32
Section 3: When Coverage Begins 45
Section 4: When Coverage Ends 49
Section 5: How to File a Claim 53
Section 6: Questions, Complaints and Appeals.....55
Section 7: Coordination of Benefits 61
Section 8: General Legal Provisions 67
Section 9: Defined Terms 75
Section 10: Consolidated Appropriations Act Summary.....90
Notice of Certain Mandatory Benefits 92
Disclosure of Provider Status Notice 95
Preferred Provider Health Benefit Plan Notice 96
Section 6: Questions, Complaints and Appeals.....97

Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Policy is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility rules specified in the Policy which includes this C*ertificate* and the Group *Application*.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Policy.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Co-payment and/or Co-insurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount or the Recognized Amount when applicable, you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance, as appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

2. Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

3. Clinical Trials

Routine patient care costs incurred while taking part in a qualifying Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
  - The provision of the Experimental or Investigational Service(s) or item.
  - The clinically appropriate monitoring of the effects of the service or item, or
  - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.

  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services that clearly do not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.
- Any item or service that is not a Covered Health Care Service, regardless of whether the item or service is required in connection with the participation in a clinical trial.
- Any item or service that is specifically excluded from coverage under this Policy.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - An institution review board of an institution in Texas that has an agreement with the *Office for Human Research Protections* to the *U.S. Department of Health and Human Services.*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.

- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial. We may, at any time, request documentation about the trial.

4. Congenital Heart Disease (CHD) Surgeries

CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta.
- Aortic stenosis.
- Tetralogy of Fallot.
- Transposition of the great vessels.
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for CHD services.

5. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that happens as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Policy, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.

- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

6. Diabetes Services

Diabetes equipment, diabetes supplies and diabetes self-management training programs when provided by or under the direction of a Doctor of Medicine, Doctor of Osteopathy or a Certified Educator. Benefits also include new treatment modalities upon the approval of the *FDA*, supplies, including medications and equipment for the control of diabetes shall be dispensed as written, including brand-name products, unless substitution is approved by the Physician or practitioner who issues the written order.

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals. Benefits are also available for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regimen and periodic continuing education training as warranted by the development of new techniques and treatment of diabetes.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Diabetes equipment is limited to:

- Blood glucose monitors (including noninvasive monitors and monitors designed to be used by blind individuals).
- Insulin pumps, both external and implantable, and associated appurtenances which include insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin and other required disposable supplies. Benefits are included for repairs and necessary maintenance of insulin pumps that are not otherwise provided for under warranty or purchase agreement. Benefits are also included for rental fees for pumps during the repair and necessary maintenance of insulin pumps (neither of which shall exceed the purchase price of a similar replacement pump).
- Podiatric appliances including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes.

Diabetes supplies are limited to:

- Test strips for blood glucose monitors.
- Lancet and lancet devices.
- Visual reading and urine testing strips and tablets that test for glucose, ketones and protein.
- Insulin and insulin analog preparations.
- Injection aids, including devices used to assist with insulin injection and needleless systems.
- Insulin syringes.
- Biohazard disposal containers.

- Glucagon emergency kits.
- Prescription and non-prescription oral agents for controlling blood sugar levels.

Note: If an *Outpatient Prescription Drug Rider* is included under the Policy, Benefits for the diabetes supplies above will be provided under the *Outpatient Prescription Drug Rider*. Otherwise, the Benefits will be provided under this Benefit category.

7. Durable Medical Equipment (DME), Orthotics and Supplies

Benefits are provided for DME and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, we will pay only the amount that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*.
- External cochlear devices and systems, including external speech processor and controller with necessary components replacement every three years. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*. Benefits for cochlear implants are limited to one in each ear with internal replacement as medically or audiologically necessary.

Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998.*

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

Orthotic Devices

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations,* under *Medical Supplies and Equipment.*

These Benefits apply to external DME. Unless otherwise excluded, items that are fully implanted into the body are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate*.

8. Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility, Independent Freestanding Emergency Department, or comparable emergency facility.

When a Covered Person cannot reach a Network provider, we will reimburse the following Emergency Health Care Services by an out-of-Network provider at the Network level of Benefits until the Covered Person can reasonably be expected to transfer to a Network Physician or provider.

- A medical screening exam or other evaluation required by state or federal law to be provided in the emergency facility or a Hospital that is necessary to determine whether a medical emergency condition exists.
- Necessary Emergency Health Care Services, including the treatment and stabilization of an emergency medical condition.
- Services originating in a Hospital emergency facility or Independent Freestanding Emergency Department following treatment and stabilization of an emergency medical condition.
- Supplies related to the Emergency Health Care Services.

When Emergency Health Care Services are received in a Physician's office, the Benefits will be provided as described in *Physician's Office Services - Sickness and Injury* below.

When Emergency Health Care Services are received on an inpatient basis, Benefits will be provided as described in *Hospital - Inpatient Stay* below.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

9. Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a Physician. Examples include:

- Formulas necessary to treat phenylketonuria (PKU) or other heritable diseases to the same extent as other available drugs.
- Amino acid-based elemental formulas that are used for the diagnosis and treatment of:
  - Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins.
  - Severe food protein-induced enterocolitis syndrome.
  - Eosinophilic disorders, as evidenced by the results of a biopsy.
  - Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Benefits include services associated with administering the formula.

10. Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.

- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under your *Outpatient Prescription Drug Rider* or under *Pharmaceutical Products - Outpatient* in this section.

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

Benefits are not available for long-term storage costs (greater than one year).

11. Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

12. Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a disabling condition to learn or improve skills and functioning for daily living. We will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when both of the following conditions are met:

- Treatment is administered by any of the following:
  - Licensed speech-language pathologist.
  - Licensed audiologist.
  - Licensed occupational therapist.
  - Licensed physical therapist.
  - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.

- Day care.
- Therapeutic recreation.
- Educational/Vocational training.
- Residential Treatment.
- A service or treatment plan that does not help you meet functional goals.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

We may require the following be provided:

- Medical records.
- Other necessary data to allow us to prove that medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress we may request additional medical records.

Habilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices.*

13. Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). These are electronic amplifying devices designed to bring sound more effectively into the ear. These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid, associated fitting charges, testing, dispensing services and the provision of ear molds as necessary to maintain optimal fit of the hearing aid.

Benefits for habilitation and rehabilitation services as necessary for educational gain related to hearing aids and cochlear implants are a Covered Health Care Service for which Benefits are available under *Habilitative Services* and *Rehabilitative Services-Outpatient Therapy and Manipulative Treatment*.

Benefits are also provided for certain *U.S. Food and Drug Administration (FDA)* approved over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam.
- A fitting by a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider.
- A written prescription or other order.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, we will pay only the amount that we would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this *Certificate*. Benefits are limited to one bone anchored hearing aid per Covered Person during the entire period the Covered Person is enrolled under the Policy. Benefits do not include repairs and/or replacements for bone anchored hearing aids, other than for malfunctions.

14. Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse or a licensed vocational nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Physical, occupational, speech or respiratory therapy.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.
- Medical equipment and supplies other than drugs or medicines.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

15. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can call us at the telephone number on your ID card for information about our guidelines for hospice care.

16. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Inpatient care for a minimum of 48 hours following a mastectomy and 24 hours following a lymph node dissection for the treatment of breast cancer. The Covered Person and the treating Physician may determine that a shorter period of inpatient care is appropriate.
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

17. Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office include:

- Lab and radiology/X-ray.

- Mammography, including Diagnostic Imaging. Coverage for Diagnostic Imaging will be no less favorable than coverage for screening mammograms.
- Annual breast cancer screenings by all forms of Low-dose Mammography in females 35 years of age and older for the presence of occult breast cancer, including 3-D imaging.
- Noninvasive screening tests for atherosclerosis and abnormal artery structure such as ultrasonography measuring carotid intima-media thickening and plaque.
- Prostate-specific antigen test for the detection of prostate cancer.
- A newborn screening test kit in the amount provided by the Health and Safety Code under §33.019. Benefits will be provided for administration of the screening test kit under the corresponding Benefit category in this *Certificate*.
- Biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition when the test is supported by medical and scientific evidence.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

Mammography screenings that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force* are described under *Preventive Care Services*.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply, when services are provided in a Physician's office.

18. Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Computed tomography (CT) scan measuring coronary artery calcification.
- Diagnostic Imaging in relation to breast imaging. Coverage for Diagnostic Imaging will be no less favorable than coverage for screening mammograms.

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply, when services are provided in a Physician's office.

19. Mental Health Care and Substance-Related and Addictive Disorders Services

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits and services under this section are provided under the same terms and conditions without quantitative or non-quantitative treatment limitations that are more restrictive as are applicable to medical and surgical treatment. Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA))* that are the following:
    - Focused on the treatment of core deficits of Autism Spectrum Disorder.
    - Provided by a *Board Certified Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
    - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

    This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder including the screening of a child for Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this *Certificate*.

    Benefits are provided for generally recognized services when prescribed by the Enrolled Dependent child's Primary Care Physician in the treatment plan recommended by that Physician. The individual providing generally recognized services must be a health care practitioner who is licensed, certified, or registered by an appropriate agency of the State of Texas; whose professional credentials are recognized and accepted by an appropriate agency of the United States; or certified as a provider under the TRICARE military health system.
- Mental Health Care Services for the following psychiatric illnesses (defined as Serious Mental Illness in *Section 9: Defined Terms*):
    - Bipolar disorders (hypomanic, manic, depressive, and mixed).
    - Depression in childhood and adolescence.
    - Major depressive disorders (single episode or recurrent).

- Obsessive-compulsive disorders.
- Paranoid and other psychotic disorders.
- Schizo-affective disorders (bipolar or depressive).
- Schizophrenia.

  Benefits are provided for alternative Mental Health Care Services for treatment of a Serious Mental Illness in a Residential Treatment Center for Children and Adolescents or from a Crisis Stabilization Unit, as required by State of Texas insurance law.

- Chemical Dependency services including detoxification from abusive chemicals or substances, limited to physical detoxification when necessary to protect your physical health and well-being. Detoxification is the process of withdrawing a person from a specific psychoactive substance in a safe and effective manner.

The Mental Health/Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for assistance in locating a provider and coordination of care.

20. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

21. Pharmaceutical Products - Outpatient

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by us), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *Certificate*. Benefits for medication normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drug Rider.*

If you require certain Pharmaceutical Products, including Specialty Pharmaceutical Products, we will assist you in choosing Designated Dispensing Entity. Such Designated Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, you/your provider may contact us, and we will assist you/your provider in selecting another specialty pharmacy to obtain your Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.

22. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

23. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections.

Benefits also include necessary diagnostic follow-up care relating to the screening test for hearing loss of a Dependent child.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

24. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related Complications of Pregnancy.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following an uncomplicated normal vaginal delivery.
- 96 hours for the mother and newborn child following an uncomplicated cesarean section delivery.
- 96 hours for the mother and newborn child following a non-elective cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. If the discharge occurs earlier or if the delivery does not occur in a Hospital or other facility, Benefits are included for post-delivery care when provided by a Physician, a registered nurse or other appropriately licensed provider, either in the mother's home or at another location determined to be appropriate.

Post-delivery care includes services provided in accordance with accepted maternal and neonatal physical assessment, parent education, breast or bottle feeding, educational/training and performance of necessary and appropriate clinical tests.

25. Preimplantation Genetic Testing (PGT) and Related Services

Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
  - Ovulation induction (or controlled ovarian stimulation).
  - Egg retrieval, fertilization and embryo culture.
  - Embryo biopsy.
  - Embryo transfer.
  - Cryo-preservation and short-term embryo storage (less than one year).

Benefits are not available for long-term storage costs (greater than one year).

26. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*

  Immunizations for children including:
  - Diphtheria.
  - Haemophilus influenza type B.
  - Hepatitis B.
  - Measles.
  - Mumps.
  - Pertussis.
  - Polio.
  - Rubella.
  - Tetanus.
  - Varicella.
  - Any other immunization required for children by law.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.

- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration,* including contraceptive services and supplies. Women may access obstetrics and gynecology services directly from an obstetrician or gynecologist. You may receive these services without prior authorization or a referral from your Primary Care Physician.

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting us at www.myuhc.com or the telephone number on your ID card.

  If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. We will determine the following:

  - Which pump is the most cost effective.
  - Whether the pump should be purchased or rented (and the duration of any rental).
  - Timing of purchase or rental.
- Colorectal cancer screenings for Covered Persons age 45 and older including:
  - All colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of "A" or "B" by the *United States Preventive Services Task Force* for average-risk individuals, including the services that may be assigned a grade of "A" or "B" in the future; and
  - An initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

27. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998.* Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies.*

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate.*

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most appropriate model of prosthetic device that meets the minimum specifications for your needs, as determined by your treating Physician. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations,* under *Devices, Appliances and Prosthetics.*

28. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Benefits are provided for the reconstructive procedures for craniofacial abnormalities to improve the function of, or attempt to create the normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumor, infections, or disease.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

29. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or determined to be Medically Necessary by your Physician.

Benefits are available only for rehabilitation services that are expected to restore a Covered Person to the previous level of functioning. Benefits for rehabilitation services are not available for services that are expected to provide a higher level of functioning than the Covered Person previously possessed. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

30. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include:

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Benefits that apply to certain preventive screenings are described under *Preventive Care Services*.

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply, when services are provided in a Physician's office.

31. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

32. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal, ear wax removal, and cast application.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply, when services are provided in a Physician's office.

33. Temporomandibular Joint (TMJ) Services

Services for the evaluation and treatment of TMJ and associated muscles; including the jaw and the craniomandibular joint, which are required as a result of an accident, trauma, congenital defect, developmental defect, or pathology.

Diagnosis: Exam, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including:

- Clinical exams.
- Oral appliances (orthotic splints).
- Arthrocentesis.
- Trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is radiographic evidence of joint abnormality.
- Non-surgical treatment has not resolved the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include:

- Arthrocentesis.
- Arthroscopy.
- Arthroplasty.
- Arthrotomy.
- Open or closed reduction of dislocations.

Benefits for surgical services also include *FDA* -approved TMJ prosthetic replacements when all other treatment has failed.

34. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital, Alternate Facility, or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

Please refer to your *Schedule of Benefits* under *Physician's Office Services - Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply, when services are provided in a Physician's office.

35. Transplantation Services

Organ and tissue transplants, including CAR-T cell therapy for malignancies, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:

- Bone marrow, including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the Policy, limited to donor:

- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for transplant services.

36. Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

37. Urinary Catheters

Benefits for external, indwelling, and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

38. Virtual Care Services

Virtual care for Covered Health Care Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, or fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

Additional Benefits Required By Texas Law

39. Acquired Brain Injury

Benefits are provided for Covered Health Care Services that are determined by a Physician to be Medically Necessary as a result of and related to an acquired brain injury. Acquired brain injury is a neurological insult to the brain which is not hereditary, congenital, or degenerative. The Injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of

physical functioning, sensory processing, cognition, or psychosocial behavior. Benefits are provided for the Covered Health Care Services listed below when they are clinically proven, goal-oriented, efficacious, based on individualized treatment plans, required for and related to treatment of an acquired brain injury and provided by or under the direction of a Physician with the goal of returning the Covered Person to, or maintaining the Covered Person in, the most integrated living environment appropriate to the Covered Person.

- Cognitive communication therapy. Services designed to address modalities of comprehension and expression, including understanding, reading, writing and verbal expression of information.
- Cognitive rehabilitation therapy. Services designed to address therapeutic cognitive activities based on an assessment and understanding of the individual's brain-behavioral deficits.
- Community reintegration services. Services that facilitate the continuum of care as an affected individual transitions into the community.
- Neurobehavioral testing. An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.
- Neurobehavioral treatment. Interventions that focus on behavior and the variables that control behavior.
- Neurocognitive rehabilitation. Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
- Neurocognitive therapy. Services designed to address neurological deficits in informational processing and to facilitate the development of higher-level cognitive abilities.
- Neurofeedback therapy. Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
- Neurophysiological testing. An evaluation of the functions of the nervous system.
- Neurophysiological treatment. Interventions that focus on the functions of the nervous system.
- Neuropsychological testing. The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
- Neuropsychological treatment. Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
- Outpatient day treatment services - Structured services provided to address deficits in physiological, behavioral and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-Residential Treatment settings.
- Post-acute care treatment services - Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.
- Post-acute care services necessary as a result of and related to an acquired brain injury are limited to the following: post-acute care treatment is limited to reasonable expenses related to periodic reevaluation of care provided to an individual who has incurred an acquired brain injury, has been unresponsive to treatment and becomes responsive to treatment at a later date. Reasonable costs

may be determined by cost; the time that has expired since the previous evaluation; any difference in the expertise of the Physician or practitioner performing the evaluation; changes in technology and advances in medicine. For services provided by a licensed Assisted Living Facility through a program that includes an overnight stay, each overnight stay is equal to a visit.

- Post-acute transition services. Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
- Psychophysiological testing. An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
- Psychophysiological treatment. Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
- Remediation. The process of restoring or improving a specific function.
- Treatment facilities. Treatment for an acquired brain injury may be provided at a facility at which the services listed above may be provided including a Hospital, acute or post-acute rehabilitation hospital and Assisted Living Facility. Although Benefits may be available for services at Assisted Living Facilities, Benefits are not available for Custodial Care, Private Duty Nursing, domiciliary care, and personal care assistants as outlined in *Types of Care* in *Section 2: Exclusions and Limitations* in this *Certificate of Coverage*, regardless of where the services are provided.

40. Developmental Delay Services

Rehabilitative and habilitative services that are determined to be necessary to, and provided in accordance with, an individualized family service plan issued by the *Interagency Council on Early Childhood Intervention*.

Covered Health Care Services include:

- Occupational therapy evaluations and services.
- Physical therapy evaluations and services.
- Speech therapy evaluations and services.
- Dietary or nutritional evaluations.

41. Human Papillomavirus, Cervical Cancer and Ovarian Cancer Screenings

Benefits for human papillomavirus, cervical cancer screenings and ovarian cancer screenings will be provided to each woman 18 years of age and older that is an Eligible Person enrolled under the Policy.

Coverage includes the following:

- An annual medically recognized diagnostic exam for the early detection of cervical cancer.
- A conventional pap smear screening or a screening using liquid-based cytology methods, as approved by the *U.S. Food and Drug Administration (FDA),* alone or in combination with a test approved by the *FDA* for the detection of the human papillomavirus.
- An annual CA 125 blood test, or any other test or screening approved by the *FDA* for the early detection of ovarian cancer.

Screenings provided under this section must be performed in accordance with the guidelines adopted by:

- *The American College of Obstetricians and Gynecologists;* or
- Another similar national organization of medical professionals recognized by the commissioner.

Human papillomavirus and cervical cancer screenings that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force* or as provided for in

comprehensive guidelines supported by the *Health Resource and Services Administration* are described under *Preventive Care Services.*

42. Osteoporosis Detection and Prevention

Benefits for a medically accepted bone mass measurements for the detection of low bone mass, when provided by or under the direction of a Physician. Benefits are provided only to a Covered Person who meets at least one of the following:

- A postmenopausal woman who is not receiving estrogen replacement therapy.
- An individual with vertebral abnormalities, primary hyperparathyroidism, or history of bone fractures.
- An individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

43. Speech and Hearing Services

Services required (as determined by the Physician) as treatment for the loss or impairment of speech or hearing. Covered Health Care Services include developmental and educational speech and hearing therapy.

Benefits are also available for hearing aids and costs associated with the fitting of hearing aids as described under *Hearing Aids* above.

44. Telehealth, Telemedicine and Teledentistry Services

Benefits include Telehealth Services, Telemedicine Medical Services and Teledentistry Dental Services. Benefits are also provided for Remote Physiologic Monitoring. An in-person consultation is not required between the health care provider and the patient for services to be provided. Services provided by telemedicine, telehealth and teledentistry are subject to the same terms and conditions of the Policy as any service provided in-person.

Telehealth Services, Telemedicine Medical Services and Teledentistry Dental Services do not include virtual care services provided by a Designated Virtual Network Provider for which Benefits are provided as described under *Virtual Care Services*.

You may find additional information regarding Telehealth Services, Telemedicine Medical Services or Teledentistry Dental Services at www.myuhc.com.

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

To help you find exclusions, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through a Rider to the Policy.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services*, those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Wilderness, adventure, camping, outdoor, or other similar programs.
7. Art therapy, music therapy, dance therapy, animal-assisted therapy, and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia).

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.*

This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.
- Services required by a Covered Person who is unable to undergo dental treatment in an office setting or under local anesthesia because of a documented physical, mental, or medical reason.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

   - Removal, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA) requirement.* This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.*

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.*

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.

2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services.*

3. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.

- Trusses.
- Ultrasonic nebulizers.

4. Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
8. Powered and non-powered exoskeleton devices.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to prescription and non-prescription oral agents for controlling blood sugar levels. Note: If an *Outpatient Prescription Drug Rider* is included under the Policy, Benefits for the prescription and non-prescription oral agents will be provided under the *Outpatient Prescription Drug Rider*. Otherwise, the Benefits will be provided under the *Certificate*.
2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration. This exclusion does not apply to self-administered medications for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter drugs and treatments for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by us or our designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 1: Covered Health Care Services.*
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations will occur no more often than annually on the Policy anniversary date.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to

another covered Pharmaceutical Product. Such determinations will occur no more often than annually on the Policy anniversary date.

9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations will occur no more often than annually on the Policy anniversary date.
10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations will occur no more often than annually on the Policy anniversary date.
11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.
12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*

F. Foot Care

1. Routine foot care. Examples include:
   - Cutting or removal of corns and calluses.
   - Nail trimming, nail cutting, or nail debridement.
   - Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Shoes. This exclusion does not apply to podiatric appliances or therapeutic footwear for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
5. Shoe orthotics. This exclusion does not apply to orthotics for which Benefits are provided as described under *Diabetes Services* or *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
6. Shoe inserts.
7. Arch supports.

G. Gender Dysphoria

1. Cosmetic Procedures, including the following:
   - Abdominoplasty.
   - Blepharoplasty.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling for facial feminizations.
   - Hair removal, except as part of a genital reconstruction procedure by a Physician for the treatment of gender dysphoria.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Liposuction.
   - Mastopexy.
   - Pectoral implants for chest masculinization.
   - Rhinoplasty.
   - Skin resurfacing.

H. Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices* in *Section 1: Covered Health Care Services.* This exception does not apply to supplies for the administration of medical food products.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
   - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Care Services.*
   - Urinary catheters and related urologic supplies for which Benefits are provided as described under *Urinary Catheters* in *Section 1: Covered Health Care Services*.

2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services.*
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

I. Mental Health Care and Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Care Services.*

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
7. Transitional Living services, (including recovery residences).
8. Non-medical 24-hour withdrawal management, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.
9. Residential care for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment. Benefits will be provided under the appropriate medical/surgical Benefits listed in *Section 1: Covered Health Care Services* rather than the *Mental Health Care and Substance-Related and Addictive Disorders Services* Benefit.

J. Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical or behavioral/mental health related nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
    - Nutritional education is required for a disease in which patient self-management is a part of treatment.

- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services*.
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes. This exclusion does not apply to:
   - Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in *Section 1: Covered Health Care Services*, which meet the definition of a Covered Health Care Service
   - Specialized enteral formulas for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services*.

K. Personal Care, Comfort or Convenience

4. Television.
5. Telephone.
6. Beauty/barber service.
7. Guest service.
8. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot and cold compresses.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.
   - Motorized beds.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.

- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

M. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).

3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly.
6. Habilitative services for maintenance/preventive treatment.
7. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
8. Biofeedback. This exclusion does not apply when the service is rendered with the diagnosis of acquired brain injury.
9. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.
10. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment.
11. Surgical and non-surgical treatment of obesity.
12. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
13. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
14. Helicobacter pylori *(H. pylori)* serologic testing.
15. Intracellular micronutrient testing.
16. Cellular and Gene Therapy services not received from a Network Transplant Provider.

N. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. This exclusion does not apply to dentists.
2. Services performed by a provider with your same legal address.
3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:
   - Has not been involved in your medical care prior to ordering the service, or
   - Is not involved in your medical care after the service is received.

   This exclusion does not apply to mammography or Emergency Health Care Services.

O. Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to Benefits as described under *In Vitro Fertilization Services, Fertility Preservation for Iatrogenic Infertility* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.*
2. The following services related to a Gestational Carrier or Surrogate:
   - All costs related to reproductive techniques including:
     - Assisted reproductive technology.
     - Artificial insemination.
     - Intrauterine insemination.
     - Obtaining and transferring embryo(s).
     - Preimplantation Genetic Testing (PGT) and related services.
   - Health care services including:
     - Inpatient or outpatient prenatal care and/or preventive care.
     - Screenings and/or diagnostic testing.
     - Delivery and post-natal care.

     The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.
   - All fees including:
     - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
     - Surrogate insurance premiums.
     - Travel or transportation fees.
3. Costs of donor eggs and donor sperm.
4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided as described under *Fertility Preservation for Iatrogenic Infertility* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.*
5. The reversal of voluntary sterilization.
6. Fetal reduction surgery. This exclusion does not apply to fetal reduction surgery which is performed in order to save the life or preserve the health of an unborn child; or when, as certified by a Physician, a woman has a life-threatening physical condition where she is in danger of death or serious risk of substantial impairment of a major bodily function unless fetal reduction surgery is performed.
7. Elective fertility preservation.
8. In vitro fertilization regardless of the reason for treatment. This exclusion does not apply to in vitro fertilization for which Benefits are provided as described under *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.*

P. Services Provided under another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

3. Health care services during active military duty.

Q. Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services*.

2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)

3. Health care services for transplants involving animal organs.

4. Health care services for human organ transplant or post-transplant care when:

   - The transplant operation is performed in China, or another country known to have participated in forced organ harvesting.
   - The human organ to be transplanted was procured by a sale or donation originating in China or another country known to have participated in forced organ harvesting.

R. Travel

5. Health care services provided in a foreign country, unless required as Emergency Health Care Services.

6. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Network Transplant Provider or other Network provider may be paid back as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services.*

S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.

2. Custodial Care or maintenance care.

3. Domiciliary care.

4. Private Duty Nursing.

5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.

6. Rest cures.

7. Services of personal care aides.

8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

T. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Routine vision exams, including refractive exams to determine the need for vision correction.
3. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

U. All Other Exclusions

6. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
    - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
    - Medically Necessary.
    - Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
7. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
    - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
    - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
    - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
    - Required to get or maintain a license of any type.
8. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
9. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
10. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
11. In the event an out-of-Network provider waives, does not pursue, or fails to collect, Co-payments, Co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments, Co-insurance and/or deductible are waived.

12. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
13. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
14. Autopsy.
15. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
16. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Group. The Group will submit the completed forms to us, along with any required Premium. We will not provide Benefits for health care services that you receive before your effective date of coverage.

What If You Are Hospitalized When Your Coverage Begins?

We will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of the Policy.

These Benefits are subject to your previous carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible. For plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Care Services from Network providers.

What If You Are Eligible for Medicare?

Your Benefits may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

Your Benefits may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but do not follow the rules of that plan. Please see *How Are Benefits Paid When You Are Medicare Eligible?* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.

Who Is Eligible for Coverage?

Eligibility for enrollment is administered by the Group consistent with the Policy which includes this *Certificate* and Group *Application.*

Eligible Person

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 9: Defined Terms*.

Eligible Persons must live within the United States.

If both spouses are Eligible Persons of the Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group in accordance with the eligibility rules. We must receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- The Subscriber is a party in a suit seeking adoption.
- The date the adoption becomes final.
- Marriage.
- Legal guardianship.
- Court or administrative order, including a *Qualified Medical Child Support Order* for a Dependent child.
- Registering a Domestic Partner.

Coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event.

Coverage for a new Dependent child by birth or adoption begins on the date of the event and remains in effect for 31 days. To continue coverage beyond the initial 31-day period, the Subscriber must notify us of the event and pay any required Premium within 31 days of the event. Benefits for Covered Health Care Services for congenital defects and birth abnormalities (including Congenital Anomalies) are available at the same level as those for any other Sickness or Injury.

Coverage for a Dependent child when required by a medical support order begins on the date of receipt of either the medical support order, or the notice of the medical support order, and remains in effect for 31 days. To continue coverage beyond the initial 31-day period, we must receive a completed enrollment form and payment of any required Premium within 31 days of receipt of the medical support order. The Subscriber, the custodial parent, a child support agency, or the Dependent child (if over age 18) may complete and sign the enrollment form on behalf of the Dependent child. If the Eligible Person is not already enrolled, he or she is also eligible to enroll if required by a medical support order to provide health care coverage to his or her Dependent child. The Eligible Person must provide proof, satisfactory to us, of the requirement to provide health care coverage.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- The Subscriber is a party in a suit seeking adoption.
- The date the adoption becomes final.
- Marriage.
- Court or administrative order.
- Registering a Domestic Partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including legal separation, divorce or death as well as a child of a covered employee who has lost coverage under *Chapter 62 Health and Safety Code, Child Health Plan for Certain Low-Income Children* or *Title XIX of the Social Security Act* (42 U.S.C. §§1396, et seq., *Grants to States for Medical Assistance Programs*) other than coverage consisting solely of Benefits under Section 1928 of that Act (42 U.S.C. §1396, *Program for Distribution of Pediatric Vaccines*)).
    - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.

- In the case of COBRA continuation coverage, the coverage ended.
- The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
- The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
- The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, we will still pay claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Please note that if you are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In this event, the Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  For Texas residents, your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent and we receive written notice from the Group instructing us to end your coverage consistent with Texas regulatory requirements. For non-Texas residents, your coverage ends on the last day of the calendar month in which we receive written notice from the Group instructing us to end your coverage, or the date requested in the notice, if later.

  Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends on the last day of the calendar month in which we receive the required notice from the Group to end your coverage, or on the date requested in the notice, if later.

- **Subscriber Retires or Is Pensioned**

  For Texas residents, your coverage ends the last day of the calendar month in which the Subscriber is retired or receiving benefits under the Group's pension or retirement plan and we receive written notice from the Group instructing us to end your coverage consistent with Texas regulatory requirements. For non-Texas residents, your coverage ends on the last day of the calendar month in which we receive written notice from the Group instructing us to end your coverage, or the date requested in the notice, if later. The Group is responsible for providing the required notice to us to end your coverage.

This provision applies unless there is specific coverage classification for retired or pensioned persons in the Group's *Application*, and only if the Subscriber continues to meet any applicable eligibility rules. The Group can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 30 days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental, developmental, or physical disability.
- The Enrolled Dependent child depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Policy.

You must furnish us with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that exam.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at our expense. We will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Extended Coverage for Total Disability

Coverage when you are Totally Disabled on the date the entire Policy ends will not end automatically. We will extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Three months from the date coverage would have ended when the entire Policy ends.

Continuation of Coverage

If your coverage ends under the Policy, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Groups that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Group is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Continuation of Coverage under State Law

You may elect state continuation as described under the State Continuation Coverage provisions below.

Qualifying Events for State Continuation Coverage Due to Reasons other than Severance of the Family Relationship

A Covered Person whose coverage terminates due to any reason except involuntary termination for cause, and who has been continuously covered under the Policy (and under any Group contract providing similar services and Benefits that it replaced) for at least three consecutive months immediately prior to termination, is entitled to continue coverage under state law. A person whose coverage terminates due to severance of the family relationship may either continue coverage as described immediately below, or if he or she meets the requirements described in *Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship*, may continue coverage as described in that provision.

Notification Requirements, Election Period and Premium Payment for State Continuation Coverage Due to Reasons Other than Severance of the Family Relationship

The Covered Person must provide a written request for continuation coverage to the Group's designated plan administrator within 60 days after the later of these dates:

- The date Group coverage would otherwise terminate.
- The date the Covered Person is given notice of the right to elect continuation.

The Covered Person must pay the initial Premium for the continuation coverage to the Group's designated plan administrator within 45 days after the date of the initial election of coverage continuation. Following the payment of the initial Premium, the Covered Person must pay the monthly Premium for the coverage continuation to the designated plan administrator each month. Payment of the monthly continuation Premium will be considered timely if made on or before the 30th day after the date on which the payment is due.

Terminating Events for State Continuation Coverage Due to Reasons Other than Severance of the Family Relationship

State Continuation coverage due to reasons other than severance of the family relationship will end on the earliest of the following dates:

- Nine months from the date state continuation coverage was elected, if the Covered Person is not eligible for continuation of coverage under Federal law (COBRA).

- Six months from the date state continuation coverage was elected, if the state continuation coverage followed continuation coverage under Federal law (COBRA).
- The date coverage ends for failure to make timely payment of the Premium.

Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship

If both of the following are true, a Covered Person whose coverage terminates may elect state continuation coverage under the Policy:

- The Covered Person has been covered under the Policy for at least one year, or is an infant under one year of age.
- The Covered Person's coverage under the Policy was terminated for one of the reasons set forth below:
  - Termination of the Subscriber from employment with the Group.
  - Death of the Subscriber.
  - Divorce of the Subscriber.
  - Retirement of the Subscriber.

Notification Requirements, Election Period and Premium Payment for State Continuation Coverage Due to Severance of the Family Relationship

A Covered Person must provide written notice to the Group within 15 days of any severance of the family relationship that might qualify for the continuation as described in *Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship*. Upon receipt of such notice, or upon receipt of notice of the Subscriber's death or retirement, the Group shall immediately give written notice of the right to state continuation to each affected Enrolled Dependent. Within 60 days of severance of the family relationship or the Subscriber's death or retirement, the Enrolled Dependent must give written notice to the Group of his or her intent to elect state continuation. Coverage under the Policy remains in effect during the 60-day election period provided the required Premium is paid. The Covered Person must pay the monthly Premium for the coverage continuation to the designated plan administrator each month. Payment of the monthly continuation Premium will be considered timely if made on or before the 30th day after the date on which the payment is due.

Termination Events for State Continuation Coverage Due to Severance of the Family Relationship

State continuation coverage due to severance of the family relationship will end on the earliest of the following dates:

- Three years from the date that the family relationship was severed or the date of the Subscriber's death or retirement.
- The date the Covered Person fails to make timely payment of the Premium.
- The date the Covered Person becomes eligible for substantially similar coverage under another health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or by any other plan or program.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Health Care Services. If a Network provider bills you for any Covered Health Care Service, contact us. However, you are required to meet any applicable deductible and to pay any required Co-payments and Co-insurance to a Network provider.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within 15 months of the date of service, Benefits for that health care service will be denied or reduced, as determined by us. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card.

When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum Rx

PO Box 650629

Dallas, TX 75265-0629

Payment of Benefits

If you provide written authorization to pay Benefits to the Physician or other health care provider and provides it to us with a claim for Benefits, all or a portion of any Allowed Amounts due to a provider may

be paid directly to the provider instead of being paid to the Subscriber. We will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you, your designated beneficiary, your estate, or if you are a minor or otherwise not competent to give a valid release, your parent, guardian, or other person actually supporting you, unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.

Allowed Amounts due to an out-of-Network provider for Covered Health Care Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

Payment of Benefits under the Policy shall be in cash or cash equivalents, or in a form of other consideration that we determine to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes us, or to other plans for which we make payments where we have taken an assignment of the other plans' recovery rights for value.

Payment/Reimbursement for Certain Publicly Provided Services

As required by Texas law, we will pay Benefits on behalf of a child to the *Texas Health and Human Services Commission*, if:

- The parent who purchased the Policy or who is required to pay child support by a court order or court-approved agreement is;
  - a possessory conservator of the child under a court order issued in this state; or
  - not entitled to possession or access to the child.
- The *Texas Health and Human Services Commission* is paying Benefits on behalf of the child under Chapter 31 or 32, Human Resources Code.
- We are notified, through an attachment to the claim for Benefits at the time the claim is first submitted, that the Benefits must be paid directly to the *Texas Health and Human Services Commission*.

Payment/Reimbursement of Benefits to Conservator of Minor

As required by Texas law, we will pay Benefits to a court appointed possessory or managing conservator of a child if the court appointed person includes the following information when submitting a claim to us:

- Written notice that the person is a possessory or managing conservator of the child on whose behalf the claim is made.
- A certified copy of a court order designating the person as a possessory or managing conservator of the child or other evidence designated by rule of the commissioner that the person is eligible for the Benefits as this section provides.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint.

We will promptly investigate each complaint. The total time for acknowledgement, investigation and resolution of the complaint will not exceed 30 calendar days after we receive the written complaint.

Complaints concerning an Emergency or denials of continued hospitalization will be investigated and resolved in accordance with the medical immediacy of the case, and will not exceed one business day from receipt of the complaint.

We will not engage in any retaliatory action against any Covered Person, Physician or provider. We will not retaliate for any reason including, cancellation of coverage or a provider contract, or refusal to renew coverage or a provider contract because the Covered Person, Physician, provider or person acting on behalf of the Covered Person has filed a complaint against the Policy or has appealed a decision.

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care.

Prior Authorization

Prior authorization, included within the pre-service request, is a request to us for proposed services that will result in one of the following:

- A pre-authorization;
- A confirmation of receipt of your request, when there are no clinical issues; or
- An Adverse Determination.

If you receive an Adverse Determination in response to your request for prior authorization of services, you may appeal the decision. Please refer to *Procedures for Appealing an Adverse Determination* below.

For procedures associated with urgent requests for prior authorization of services, see *Urgent Appeals that Require Immediate Action* below.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination, Non-Clinical Benefit Determination or a rescission of coverage determination, you can contact us orally or in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial. The appeals process will be completed no later than 30 days after the written request is received.

If an appeal is upheld, within 10 working days of the appeal denial your treating Physician may request an additional review. A Physician who is of the same or similar specialty as the health care provider who would typically manage the medical condition, procedure, or treatment will conduct the review. The specialty review will be completed within 15 working days from receipt of the request.

Please note that our decision is based only on whether Benefits are available under the Policy for the proposed treatment or procedure. The decision for you to receive services is between you and your Physician.

Adverse Determinations

An Adverse Determination is a decision that is made by us or our utilization review agent that the health care services furnished or proposed to be furnished to a Covered Person are:

- Not Medically Necessary or appropriate.
- Experimental or Investigational Services.

Adverse Determination does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. An Adverse Determination includes a decision by us not to furnish a prescribed drug that your Physician determines is Medically Necessary. A complete definition of Adverse Determination is contained in *Section 9: Defined Terms.*

Notice of Adverse Determinations

A utilization review agent will provide notice of an Adverse Determination as follows:

- With respect to a patient who is hospitalized at the time of the Adverse Determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the Adverse Determination;
- With respect to a patient who is not hospitalized at the time of the Adverse Determination, within three working days in writing to the provider of record and the patient; or
- Within the time appropriate to the circumstances relating to the delivery of the services to the patient and the patient's condition, provided that when denying post-stabilization care subsequent to emergency treatment as requested by a treating Physician or other health care provider, notice will be provided to the treating Physician or other health care provider no later than one hour after the time of the request.

A utilization review agent will provide notice of an Adverse Determination for a concurrent review of the provision of the prescription drug or intravenous infusions for which the patient is receiving health benefits under this Certificate no later than the 30th day before the date on which the provision of prescription drugs or intravenous infusion will be discontinued.

Procedures for Appealing an Adverse Determination

If you, your designated representative or your provider of record receive an Adverse Determination in response to a claim or a request for prior authorization of services, you, your designated representative or your provider of record may appeal the Adverse Determination orally or in writing.

If you, your designated representative or your provider of record orally appeal the Adverse Determination, we or our utilization review agent will send you, your designated representative or your provider of record a one-page appeal form.

Upon receipt of your appeal we will, within five working days, send you a letter acknowledging receipt of your appeal and provide you with a description of the Adverse Determination appeal process and a list of documents necessary to process your appeal.

Our review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Retrospective Review

If the Adverse Determination relates to a retrospective review, you will receive notice no later than 30 days after we receive your claim. We may extend this period for up to an additional 15 days if we determine an extension is necessary due to matters beyond our control. If an extension is needed, you will be notified within 30 days after we receive your claim. If the extension is necessary because we have not received information from you or your provider, we will specifically describe the information needed and allow 45 days for the information to be submitted. We will make a decision within 30 days of the date of the extension notice until the earlier of the date you or your provider respond to the request for additional information or the date the information was to be submitted.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will notify you of the decision by the end of the next business day (not to exceed 72 hours if a holiday or weekend) following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Expedited Appeals for Denial of Emergency Care, Continued Hospitalization, Prescription Drugs, or Intravenous Infusions

Procedures for written expedited appeals of an Adverse Determination for denials of Emergency Care, continued hospitalization, Prescription Drugs, or intravenous infusions will include a review by a health care provider who:

- Has not previously reviewed the case; and
- Is the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

The time for resolution of an expedited appeal is based on the medical or dental immediacy of the condition, procedure, or treatment under review, provided that the resolution of the appeal may not exceed one working day from the date all information necessary to complete the appeal is received.

The expedited appeal determination may be provided by telephone or electronic transmission, but will be followed with a letter within three working days of the initial telephonic or electronic notification.

Federal External Review Program

You may be entitled to request an external review of our determination after exhausting your internal appeals if either of the following apply:

- You are not satisfied with the determination made by us.
- We fail to respond to your appeal within the timeframe required by the applicable regulations.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations as defined below, by contacting us at the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received our final appeal decision.

An external review request should include all of the following:

- A specific request for an external review.
- Your name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an *Independent Review Organization (IRO)*. We have entered into agreements with three or more *IRO*s that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review includes all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the *IRO*.
- A decision by the *IRO*.

After receipt of the request, we will complete a preliminary review within the applicable timeframe, to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that we may process the request.

After we complete this review, we will issue a notification in writing to you. If the request is eligible for external review, we will assign an *IRO* to conduct such review. We will assign requests by either rotating the assignment of claims among the *IRO*s or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days after the date you receive the *IRO*'s request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

We will provide to the assigned *IRO* the documents and information considered in making our determination. The documents include:

- All relevant medical records.
- All other documents relied upon by us.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request. We will include it with the documents forwarded to the *IRO*.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by us. The *IRO* will provide written notice of its determination (the *"Final External Review Decision"*) within 45 days after it receives the request for the external review (unless they request additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and us, and it will include the clinical basis for the determination.

If we receive a *Final External Review Decision* reversing our determination, we will provide coverage or payment for the Benefit claim at issue according to the terms and conditions of the Policy, and any applicable law regarding plan remedies. If the *Final External Review Decision* agrees with our determination, we will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter for the expedited external review, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review, separately or at the same time you have filed a request for an expedited internal appeal, if you receive any of the following:

- An adverse benefit determination of a claim or appeal that involves a medical condition for which the time frame for completion of an expedited internal appeal would either jeopardize:
  - The life or health of the individual.
  - The individual's ability to regain maximum function.
- An adverse benefit determination involving the denial of prescription drugs or intravenous infusions for which you are receiving Benefits.

In addition, you must have filed a request for an expedited internal appeal.

- A final appeal decision, that either:
  - Involves a medical condition where the timeframe for completion of a standard external review would either jeopardize the life or health of the individual or jeopardize the individual's ability to regain maximum function.
  - Concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency care services, but has not been discharged from a facility.

Immediately upon receipt of the request, we will determine whether the individual meets both of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that we may process the request.

After we complete the review, we will send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, we will assign an *IRO* in the same manner we utilize to assign standard external reviews to *IRO*s. We will provide all required documents and information we used in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available method in a timely manner. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by us. The *IRO* will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the *IRO's* final external review decision is first communicated verbally, the *IRO* will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

You may call us at the telephone number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is specific to Texas law regarding coordination of benefits.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan**. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan**. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

Definitions

For purposes of this section, terms are defined as follows:

A. **Plan**. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This Plan.** This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. **Order of Benefit Determination Rules**. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is

secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense. A Policy may not reduce benefits on the basis that: another Plan exists and the Covered Person did not enroll in that Plan; a person is or could have been covered under another Plan, except with respect to Part B of Medicare; or a person has elected an option under another Plan providing a lower level of Benefits than another option that could have been elected.

D. **Allowable Expense.** Allowable Expense is a health care expense, including deductibles, Co-insurance and Co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

   The following are examples of expenses or services that are not Allowable Expenses:

   1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
   2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
   3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
   4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
   5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. **Closed Panel Plan.** Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial Parent.** Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

What Are the Rules for Determining the Order of Benefit Payments?

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-Network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. If the Primary Plan is a Closed Panel Plan and the Secondary Plan is not, the Secondary Plan must pay or provide Benefits as if it were the Primary Plan when a Covered Person uses an out-of-Network Physician, except for Emergency services or authorized referrals that are paid or provided by the Primary Plan.

E. When multiple contracts providing coordinated coverage are treated as a single Plan under this subchapter, this section applies only to the Plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides Benefits under the Plan, the carrier designated as primary within the Plan must be responsible for the Plan's compliance with this subchapter.

F. If a person is covered by more than one Secondary Plan, the Order of Benefit Determination Rules of this subchapter decide the order in which Secondary Plans' Benefits are determined in relation to each other. Each Secondary Plan must take into consideration the Benefits of the Primary Plan or Plans and the Benefits of any other Plan that, under the rules of this subchapter, has its Benefits determined before those of that Secondary Plan.

G. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person 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, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent 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. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled G.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and

as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled G.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, should the plan wish to coordinate benefits, the Secondary Plan must calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan result in the total benefits paid or provided by all Plans for the claim equaling 100 percent of the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Important: If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under this Coverage Plan), you should enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are secondary to Medicare, we will pay Benefits under this Coverage Plan as if you were covered under both Medicare Part A and Part B. As a result, your out-of-pocket costs will be higher.

If you have not enrolled in Medicare, Benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider if either of the following applies:

- You are eligible for, but not enrolled in, Medicare and this Coverage Plan is secondary to Medicare.
- You have enrolled in Medicare but choose to obtain services from a doctor that opts-out of the Medicare program.

When calculating the Coverage Plan's Benefit in these situations, we use Medicare's allowable expense or Medicare's limiting charge as the Allowable Expense.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Does This Plan Have the Right of Recovery?

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

How Are Benefits Paid When This Plan is Secondary to Medicare?

If This Plan is secondary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits.

Section 8: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Policy and how it may affect you. We help finance or administer the Group's Policy in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Group's Policy will cover or pay for the health care that you may receive. The Policy pays for Covered Health Care Services, which are more fully described in this *Certificate*.
- The Policy may not pay for all treatments you or your Physician may believe are needed. If the Policy does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

What Is Our Relationship with Providers and Groups?

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.

We do not provide health care services or supplies, or practice medicine. We arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. We are not responsible for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Group's Policy. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Group's Policy.

The Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of when the Policy ends.

When the Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Groups?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any deductible and any amount that exceeds the Allowed Amount, when applicable.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to you.

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy after it has been in force for two years unless it is a fraudulent statement.

Do We Pay Incentives to Providers?

We pay Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health care services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. The applicable Co-payment and/or Co-insurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Co-payment and/or Co-insurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-payment and/or Co-insurance as described in the *Schedule of Benefits*.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also call us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above.

Do We Receive Rebates and Other Payments?

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed onto you, they may be taken into account in determining your Co-payment and/or Co-insurance.

Who Interprets Benefits and Other Provisions under the Policy?

In accordance with state and federal law, we will do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may assign this authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we have the right, as we determine and without your approval, to change, interpret, withdraw or add Benefits or end the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Policy are effective upon the Group's next anniversary date after a 60-day written notice has been sent to the Group and to the Commissioner, except as otherwise permitted by law.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the Policy and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you, including provider billing and provider payment records. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements you may contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Is Workers' Compensation Affected?

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

How Are Benefits Paid When You Are Medicare Eligible?

Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Subrogation and Reimbursement

We have the right to subrogation and reimbursement. References to "you" or "your" in this *Subrogation and Reimbursement* section shall include you, your Estate and your heirs and beneficiaries unless otherwise stated.

Subrogation

Subrogation applies when we have paid Benefits on your behalf for a Sickness or Injury for which a third party is considered responsible. The right to subrogation means that we are substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits we have paid that are related to the Sickness or Injury for which a third party is considered responsible.

Subrogation Example:

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Policy to treat your injuries. Under subrogation, the Policy has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

Reimbursement

Reimbursement is the payment by you out of the recovery received from any third party to us to be limited to the amount of medical Benefits paid by us. We may request and receive reimbursement of any type of recovery for the reasonable value of any services and Benefits we provided to you subject *to Section 140.005* of the *Civil Practice and Remedies Code*. We may receive reimbursement for the total amount of past Benefits paid, not to exceed the amount you receive from any third party.

Reimbursement Example:

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Policy as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Policy 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- Your employer in a workers' compensation case or other matter alleging liability.

- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators. We may pursue recovery against an underinsured or uninsured motorist for medical payments coverage if the Covered Person or their immediate family did not pay the premiums for the coverage.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Contacting us to obtain our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with us is considered a breach of contract. As such, we have the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to you or your representative not cooperating with us.
- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party.
- Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries.
- We may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages.
- Benefits paid by us may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and we allege some or all of those funds are due and owed to us, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.

- By participating in and accepting Benefits under the Policy, you agree that (i) any amounts recovered by you from any third party shall constitute Policy assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Policy (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by us to enforce its reimbursement rights.
- Our right to recovery will not be reduced due to your own negligence.
- We may take necessary and appropriate action to preserve our rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party. We may also file a lawsuit to enforce the plans right of subrogation or reimbursement.
- You may not accept any settlement that does not fully reimburse us, without our written approval.
- We have the final authority to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death our right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse us is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interest unless we provide written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Policy, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, we may terminate Benefits to you, your dependents or the subscriber, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to your failure to abide by the terms of the Policy. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- We and all Administrators administering the terms and conditions of the Policy's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of our final authority to (1) construe and enforce the terms of the Policy's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to us.

When Do We Receive Refunds of Overpayments?

If we pay Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Policy. If the refund is due from a person or organization other than you, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Policy; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which our overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Is There a Limitation of Action?

Prior to bringing any legal action against us to recover reimbursement we recommend that you complete all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. If you want to bring a legal action against us you must do so after the 61st day written proof of loss is filed or within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Continuity of Care

If you are undergoing a course of treatment from a Network Physician or provider at the time that Network Physician or provider's contract terminates with us, you may be entitled to continue that care at the Network Benefit level. Continuity of care is available in special circumstances in which the treating Physician or health care provider reasonably believes discontinuing care by the treating Physician could cause harm to the Covered Person. Special circumstances include Covered Persons with a disability, acute condition, life-threatening illness, pregnant and undergoing a course of treatment for the pregnancy, undergoing inpatient care, or scheduled to undergo nonelective surgery, including receipt of postoperative care.

The treating Physician or provider must submit the continuity of care request. If continuity of care is approved, it may not be continued beyond 90 days after the Physician or provider's contract is terminated, or nine months after the Physician or provider's contract is terminated, if the Covered Person has been diagnosed as having a terminal illness at the time of termination. If the Covered Person is pregnant at the time of termination, coverage at the Network level will continue through the delivery of the child, immediate postpartum care and the follow-up checkup within the six-week period after delivery.

If you have questions regarding this continuity of care policy or would like help determining whether you are eligible for continuity of care Benefits, please contact us at www.myuhc.com or the telephone number on your ID card.

What Is the Entire Policy?

The Policy, this *Certificate*, the *Schedule of Benefits*, the Group's *Application* and any Riders and/or Amendments, make up the entire Policy that is issued to the Group.

Section 9: Defined Terms

Adverse Determination - a determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not Medically Necessary or appropriate or are Experimental or Investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

Air Ambulance - medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance as defined in *42 CFR 414.605*.

Allowed Amounts - for Covered Health Care Services, incurred while the Policy is in effect, Allowed Amounts are determined by us or determined as required by law as shown in the *Schedule of Benefits*.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law. We develop these guidelines, as we determine, after review of all provider billings generally in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Alternate Facility - a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis and includes a Crisis Stabilization Unit, a Psychiatric Day Treatment Facility, a Mental Health Care Center, and a Residential Treatment Center for Children and Adolescents.

Amendment - any attached written description of added or changed provisions to the Policy. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Ancillary Services - items and services provided by out-of-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by an out-of-Network Physician when no other Network Physician is available.

Annual Deductible - the total of the Allowed Amount or the Recognized Amount when applicable, you must pay for Covered Health Care Services per year before we will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts or the Recognized Amounts when applicable. The

Schedule of Benefits will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Assisted Living Facility - a facility regulated by Chapter 247 of the Health and Safety Code.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Care Services that are available under the Policy.

Breast Tomosynthesis - a radiologic mammography procedure that involves the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which applicable breast cancer screening diagnosis may be determined.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Chemical Dependency - the abuse of, a psychological or physical dependence on, or an addiction to alcohol or a controlled substance. For the purposes of this definition, "controlled substance" means an abusable volatile chemical, as defined by Section 485.001, Health and Safety Code, or a substance designated as a controlled substance under Chapter 481, Health and Safety Code.

Co-insurance - the charge, stated as a percentage of the Allowed Amount or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Care Services.

Complications of Pregnancy - conditions requiring Hospital confinement (when Pregnancy is not terminated) whose diagnoses are distinct from Pregnancy but are adversely affected by Pregnancy or are caused by Pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician prescribed rest during the period of Pregnancy, morning Sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult Pregnancy not constituting a nosologically distinct Complication of Pregnancy; and non-elective cesarean section, termination of ectopic Pregnancy and spontaneous termination of Pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Co-payment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Co-payment.
- The Allowed Amount or the Recognized Amount when applicable.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

Covered Person - the Subscriber or a Dependent, but this term applies only while the person is enrolled under the Policy. We use "you" and "your" in this *Certificate* to refer to a Covered Person.

Crisis Stabilization Unit - a 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structure activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - the Subscriber's legal spouse, including common law spouse, or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section 3: When Coverage Begins*, eligibility for enrollment and qualification as a Dependent is administered by the Group consistent with the eligibility rules noted in the Policy which includes this *Certificate* and the Group *Application.* The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for who the Subscriber is a party in a suit seeking adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the month during which the child reaches age 26 except as provided in *Section 4: When Coverage Ends* under *Coverage for a Disabled Dependent Child.*
- A Dependent includes a grandchild of the Subscriber, who is unmarried, under 26 years of age and is a Dependent of the Subscriber for federal income tax purposes at the time the application for coverage of the grandchild is made

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month during which the child reaches the limiting age.

The Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Dispensing Entity - a pharmacy, provider, or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies, providers, or facilities are Designated Dispensing Entities.

Designated Network Benefits - the description of how Benefits are paid for certain Covered Health Care Services provided by a provider or facility that has been identified as a Designated Provider. The *Schedule of Benefits* will tell you if your plan offers Designated Network Benefits and how they apply.

Designated Provider - a provider and/or facility that we have identified through our UnitedHealth Premium designation program as a Designated Provider. The UnitedHealth Premium program provides Physician designations based on quality and cost efficiency criteria to help you make more informed choices about your medical care.

Not all Network Hospitals or Network Physicians are Designated Providers. You can find out if your provider is a Designated Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

Diagnostic Imaging - an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate:

- A subjective or objective breast abnormality detected by a Physician or patient.
- An abnormality seen by a Physician on a screening mammogram.
- A breast abnormality previously identified by a Physician as probably benign for which follow-up imaging is recommended by a Physician.
- An individual with a personal history of breast cancer or dense breast tissue.

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has a Domestic Partnership.

Domestic Partnership - a relationship between a Subscriber and one other person of the opposite or same sex. All of the following requirements apply to both persons. They must:

- Not be related by blood or a degree of closeness that is prohibited by law in the state of residence.
- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Share the same permanent residence and the common necessities of life.
- Be at least 18 years of age.
- Be mentally able to consent to contract.
- They must be financially interdependent.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.

- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility rules in accordance with the Policy which includes this *Certificate* and the Group *Application.* An Eligible Person must live within the United States.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn fetus) in serious jeopardy;
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.

Emergency Health Care Services - with respect to an Emergency:

- An appropriate medical screening exam (as required under section *1867 of the Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)* that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act,* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3)* of the *Social Security Act (42 U.S.C. 1395dd(e)(3)).*
- Emergency Health Care Services include items and services otherwise covered under the Policy when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:

  a) The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

  b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

  c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

  d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

  e) Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

1. Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
    - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
    - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
    - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
    - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
2. Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
3. The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
4. Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Drugs prescribed to treat a chronic, disabling, or life-threatening illness if the drug is both of the following:
    - Has been approved by the *FDA* for at least one indication.
    - Is recognized for treatment of the indication for which the drug is prescribed in either of the following:
        - A prescription drug reference compendium approved by the *Commissioner of the Texas Department of Insurance*.
        - Substantially accepted peer-reviewed medical literature.
- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
- We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
    - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services;*and
    - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Care Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The Gestational Carrier does not provide the egg and is therefore not biologically related to the child.

Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Iatrogenic Infertility - an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Independent Freestanding Emergency Department - a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and
- Provides Emergency Health Care Services.

Independent Review Organization (IRO) - an organization certified to hear appeals of Adverse Determinations.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Treatment - a structured outpatient treatment program.

- For Mental Health Care Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Care - skilled nursing care that is provided either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

Low-dose Mammography - includes:

- The x-ray exam of the breast using equipment dedication specifically for mammography, including an x-ray tube, filter, compression device, and screens, with an average radiation exposure delivery of less than one rad mid-breast and with two views for each breast.
- Digital mammography.
- Breast Tomosynthesis.

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medically Necessary - health care services that are all of the following as determined by us or our designee:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.

- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Care Center - a tax supported institution of the State of Texas, including community centers for mental health and intellectual disability services.

Mental Health Care Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association.* The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care Services, or to be a Network provider for only some of our products. In this case,

the provider will be a Network provider for the Covered Health Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

Network Transplant Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver transplant and/or cellular and gene therapy services. Network Transplant Providers may or may not be located within your geographic area. If travel is necessary to obtain such Covered Health Care Services from a Network Transplant Provider, you may be eligible for reimbursement of certain travel expenses. A Hospital or Physician that is in the Network for medical services may not be a Network Transplant Provider. To receive Network Benefits for transplantation and cellular gene therapy services, it is important that we, in consultation with your provider, assist you with locating a Network Transplant Provider for care.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates:

- The date as determined by us or our designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented.
- December 31st of the following calendar year.

Non-Clinical Benefit Determination - a determination made by us that proposed or delivered services are or are not covered services according to the terms of the insurance Policy without reference to the medical necessity or appropriateness of the services. A Non-Clinical Benefit Determination that services are not covered is not an Adverse Determination.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Policy. The Group sets the period of time that is the Open Enrollment Period.

Orthotic Device - a custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. The *Schedule of Benefits* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment/High Intensity Outpatient - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Care Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any acupuncturist, advanced practice nurse, audiologist, chemical dependency counselor, dietitian, hearing instrument fitter and dispenser, hospitalist, licensed clinical social worker, licensed professional counselor, marriage and family therapist, occupational therapist, pharmacist, physical therapist, Physician, Physician assistant, psychological associate, speech language pathologies, surgical assistant, podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the

scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Group that includes all of the following:

- *Group Policy*.
- *Certificate*.
- *Schedule of Benefits*.
- Group *Application*.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Group.

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Preimplantation Genetic Testing (PGT) - a test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-M - for monogenic disorder (formerly single-gene PGD).
- PGT-SR - for structural rearrangements (formerly chromosomal PGD).

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Psychiatric Day Treatment Facility - a mental health care facility that provides treatment for individuals suffering from acute mental and nervous disorders in a structured psychiatric program, utilizing individualized treatment plans with specific attainable goals and objectives that are appropriate both to

the patient and to the treatment modality of the program. The facility must be clinically supervised by a *Doctor of Medicine* who is certified in psychiatry by the *American Board of Psychiatry and Neurology*.

Recognized Amount - the amount which Co-payment, Co-insurance and applicable deductible, is based on for the below Covered Health Care Services when provided by out-of-Network providers:

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

1) An *All Payer Model Agreement* if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law, or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by an out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Care Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health care professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, under the active participation and direction of a Physician.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Residential Treatment Center for Children and Adolescents - a child-care institution that is both of the following:

- Provides residential care and treatment for emotionally disturbed children and adolescents
- Accredited as a Residential Treatment center by:
  - *The Council of Accreditation.*
  - *The Joint Commission on Accreditation of Hospitals.*
  - *The American Association of Psychiatric Services for Children.*

Rider - any attached written description of additional Covered Health Care Services not described in this *Certificate*. Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. (Note that Benefits for Outpatient Prescription Drugs, while presented in Rider format, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy.) Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Secretary - as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Serious Mental Illness - the following psychiatric illnesses as defined in the current *Diagnostic and Statistical Manual of the American Psychiatric Association:*

- Schizophrenia.
- Paranoid and other psychotic disorders.
- Bipolar disorders (hypomanic, manic, depressive, and mixed).
- Major depressive disorders (single episode or recurrent).
- Schizo-affective disorders (bipolar or depressive).
- Obsessive-compulsive disorders.
- Depression in childhood and adolescence.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, skilled teaching, skilled habilitation, and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Pharmaceutical Product - Pharmaceutical Products that are generally high cost, biotechnology drugs used to treat patients with certain illnesses.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Group.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person.

Teledentistry Dental Service - a health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

Telehealth Service - a health care service, other than a Telemedicine Medical Service or a Teledentistry Dental Service, delivered by a health care professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health care professional's license, certification, or entitlement to a patient at a different physical location than the health care professional using telecommunications or information technology.

Telemedicine Medical Service - a health care service delivered by a Physician licensed in this state, or a health care professional acting under the delegation and supervision of a Physician licensed in this state, and acting within the scope of the Physician's or health care professional's license to a patient at a different physical location than the Physician or health care professional using telecommunications or information technology.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Living - Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through facilities, group homes and supervised apartments which provide 24-hour supervision, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria,* and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Unproven Service(s) - services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and

inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

Section 10: Consolidated Appropriations Act Summary

The Policy complies with the applicable provisions of the *Consolidated Appropriations Act (the "Act") (P.L. 116-260)*.

No Surprises Act

Balance Billing

Under the Act, the *No Surprises Act* prohibits balance billing by out-of-Network providers in the following instances:

- When Ancillary Services are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians.
- When non-Ancillary Services are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described in the Act.
- When Emergency Health Care Services are provided by an out-of-Network provider.
- When Air Ambulance services are provided by an out-of-Network provider.

In these instances, the out-of-Network provider may not bill you for amounts in excess of your applicable Co-payment, Co-insurance or deductible (cost share). Your cost share will be provided at the same level as if provided by a Network provider and is determined based on the Recognized Amount.

For the purpose of this Summary, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Determination of Our Payment to the Out-of-Network Provider:

When Covered Health Care Services are received from out-of-Network providers for the instances as described above, Allowed Amounts, which are used to determine our payment to out-of-Network providers, are based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement.*
- The reimbursement rate as determined by state law.
- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

Continuity of Care

The Act provides that if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If

you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

Provider Directories

The Act provides that if you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly by us prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing that would be no greater than if the service had been provided from a Network provider.

Notice of Certain Mandatory Benefits

This notice is to advise you of certain coverage and/or Benefits provided by your Policy with UnitedHealthcare Insurance Company.

Please note that the Benefits specified below are subject to all terms, conditions, exclusions and limitations stated in your Policy, including, but not limited to, any applicable deductible, Co-insurance or Co-payment amounts, and prior authorization requirements.

Mastectomy or Lymph Node Dissection

If, due to treatment of breast cancer, any Covered Person under your Policy has either a mastectomy or a lymph node dissection, the Policy will provide coverage for inpatient care for a minimum of:

A. 48 hours following a mastectomy; and

B. 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the individual receiving the treatment and the attending Physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not:

A. Deny any Covered Person's eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours;

B. Provide money payments or rebates to encourage any Covered Person to accept less than the minimum inpatient hours;

C. Reduce or limit the amount paid to the attending Physician, or otherwise penalize the Physician, because the Physician required a Covered Person to receive the minimum inpatient hours; or

D. Provide financial or other incentives to the attending Physician to encourage the Physician to provide care that is less than the minimum hours.

If any person covered by this plan has questions concerning the above, please call UnitedHealthcare Insurance Company at 1-800-357-1371 or write us at 185 Asylum Street, Hartford, CT 06103. You may also visit www.myuhc.com or call the telephone number on your ID card.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Enrollment

Coverage and/or Benefits are provided to each Covered Person for reconstructive surgery after mastectomy, including:

A. All stages of the reconstruction of the breast on which mastectomy has been performed;

B. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and

C. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or Benefits must be provided in a manner determined to be appropriate in consultation with the Covered Person and the attending Physician.

Refer to the Schedule of Benefits for specific deductibles and/or Co-payments applicable to the coverage and/or Benefits, which may not be greater than the deductibles and/or Co-payments applicable to other coverage and/or Benefits under the health benefit plan.

Prohibitions: We may not:

A. Offer the Covered Person a financial incentive to forego breast reconstruction or waive the coverage and/or Benefits shown above;

B. Condition, limit, or deny any Covered Person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or Benefits shown above; or

C. Reduce or limit the amount paid to the Physician or provider, nor otherwise penalize, or provide a financial incentive to induce the Physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or Benefits shown above.

If any person covered by this plan has questions concerning the above, please call UnitedHealthcare Insurance Company at 1-800-357-1371 or write us at 185 Asylum Street, Hartford, CT 06103. You may also visit www.myuhc.com or call the telephone number on your ID card.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Annual

Your Policy, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If any person covered by this plan has questions concerning the above, please call UnitedHealthcare Insurance Company at 1-800-357-1371 or write us at 185 Asylum Street, Hartford, CT 06103. You may also visit www.myuhc.com or call the telephone number on your ID card.

Examinations for Detection of Prostate Cancer

Benefits are provided for each male who is a Covered Person for an annual medically recognized diagnostic examination for the detection of prostate cancer. Covered expenses include:

A. A physical examination for the detection of prostate cancer; and

B. A prostate-specific antigen test for each male Covered Person who is

1. at least 50 years of age; or

2. at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

If any person covered by this plan has questions concerning the above, please call UnitedHealthcare Insurance Company at 1-800-357-1371 or write us at 185 Asylum Street, Hartford, CT 06103. You may also visit www.myuhc.com or call the telephone number on your ID card.

Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth Benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

A. 48 hours following an uncomplicated vaginal delivery, and

B. 96 hours following an uncomplicated delivery by cesarean section.

This Benefit does not require a covered female who is eligible for maternity/childbirth Benefits to give birth in a Hospital or other health care facility or remain in a Hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a Physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Prohibitions: We may not:

A. Modify the terms of this coverage based on any Covered Person requesting less than the minimum coverage required;

B. Offer the mother financial incentives or other compensation for waiver of the minimum number of hours required;

C. Refuse to accept a Physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the Physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians;

D. Reduce payments or reimbursements below the usual and customary rate; or

E. Penalize a Physician for recommending inpatient care for the mother and/or the newborn child.

If any person covered by this plan has questions concerning the above, please call UnitedHealthcare Insurance Company at 1-800-357-1371 or write us at 185 Asylum Street, Hartford, CT 06103. You may also visit www.myuhc.com or call the telephone number on your ID card.

Testing for the detection of Colorectal Cancer

Benefits are provided, for each Covered Person who is 45 years of age or older and at normal risk for developing colon cancer, for a medically recognized screening examination for the detection of colorectal cancer. Covered expenses include:

A. All colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of "A" or "B" by the United States Preventive Services Task Force for average-risk individuals, including the services that may be assigned a grade of "A" or "B" in the future; and

B. An initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

If any person covered by this plan has questions concerning the above, please call UnitedHealthcare Insurance Company at 1-800-357-1371 or write us at 185 Asylum Street, Hartford, CT 06103. You may also visit www.myuhc.com or call the telephone number on your ID card.

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Covered expenses also include:

A. A CA 125 blood test, or any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer; and

B. A conventional pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

If any person covered by this plan has questions concerning the above, please call UnitedHealthcare Insurance Company at 1-800-357-1371 or write us at 185 Asylum Street, Hartford, CT 06103. You may also visit www.myuhc.com or call the telephone number on your ID card.

Disclosure of Provider Status Notice

As required by Chapter 1456 of the Texas Insurance Code, this notice provides information regarding the status of providers.

Some Physicians and providers, including diagnostic imaging and laboratory service providers, at contracted facilities may not be contracted with UnitedHealthcare Insurance Company. Facilities include a Hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center or other facility that provides health care services.

If you receive health care services at a contracted facility and the Physician or provider, or diagnostic imaging and laboratory service provider is not contracted with UnitedHealthcare Insurance Company, you may be responsible for payment of all or part of the fees for those services not paid or covered by your health plan, unless balance billing for those services is prohibited.

Balance billing is the practice of charging the enrollee the amount a health benefit plan does not pay for non-covered or out-of-Network health care services.

Should you have a complaint regarding payments of health care services, you may contact the *Texas Department of Insurance Consumer Protection Division* at 1-800-252-3439 or email ConsumerProtection@tdi.texas.gov.

Preferred Provider Health Benefit Plan Notice

- You have the right to an adequate Network of preferred providers (also known as "Network providers"). If you believe that the Network is inadequate, you may file a complaint with the Texas Department of Insurance.
- You have the right, in most cases, to obtain estimates in advance:
  - from out-of-Network providers of what they will charge for their services; and
  - from your insurer of what it will pay for the services.
- You may obtain a current directory of preferred providers by visiting www.myuhc.com or by calling the number on the back of your ID card for assistance in finding available preferred providers.
- If you are treated by a provider or facility that is not a preferred provider, you may be balance billed for anything not paid by the insurer unless the service or supply is subject to a law prohibiting balance billing.
- If there is an amount billed by the out-of-Network provider and unpaid by the insurer or administrator, after Co-payments, Co-insurances, and deductibles for which an enrollee may not be billed, and the services were for emergency care or out-of-Network laboratory or diagnostic imaging services, you may request mediation. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.
- If directory information is materially inaccurate and you rely on it, you may be entitled to have an out-of-Network claim paid at the Network level of reimbursement and your out-of-pocket expenses counted toward your Network deductible and Out-of-Pocket Limit.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will send you a one-page complaint form that you must return to us for prompt resolution of the complaint.

We will promptly investigate each complaint. Within five business days, we will send a letter acknowledging the date we received your complaint. The total time for acknowledgement, investigation and resolution of the complaint, including the response letter, will not exceed 30 calendar days after we receive the written complaint or one-page complaint form.

Complaints concerning an Emergency or denials of continued hospitalization will be investigated and resolved in accordance with the medical immediacy of the case, and will not exceed one business day from receipt of the complaint.

We will not engage in any retaliatory action against any Covered Person, Physician or provider. We will not retaliate for any reason including, cancellation of coverage or a provider contract, or refusal to renew coverage or a provider contract because the Covered Person, Physician, provider or person acting on behalf of the Covered Person has filed a complaint against the Contract or has appealed a decision.

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require pre-authorization or benefit confirmation prior to receiving medical care.

Pre-Authorization

Pre-authorization, included within the pre-service request, is a request to us for proposed services that will result in one of the following:

- A pre-authorization;
- A confirmation of receipt of your request, when there are no clinical issues; or
- An Adverse Determination.

If you receive an Adverse Determination in response to your request for pre-authorization of services, you may appeal the decision. Please refer to *Procedures for Appealing an Adverse Determination* below.

For procedures associated with urgent requests for pre-authorization of services, see *Urgent Appeals that Require Immediate Action* below.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination, or a rescission of coverage determination, you can contact us orally or in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial. The appeals process will be completed no later than 30 days after the written request is received.

Please note that our decision is based only on whether Benefits are available under the Contract for the proposed treatment or procedure. The decision for you to receive services is between you and your Physician.

Complaint Appeal Procedures

If we do not resolve your complaint to your satisfaction, you have the right to appeal our decision.

We will send an acknowledgment letter to the complainant within five business days after the date we receive the written request for an appeal.

We will appoint members to the complaint appeal panel, which advises us on the resolution of the appeal. The members of the complaint appeal panel cannot have been involved with your complaint in the past. The complaint appeal panel will include an equal number of our staff, Physicians or other providers with experience in the area of care to which your appeal relates, and enrollees.

No later than the fifth business day before the complaint appeal panel meets, we will provide to you or your designated representative with the following:

- Any documentation that will be presented by our staff to the complaint appeal panel.
- The specialization of any Physician or provider consulted during the investigation of your appeal.
- The name and affiliation of each of the members of our complaint appeal panel.

You, or your designated representative if you are a minor or disabled, have the right to:

- Appear in person before the complaint appeal panel at the site at which the Covered Person normally receives health care services, or at another site agreed to by the complainant.
- Address an appeal over the phone or in writing to the complaint appeal panel.
- Present alternative expert testimony.
- Request the presence of, and to question, any person that was involved in making the prior determination that resulted in your appeal.

We will complete the appeals process not later than the 30th calendar day after we receive your written appeal. Our final decision on the appeal will include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

Investigation and resolution of appeals involving ongoing Emergencies or denials of continued hospitalization will be resolved in accordance with the medical immediacy of the case but no later than one business day after your request for appeal. At your request, we will provide, instead of a complaint appeal panel, a review by a Physician or provider who has not previously reviewed the case and who is of the same or similar specialty as ordinarily manages the medical condition, procedure, or treatment under appeal. The Physician or provider reviewing the appeal may interview you or your designated representative and will make a decision on the appeal. Initial notice of the decision on the appeal including a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision may be delivered orally to you but will be followed by a written notice of the determination within three days.

Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through our complaint system process and who are dissatisfied with the resolution, may file a complaint with the *Texas Department of Insurance* at P.O. Box 12030, Austin, Texas 78711-2030. The *Department's* telephone number is 1-800-252-3439.

The *Commissioner of Insurance* will investigate a complaint against us to determine our compliance with insurance laws within 60 days after the *Department* receives your complaint and all information necessary for the *Department* to determine compliance. The *Commissioner* may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

- Additional information is needed.
- An on-site review is necessary.
- We, the Physician or provider, or you do not provide all documentation necessary to complete the investigation.
- Other circumstances beyond the control of the *Department* occur.

Adverse Determinations

An Adverse Determination is a decision that is made by us or our utilization review agent that the health care services furnished or proposed to be furnished to a Covered Person are:

- Not Medically Necessary or appropriate.
- Experimental or Investigational Services.

Adverse Determination does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. An Adverse Determination includes a decision by us not to furnish a prescribed drug that your Physician determines is Medically Necessary. A complete definition of Adverse Determination is contained in *Section 9: Defined Terms.*

Notice of Adverse Determinations

A utilization review agent will provide notice of an Adverse Determination as follows:

- With respect to a patient who is hospitalized at the time of the Adverse Determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the Adverse Determination;
- With respect to a patient who is not hospitalized at the time of the Adverse Determination, within three working days in writing to the provider of record and the patient; or
- Within the time appropriate to the circumstances relating to the delivery of the services to the patient and the patient's condition, provided that when denying post-stabilization care subsequent

to emergency treatment as requested by a treating Physician or other health care provider, notice will be provided to the treating Physician or other health care provider no later than one hour after the time of the request.

A utilization review agent will provide notice of an Adverse Determination for a concurrent review of the provision of the prescription drug or intravenous infusions for which the patient is receiving health benefits under this EOC no later than the 30th day before the date on which the provision of prescription drugs or intravenous infusion will be discontinued.

Procedures for Appealing an Adverse Determination

If you, your designated representative or your provider of record receive an Adverse Determination in response to a claim or a request for pre-authorization of services, you, your designated representative or your provider of record may appeal the Adverse Determination orally or in writing.

If you, your designated representative or your provider of record orally appeal the Adverse Determination, we or our utilization review agent will send you, your designated representative or your provider of record a one-page appeal form.

Upon receipt of your appeal we will, within five working days, send you a letter acknowledging receipt of your appeal and provide you with a description of the Adverse Determination appeal process and a list of documents necessary to process your appeal.

Our review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

We will complete the appeals process no later than the 30th calendar day after we receive your appeal.

If an appeal is upheld, within 10 working days of the appeal denial your treating Physician may request an additional review. A Physician who is of the same or similar specialty as the health care provider who would typically manage the medical condition, procedure, or treatment will conduct the review. The specialty review will be completed within 15 working days from receipt of the request.

Retrospective Review

If the Adverse Determination relates to a retrospective review, you will receive notice no later than 30 days after we receive your claim. We may extend this period for up to an additional 15 days if we determine an extension is necessary due to matters beyond our control. If an extension is needed, you will be notified within 30 days after we receive your claim. If the extension is necessary because we have not received information from you or your provider, we will specifically describe the information needed and allow 45 days for the information to be submitted. We will make a decision within 30 days of the date of the extension notice until the earlier of the date you or your provider respond to the request for additional information or the date the information was to be submitted.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.

- We will notify you of the decision by the end of the next business day (not to exceed 72 hours if a holiday or weekend) following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Expedited Appeals for Denial of Emergency Care, Continued Hospitalization, Prescription Drugs, or Intravenous Infusions

Procedures for written expedited appeals of an Adverse Determination for denials of Emergency Care, continued hospitalization, Prescription Drugs, or intravenous infusions will include a review by a health care provider who:

- Has not previously reviewed the case; and
- Is the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

The time for resolution of an expedited appeal is based on the medical or dental immediacy of the condition, procedure, or treatment under review, provided that the resolution of the appeal may not exceed one working day from the date all information necessary to complete the appeal is received.

The expedited appeal determination may be provided by telephone or electronic transmission, but will be followed with a letter within three working days of the initial telephonic or electronic notification.

Federal External Review Program

You may be entitled to request an external review of our determination after exhausting your internal appeals if either of the following apply:

- You are not satisfied with the determination made by us.
- We fail to respond to your appeal within the timeframe required by the applicable regulations.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations as defined below, by contacting us at the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received our final appeal decision.

An external review request should include all of the following:

- A specific request for an external review.
- Your name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.

- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an *Independent Review Organization (IRO)*. We have entered into agreements with three or more *IRO*s that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review includes all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the *IRO*.
- A decision by the *IRO*.

After receipt of the request, we will complete a preliminary review within the applicable timeframe, to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Contract at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that we may process the request.

After we complete this review, we will issue a notification in writing to you. If the request is eligible for external review, we will assign an *IRO* to conduct such review. We will assign requests by either rotating the assignment of claims among the *IRO*s or by using a random selection process.

The *IRO* will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days after the date you receive the *IRO*'s request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

We will provide to the assigned *IRO* the documents and information considered in making our determination. The documents include:

- All relevant medical records.
- All other documents relied upon by us.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request. We will include it with the documents forwarded to the *IRO*.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by us. The *IRO* will provide written notice of its determination (the *"Final External Review Decision"*) within 45 days after it receives the request for the external review (unless they request additional time and you agree). The *IRO* will deliver the notice of *Final External Review Decision* to you and us, and it will include the clinical basis for the determination.

If we receive a *Final External Review Decision* reversing our determination, we will provide coverage or payment for the Benefit claim at issue according to the terms and conditions of the Contract, and any

applicable law regarding plan remedies. If the *Final External Review Decision* agrees with our determination, we will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter for the expedited external review, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review, separately or at the same time you have filed a request for an expedited internal appeal, if you receive any of the following:

- An adverse benefit determination of a claim or appeal that involves a medical condition for which the time frame for completion of an expedited internal appeal would either jeopardize:
  - The life or health of the individual.
  - The individual's ability to regain maximum function.
- An adverse benefit determination involving the denial of prescription drugs or intravenous infusions for which you are receiving Benefits.

In addition, you must have filed a request for an expedited internal appeal.

- A final appeal decision, that either:
  - Involves a medical condition where the timeframe for completion of a standard external review would either jeopardize the life or health of the individual or jeopardize the individual's ability to regain maximum function.
  - Concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency care services, but has not been discharged from a facility.

Immediately upon receipt of the request, we will determine whether the individual meets both of the following:

- Is or was covered under the Contract at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that we may process the request.

After we complete the review, we will send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, we will assign an *IRO* in the same manner we utilize to assign standard external reviews to *IRO*s. We will provide all required documents and information we used in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available method in a timely manner. The *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the *IRO* will review the claim as new and not be bound by any decisions or conclusions reached by us. The *IRO* will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the *IRO* receives the request. If the *IRO*'s final external review decision is first communicated verbally, the *IRO* will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

You may call us at the telephone number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents that are provided under *Pharmaceutical Products - Outpatient* in your *Certificate of Coverage*, regardless of tier placement.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore, your Co-payment and/or Co-insurance may change or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, your Co-payment and/or Co-insurance may change or you will no longer have Benefits for that particular reference product. Such determinations will occur no more often than annually on the Policy anniversary date.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at www.myuhc.com or the telephone number on your ID card.

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior

authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Out-of-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at an out-of-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject to our review and change. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at www.myuhc.com or the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at an out-of-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Co-payment and/or Co-insurance and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

For certain Prescription Drugs Products prescribed to treat an autoimmune disease, hemophilia, or Von Willebrand disease, you are only required to obtain pre-authorization one time annually.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card. When a step therapy requirement applies to a Prescription Drug Product your provider may request an exception.

- For non-urgent step therapy exception requests, a review will be completed within 72 hours once all information needed to process the request has been received. If the exception request is not denied within 72 hours, then the request will be considered granted.
- For urgent step therapy exception requests, a review will be completed within 24 hours once all the information needed to process the request has been received. If the exception request is not denied within 24 hours, then the request will be considered granted.

If your step therapy exception request is denied, the denial may be subject to an expedited appeal. Please refer to *Section 6: Questions, Complaints and Appeals* of your *Certificate* for additional information on appealing an Adverse Determination

In the case of *FDA*-approved drugs for the treatment of stage 4 advanced, metastatic cancer, Benefits will not be subject to step therapy requirements if the use of the drug is consistent with best practices for the treatment and is supported by peer-reviewed medical literature.

If you are 18 years of age or older, you will not be required to fail to successfully respond to, or prove a history of failure of, more than one different drug for each drug prescribed to treat a serious mental illness, excluding the generic or pharmaceutical equivalent of the prescribed drug. We may require a trial of a generic or pharmaceutical equivalent of the prescribed drug as a condition of continued coverage once a year if the generic or pharmaceutical equivalent drug is added to the Prescription Drug List.

What Do You Pay?

You are responsible for paying the applicable Co-payment and/or Co-insurance described in the Benefit Information table. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Zero Cost Share Medications.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Limit stated in your *Certificate*:

- The difference between the Out-of-Network Reimbursement Rate and an out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate. ***Co-payment and Co-insurance*** Your Co-payment and/or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Co-payment and/or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. Your Co-payment and/or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting us at www.myuhc.com or the telephone	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment and/or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Preventive Medications. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Zero Cost Share Medications.

number on your ID card. Your Co-payment and/or Co-insurance for insulin will not exceed the amount allowed by applicable law. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card. **Co-payment/Co-insurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment and/or Co-insurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist:** You may receive a reduced or increased Co-payment and/or Co-insurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. **NOTE:** We may periodically change the placement of a Prescription Drug Product among the tiers or remove a Prescription Drug Product from our Prescription Drug List, based on the Prescription Drug List (PDL) Management Committee's periodic review and decisions. These changes will occur no more often than annually on the Policy anniversary date. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com or the	

telephone number on your ID card for the most up-to-date tier status.	

Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? **This May Include a Co-payment, Co-insurance or Both**
Specialty Prescription Drug Products	
The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier placement. ***Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $15 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $100 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay $300 per Prescription Order or Refill. ***Out-of-Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $15 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $100 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $300 per Prescription Order or Refill.
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
adjusted based on the drug manufacturer's packaging size, or based on supply limits. This includes contraceptive devices and outpatient contraceptive services other than oral contraceptives, which are described below. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied. • A 12-month supply of a contraceptive drug. You must fill the initial prescription for a three-month supply of the prescribed contraceptive drug. For the same contraceptive drug, future fills may be filled up to a 12-month supply at one time. You may obtain only one 12-month supply of a covered prescription contraceptive drug during each 12-month period. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered. For insulin Prescription Drug Products on any tier, the total amount of Co-payments and/or Co-insurance you pay will not exceed $25 for an individual prescription up to a 30-day supply and are not subject to the deductible. At least one insulin Prescription Drug Product from each therapeutic class is	telephone number on your ID card to find out tier status. For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $15 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay $45 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $85 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
available.	
Prescription Drugs from a Retail Out-of-Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. This includes contraceptive devices and outpatient contraceptive services other than oral contraceptives, which are described below. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied. • A 12-month supply of a contraceptive drug. You must fill the initial prescription for a three-month supply of the prescribed contraceptive drug. For the same contraceptive drug, future fills may be filled up to a 12-month supply at one time. You may obtain only one 12-month supply of a covered prescription contraceptive drug during each 12-month period. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For a Tier 1 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $15 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $45 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Out-of-Network Reimbursement Rate after you pay $85 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
delivered. For insulin Prescription Drug Products on any tier, the total amount of Co-payments and/or Co-insurance you pay will not exceed $25 for an individual prescription up to a 30-day supply and are not subject to the deductible. At least one insulin Prescription Drug Product from each therapeutic class is available.	
Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products, including Specialty Prescription Drug Products on the List of Preventive Medications. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products*. • A 12-month supply of a contraceptive drug. You must fill the initial prescription for a three-month supply of the prescribed contraceptive drug. For the same contraceptive drug, future fills may be filled up to a 12-month supply at one time. You may	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For up to a 90-day supply at a mail order Network Pharmacy or a Preferred 90 Day Retail Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: None of the Prescription Drug Charge after you pay $37.50 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay $112.50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay $212.50 per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
obtain only one 12-month supply of a covered prescription contraceptive drug during each 12-month period. You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment and/or Co-insurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills. For insulin Prescription Drug Products on any tier, the total amount of Co-payments and/or Co-insurance you pay will not exceed $25 for an individual prescription up to a 30-day supply and are not subject to the deductible. At least one insulin Prescription Drug Product from each therapeutic class is available.	

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

NOTE: The Coordination of Benefits provision in the Certificate in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in the *Certificate*.

UnitedHealthcare Insurance Company

Jessica Paik, President

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee makes tier placement changes on our behalf. The PDL Management Committee places FDA-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others; therefore, a Prescription Drug Product may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat, or according to whether it was prescribed by a Specialist.

We may periodically change the placement of a Prescription Drug Product among the tiers or remove a Prescription Drug Product from our Prescription Drug List. These changes will occur no more often than annually on the Policy anniversary date. We will provide a 60-day written notice prior to the effective date of any change. To determine whether a specific drug is included under the drug formulary, please contact us at www.myuhc.com or the telephone number on your ID card.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier placement.

Continuation of Prescription Drug Coverage

We will continue to provide Network Benefits for any Prescription Drug Product that has been approved or covered under the Policy for a medical condition or Mental Illness, regardless of whether the drug has been removed from the Prescription Drug List before the Policy renewal date. Your Physician or other health care provider with authorization to prescribe a drug may prescribe an alternative drug if the Prescription Drug Product is covered under the Policy and if it is medically appropriate.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and/or Co-insurance, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 650629

Dallas, TX 75265-0629

Specialty Pharmacy Program

If you require certain Specialty Prescription Drug Products, we may direct you to pharmacies with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to such pharmacies and you choose not to obtain your Specialty Prescription Drug Product from one of those pharmacies, you will be subject to the out-of-Network Benefit for that Specialty Prescription Drug Product.

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Co-payment or Co-insurance. You will receive a 15-day supply of their Specialty Prescription Drug Product to find out if you will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact you each time prior to dispensing the 15-day supply to confirm if you are tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, by contacting us at www.myuhc.com or the telephone number on your ID card.

When Do We Limit Selection of Pharmacies?

To support optimal therapy for the management of members with pain and minimize the occurrence of drug abuse, diversion, and inappropriate use of opioids, if we determine that you may be using opioid containing Prescription Drug Products and meet the following criteria, we may require you to choose one Network Pharmacy that will provide and coordinate all your future opioid prescription services.

If you meet the following criteria each calendar quarter for two consecutive quarters, you may be required to choose a Network Pharmacy:

- At least nine pharmacy claims for any opioid-containing products; AND
- Opioid pharmacy claims from at least three different prescribers; AND
- Opioid pharmacy claims from at least three different pharmacies.

Benefits will be paid for opioid-containing Prescription Drug Products only if you obtain these drugs at your chosen Network Pharmacy. If you don't make a choice within 31 days of the date we notify you, we will choose a Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting any applicable deductible. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Co-payment and/or Co-insurance.

We, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

We will apply any cost-sharing amounts paid by you or on your behalf for covered Prescription Drug Products toward your Co-payment, Co-insurance, deductible, or Out-of-Pocket Limit.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Refill Synchronization

We have a procedure to align the refill dates of Prescription Drug Products so drugs that are refilled at the same frequency may be refilled concurrently.

On the initial synchronization, a pro-rated cost-share amount will be charged for a partial supply based on the number of days' supply of the drug actually dispensed if the following requirements are met:

- The pharmacy or prescribing Physician or health care provider notifies us that the quantity dispensed is to synchronize the dates that the pharmacy dispenses the prescription drugs.
- Is in the best interest of the Covered Person.
- The Covered Person agrees to the synchronization.

You may obtain additional information on these procedures by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit by contacting us at www.myuhc.com or the telephone number on your ID card.

Outpatient Prescription Drug Rider Table of Contents

Section 1: Benefits for Prescription Drug Products 17
Section 2: Exclusions 19
Section 3: Defined Terms 22
Section 5: Your Right to Request an Exception for Contraceptives ...25

Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Co-payments and/or Co-insurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

Insulin and Insulin-Related Equipment or Supplies

Coverage is provided for Emergency refills of insulin and insulin-related equipment or supplies, in accordance with Texas law, in the same manner as for nonemergency refills of insulin and insulin related equipment or supplies. Your Co-payment and/or Co-insurance for insulin will not exceed the amount allowed by applicable law.

Prescription Eye Drops

Refills of prescription eye drops are covered if the Covered Person pays at the pharmacy the maximum amount allowed. The original prescription must state that additional quantities of the eye drops are needed, the refill may not exceed the total quantity of dosage units authorized by the prescribing provider on the original prescription, including refills.

Refills may be dispensed on or before the last day of the prescribed dosage period:

- Not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops is dispensed.
- Not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed.
- Not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the out-of-Network Benefit for that Specialty Prescription Drug Product.

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail Network Pharmacy supply limits apply.

Prescription Drugs from a Retail Out-of-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail out-of-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed. You can file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim.* We will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail out-of-Network Pharmacy supply limits apply.

Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply.

Please contact us at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* also apply to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact us at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion will apply to any off-label drug that is excluded from coverage under this Rider as well as any drug that the *U.S. Food and Drug Administration (FDA)* has determined to be contraindicated for the treatment of the disease or condition. This exclusion will not apply to drugs prescribed to treat a chronic, disabling, or life-threatening disease or condition if the drug:
   - Has been approved by the *FDA* for at least one indication
   - Is recognized for treatment of the indication for which the drug is prescribed in either of the following:
     - A prescription drug reference compendium approved by the *Commissioner* of the *Texas Department of Insurance*.
     - Substantially accepted peer-reviewed medical literature.
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
7. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. Any product dispensed for the purpose of appetite suppression or weight loss.
9. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This includes all forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
10. Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.

- Vitamins with fluoride.
- Single entity vitamins.

12. Certain unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic or convenience purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the *Certificate*.
17. Certain Prescription Drug Products for tobacco cessation.
18. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 3.)
19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations will occur no more often than annually on the Policy anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter items for which Benefits are available as described in the *Certificate* under *Diabetes Services* in *Section 1: Covered Health Care Services*. This exclusion does not apply to over-the-counter drugs used for tobacco cessation.
20. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
21. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
22. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury. This exclusion does not apply to:
    - Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in *Section 1: Covered Health Care Services* of the *Certificate*.
    - Amino acid-based elemental formulas, as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services* of the *Certificate*.
    - Formulas for phenylketonuria (PKU) or other heritable diseases.
    - Enteral formulas and other modified food products.
23. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations will occur no more

often than annually on the Policy anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

24. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations will occur no more often than annually on the Policy anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
25. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations will occur no more often than annually on the Policy anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
26. Certain Prescription Drug Products that have not been prescribed by a Specialist.
27. A Prescription Drug Product that contains marijuana, including medical marijuana.
28. Dental products, including but not limited to prescription fluoride topicals.
29. A Prescription Drug Product with either:
    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

    For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:
    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

    Such determinations will occur no more often than annually on the Policy anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
30. Diagnostic kits and products, including associated services.
31. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
32. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Section 3: Defined Terms

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician will be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a Generic by us.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

List of Zero Cost Share Medications - a list that identifies certain Prescription Drug Products on the Prescription Drug List that are available at zero cost share (no cost to you) when obtained from a retail Network Pharmacy. Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available at a mail order Network Pharmacy. You may find the List of Zero Cost Share Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Out-of-Network Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Certain immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting us at www.myuhc.com or the telephone number on your ID card.

Preferred 90 Day Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network for Maintenance Medication.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our review and change. These changes will occur no more often than annually on the Policy anniversary date. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for placing Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is generally appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;

- lancets and lancet devices; and
- glucose meters, including continuous glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for fertility preservation and Preimplantation Genetic Testing (PGT) for which Benefits are described in the *Certificate* under *Fertility Preservation for Iatrogenic Infertility* and *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services.* Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com or the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

Section 5: Your Right to Request an Exception for Contraceptives

In accordance with PPACA requirements, an exception process may apply to certain Prescription Drug Products prescribed for contraception if your Physician determines that a Prescription Drug Product alternative to a PPACA Zero Cost Share Preventive Care Medication is Medically Necessary for you.

An expedited medication exception request may be available if the time needed to complete a standard exception request could significantly increase the risk to your health or ability to regain maximum function.

If a request for an exception is approved by us, Benefits provided for the Prescription Drug Product will be treated the same as a PPACA Zero Cost Share Preventive Care Medication.

For more information please visit www.uhcprovider.com under the following path: *Resources_Drug Lists and Pharmacy_Additional Resources_Patient Protection and Affordable Care Act $0 Cost-Share Preventive Medications Exemption Requests (Commercial Members)*.

One Pass Select Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Group and provides a description of the One Pass Select program.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to Covered Persons age 18 and older.

One Pass Select

One Pass Select provides a discounted fitness membership that is available for purchase. One Pass Select allows you to select a network of fitness facilities based on price, fitness-facility type, and location preferences. The four tiers listed below offer you the ability to utilize multiple locations at no additional cost per month.

Membership choices include:

Membership Tiers	Costs	Descriptions
Classic	$29/month	10,000 fitness facilities.
Standard	$64/month	12,000 fitness facilities.
Premium	$99/month	14,000 fitness facilities.
Elite	$144/month	15,000 fitness facilities.

When Does the One Pass Select Program End?

The program may end in any of the following ways:

- We may end the program effective on the next renewal date by giving the Group written notice of such termination no later than 90 days prior to the renewal date.
- In the event the Policy ends, the program shall end on the same date that the Policy ends.

You may access the One Pass Select program through www.myuhc.com or our mobile UnitedHealthcare app.

UnitedHealthcare Insurance Company

Jessica Paik, President

Real Appeal Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Real Appeal

Real Appeal provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Care Services will be individualized and may include the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Care Services, you may contact us through www.realappeal.com, https://member.realappeal.com or at the number shown on your ID card.

UnitedHealthcare Insurance Company

Jessica Paik, President

UnitedHealthcare Rewards Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Group and provides a description of the UnitedHealthcare Rewards program.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to the Subscriber or their Enrolled Dependent spouse.

UnitedHealthcare Rewards Program

The Group has implemented a program that rewards you for completing certain criteria, as described below. You may choose to complete any, or all, of the below criteria to earn a reward.

If you are unable to meet a standard related to a health factor for a reward under the program, then you might qualify for an opportunity to earn the same reward by different means. You can call us at the telephone number listed on your ID card, and we will work with you (and, if necessary, with your Physician) to find another way for you to earn the same reward.

You may receive one or more of the following:

- An activation credit that may be applied towards a device or deposited in your or distributed in other incentive types as applicable, administered by us.
- A device credit.
- Another type of incentive to help encourage you to participate in the program, administered as determined by us.

Activity Targets

You may also receive a reward when you meet one or more of the activity targets listed below, based on the device you choose to track activity.

Activity Marker	Activity Target	Reward
Participation - Fitness	15 minutes of activity as designated by the program or 5,000 steps per day	You can earn rewards for one or multiple activity markers.
Active - Fitness	30 minutes or more of activity as designated by the program or 10,000 or more steps per day	
Other Actions and/or Activities	One or more actions and/or activities defined by us and aimed at the following: • Health education; • Improving health; • Maintaining health; or • Administrative objectives	

You may access your actions and/or activity tracking and rewards on the mobile application or www.myuhc.com.

If you have not achieved any of the above daily activity targets, you may be eligible to earn a reward for synchronizing or otherwise providing your daily actions and/or activities as defined by the program. This reward may not be provided if any of the activity targets are met.

The maximum reward will not exceed 30% of the cost of coverage for all programs combined, as applicable.

Rewards

Rewards listed above, when earned, will be credited to a or distributed in other reward types as applicable, administered by us.

Device

A device, which includes an application, approved by us is used to track actions and/or activities towards earning a reward. If you choose to use a non-compatible device, you may be eligible to earn a reward; however, the reward may be limited.

UnitedHealthcare Insurance Company

Jessica Paik, President

Virtual Behavioral Health Therapy and Coaching Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for specialized virtual behavioral health care provided by AbleTo, Inc. for Covered Persons with certain co-occurring behavioral and medical conditions.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms.*

AbleTo provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

Except for Covered Persons with a high deductible health plan (HDHP) compatible with a Health Savings Account (HSA), there are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Except for the initial consultation, Covered Persons with an HSA-compatible high deductible health plan (HDHP) must meet their Annual Deductible before they are able to receive Benefits for these services. There are no deductibles, Co-payments or Co-insurance for the initial consultation.

If you would like information regarding these services, you may call us at the telephone number on your ID card.

UnitedHealthcare Insurance Company

Jessica Paik, President

Language Assistance Services

We[1] provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card, TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-866-633-2446 hodíilnih.

I

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

ΠΡΟΣΟΧΗ : Αν μιλάτε **Ελληνικά (Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας.
Παρακαλείστε να καλέσετε 1-866-633-2446.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે.
કૃપા કરી 1-866-633-2446 પર કોલ કરો.

Notice of Non-Discrimination

We[1] do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

[1]For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Care Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Co-payments, Co-insurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact your issuer.

Notice of Transition of Care

As required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260),* group health plans must provide Benefits for transition of care. If you are currently undergoing a course of treatment with a Physician or health care facility that is out-of-Network under this new plan, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 30 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement according to the applicable claim filing procedures. If you pay a Co-payment and believe that the amount of the Co-payment was incorrect, you also may submit a claim for reimbursement according to the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one-time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits according to the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information.
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally call us at the telephone number on your ID card before requesting a formal appeal. If the representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a representative. If you first informally contact us and later wish to request a formal appeal in writing, you should again contact us and request an appeal. If you request a formal appeal, a representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact us immediately.

How Do You Appeal a Claim Decision?

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of pre-service request for benefits or a claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 15 days.

  If your state requires a second level appeal, it must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- For appeals of post-service claims as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. However, if your state requires two levels of appeal, the first level appeal will take place and your will be notified of the decision within 30 days.

  If your state requires a second level appeal, it must be submitted to us within 60 days from the receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies, or surgeries.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2024:

We[2] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health care condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as www.myuhc.com. We have the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Collect, Use, and Disclose Information

We collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice.
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

We have the right to collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation (when permitted by applicable law) or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may collect, use, and disclose health information to aid in your treatment or the coordination of your care. For example, we may collect information from, or disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may collect, use, and disclose health information needed to operate and manage our business activities related to providing and managing your health care

coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.

- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may collect, use, and disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You.** We may communicate, electronically or via telephone, these treatment, payment or health care operation messages using telephone numbers or email addresses you provide to us.

We may collect, use, and disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved with Your Care.** We may collect, use, and disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

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- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the review of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as needed to carry out their duties.
- **For Organ Procurement Purposes.** We may collect, use, and disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if needed (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is needed for such functions or services. Our business associates are required, under contract with us, and according to federal law, to protect the privacy of your information and are not allowed to collect, use, and disclose any information other than as shown in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

  1. Alcohol and Substance Abuse
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases
  5. Genetic Information
  6. HIV/AIDS
  7. Mental Health
  8. Minors' Information
  9. Prescriptions
  10. Reproductive Health
  11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as stated in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited

circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, call the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests in accordance with applicable state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to change or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and get a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or according to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may get a copy of this notice on your health plan website, such as www.myuhc.com.
- **You have the right to make a written request that we correct or amend** your personal information. Depending on your state of domicile, you may have the right to request the deletion of

your personal information. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your health plan ID card or you may call us at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

  UnitedHealthcare

  Customer Service - Privacy Unit

  PO Box 740815

  Atlanta, GA 30374-0815

- **Timing.** We will respond to your telephonic or written request within 30 business days of receipt.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

[2]This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Enterprise Life Insurance Company; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; March Vision Care, Inc.; MCNA Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Foundation Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Sierra Health and Life Insurance Company, Inc. (DBA UnitedHealthcare Insurance Company USA applicable to Arkansas and Maryland only); Solstice Benefits, Inc.; Solstice Health Insurance Company; Solstice Healthplans of Arizona, Inc.; Solstice Healthplans of Colorado, Inc.; Solstice Healthplans of New Jersey Inc.; Solstice Healthplans of Ohio, Inc.; Solstice Healthplans of Texas, Inc.; Solstice Healthplans, Inc.; Solstice of Illinois, Inc.; Solstice of New York, Inc.; U.S. Behavioral Health Plan, California; UHC of California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Freedom Insurance Company; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America;

UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Integrated Services, Inc UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthcare of the Rockies, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2024

We[3] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or call us at 1-866-633-2446 or TTY 711.

[3]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Health Services, Inc.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency;

Healthplex of CT, Inc.; Healthplex of ME, Inc.; Healthplex of NC, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; LifePrint Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited: OptumHealth Care Solutions, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Arizona, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators of Texas, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; U.S. Behavioral Health Plan, California; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

UnitedHealthcare Insurance Company

Group Policy

For

City of Manor

Enrolling Group Number: 935966

Policy Effective Date: September 1, 2024

Group Policy

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

877-294-1429

This Policy is entered into by UnitedHealthcare Insurance Company and the "Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" refer to UnitedHealthcare Insurance Company.

Upon our receipt of the signed Group *Application* and payment of the first Policy Charge, this Policy is executed. The Group's *Application* is made a part of this Policy.

We agree to provide Benefits for Covered Health Care Services stated in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Policy. This Policy replaces and overrules any previous agreements relating to Benefits for Covered Health Care Services between the Group and us. The terms and conditions of this Policy will in turn be overruled by those of any future agreements relating to Benefits for Covered Health Care Services between the Group and us.

We are not an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Group's benefit plan.

This Policy is effective on the date shown in Exhibit 1 and continues in force by the timely payment of the required Policy Charges when due, subject to the end of this Policy as provided in Article 5.

When this Policy ends, as described in Article 5, this Policy and all Benefits under this Policy will end at 12:00 midnight on the date the Policy ends.

This Policy is issued as described in Exhibit 1.

Issued By:

UnitedHealthcare Insurance Company

Jessica Paik, President

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAWS AS IT

PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings as those defined in *Section 9: Defined Terms* in the attached *Certificate(s) of Coverage*. In addition, the following terms apply:

Coverage Classification - one of the categories of coverage described in Exhibit 2 for rating purposes (for example: Subscriber only, Subscriber and spouse, Subscriber and children, Subscriber and family).

Material Misrepresentation - any written statement, communication or conduct, or combination of written statement, communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

Article 2: Benefits

Subscribers and their Enrolled Dependents are entitled to Benefits for Covered Health Care Services subject to the terms, conditions, limitations and exclusions stated in the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* attached to this Policy. Each *Certificate of Coverage* and *Schedule of Benefits*, including any Riders and Amendments, describes the Covered Health Care Services, required Co-payments, and the terms, conditions, limitations and exclusions related to coverage.

Article 3: Premium Rates and Policy Charge

3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Persons are shown in the *Schedule of Premium Rates* in Exhibit 2 of this Policy or in any attached *Notice of Change*.

We have the right to change the *Schedule of Premium Rates* as described in Exhibit 1 of this Policy. We also have the right to change the *Schedule of Premium Rates* at any time if the *Schedule of Premium Rates* was based upon a Material Misrepresentation relating to health status that resulted in the Premium rates being lower than they would have been if the Material Misrepresentation had not been made. We have the right to change the *Schedule of Premium Rates* for this reason retroactive to the effective date of the *Schedule of Premium Rates* that was based on the Material Misrepresentation.

3.2 How Is the Policy Charge Calculated?

The Policy Charge will be calculated based on the number of Subscribers in each Coverage Classification that we show in our records at the time of calculation. The Policy Charge will be calculated using the Premium rates in effect at that time. Exhibit 1 describes the way in which the Policy Charge is calculated.

The Group is solely responsible for enrollment and Coverage Classification changes (including the end of a Covered Person's coverage) and for the timely payment of the Policy Charges.

3.3 When Is the Policy Charge Adjusted?

We may make retroactive adjustments for any additions or terminations of Subscribers or changes in Coverage Classification that are not reflected in our records at the time we calculate the Policy Charge. We will not grant retroactive credit for any change happening more than 60 days prior to the date we received notification of the change from the Group. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Benefits.

The Group must notify us in writing, through our electronic systems, or by other methods as determined by us within 60 days of the effective date of enrollments, terminations, or other changes. The Group must notify us in writing, through our electronic systems, or by other methods as determined by us each month of any change in the Coverage Classification for any Subscriber.

If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges will be added to the Premium at that time. In addition, any change in law or regulation that affects our cost of operation may result in an increase in Premium in an amount we determine.

3.4 How Is the Policy Charge Paid?

The Policy Charge is payable to us in advance by the Group as described under "Payment of the Policy Charge" in Exhibit 1. The Group agrees to remit to us the Policy Charge due which is based on our enrollment records as provided by the Group at the time the invoice for the Policy Charge is issued. The first Policy Charge is due and payable on or before the effective date of this Policy. Future Policy Charges are due and payable no later than the first day of each payment period shown in item 6 of Exhibit 1, while this Policy is in force. If the Policy Charge remains unpaid, the Policy will end as described below under *5.1 When Does the Policy End?*

All payments shall be made in United States currency, in immediately available funds, and shall be sent to us at the address on the invoice, or at another address that we may designate in writing. The Group agrees not to send us payments marked "paid in full", "without recourse", or similar language. In the event that the Group sends such a payment, we may accept it without losing any of our rights under this Policy and the Group will remain obligated to pay any and all amounts owed to us.

Late payment charges are assessed for any Policy Charge not received within 10 calendar days following the due date. There will be a service charge added to the Group's account for any check returned for non-sufficient funds.

The Group will reimburse any attorney's fees and costs related to collecting past due Policy Charges.

3.5 Does a Grace Period Apply?

A grace period of 31 days will be granted for the payment of any Policy Charge not paid when due. During the grace period, this Policy will continue in force. The grace period will not extend beyond the date this Policy ends.

The Group is responsible for payment of the Policy Charge during the grace period. If we receive written notice from the Group to end this Policy during the grace period, we will adjust the Policy Charge so that it applies only to the number of days this Policy was in force during the grace period.

This Policy ends as described in Article 5.1 if the grace period expires and the past due Policy Charge remains unpaid.

Article 4: Eligibility and Enrollment

4.1 What Are the Eligibility Rules?

The eligibility rules are the requirements the Group must use to determine who is eligible for coverage under the Policy. The eligibility rules must be applied consistently and can be found in this Policy, Group *Application*, and within the *Certificate of Coverage*.

4.2 Initial Enrollment Period

Eligible Persons and their Dependents may enroll for coverage under this Policy during the Initial Enrollment Period. The Initial Enrollment Period, at least 31 days in duration, is set by the Group.

4.3 Open Enrollment Period

An Open Enrollment Period will be provided for each class, as shown in Exhibit 2. During an Open Enrollment Period, Eligible Persons may enroll for coverage under this Policy.

4.4 Effective Date of Coverage

The effective date of coverage for enrolled Eligible Persons and their Dependents is stated in Exhibit 2.

Article 5: End of Policy

5.1 When Does the Policy End?

This Policy and all Benefits for Covered Health Care Services will automatically end on the earliest of the dates shown below:

A. At our option, retroactive to the last paid date of coverage if the grace period expires and the Policy Charge remains unpaid on the due date.

B. On the date specified by the Group, after at least 31 days prior written notice to us that this Policy will end.

C. On the first anniversary of the effective date following the end of a six-month consecutive period during which the minimum participation requirement as shown in Exhibit 1.

D. On the first day of the next calendar month following the end of the six-month consecutive period during which the Group had less than two eligible employees enrolled for coverage under this Policy.

E. On the date we specify, after at least 31 days prior written notice to the Group, that this Policy will end due to the Group's violation of the participation rule as shown in Exhibit 1.

F. On the date we specify, after at least 31 days prior written notice to the Group, that this Policy will end because the Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:

- The effective date of this Policy.
- The date of the act, practice or omission, if later.

After the Policy has been in force for two years, rescission may be made only in the case of fraud.

G. On the date we specify, after at least 90 days prior written notice to the Group, that this Policy will end because we will no longer issue this particular type of group health benefit plan within the applicable market. We will offer to the Group the option to purchase any other plans that we have available at the time of discontinuation.

H. On the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Group, that this Policy will end because we will no longer issue any employer health benefit plan within the applicable market.

5.2 Payment When the Policy Ends

When the Policy ends, the Group is and will remain responsible to us for the payment of any and all Premiums which are unpaid at the time the Policy ends. This will include a pro rata portion of the Policy Charge for any period this Policy was in force during any grace period preceding the end of the Policy.

For Texas residents, the Group is responsible for payment of Premium through the last day of the month in which we are notified that a Covered Person's coverage is terminated. This payment requirement applies unless the Group verifies that the Covered Person has obtained coverage under another policy or plan prior to the end of the month in which we are notified, in which case the Group is responsible for payment of Premium only until the date the Covered Person is covered under the other policy or plan.

Article 6: General Provisions

6.1 What Is the Entire Policy?

This Policy, the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, the Group *Application*, and any Amendments, *Notices of Change*, and Riders, make up the entire Policy.

6.2 Dispute Resolution

No legal proceeding or action may be brought before the 61st day or after three years of the date written proof of loss is filed. In the event the dispute is not resolved within 61 days after one party has received written notice of the dispute from the other party, and either party wishes to pursue the dispute further, either party may pursue legal remedies allowed by law. The parties may elect to pursue arbitration as described below.

The parties acknowledge that because this Policy affects interstate commerce, the *Texas Civil Practice and Remedies Code Chapter 171* applies. If the Group wishes to seek further review of the dispute, it may submit the dispute to binding arbitration according to the rules of the *Texas Civil Practice and Remedies Code Chapter 171 and/or the American Arbitration Association*.

Arbitration will take place in the county where the Covered Person resides, and both parties must agree to binding arbitration post-dispute.

The matter must be submitted to binding arbitration within one year of the date notice of the dispute was received. The arbitrators will have no power to award any punitive or exemplary damages or to vary or ignore the provisions of this Policy, and will be bound by controlling law. The parties acknowledge that each party has the right to request judicial review of an arbitration award in a court of competent jurisdiction, in accordance with the *Texas Civil Practice and Remedies Code Chapter 171*.

6.3 Time Limit on Certain Defenses

No statement made by the Group, except a fraudulent statement, can be used to void this Policy after it has been in force for a period of two years.

6.4 Amendments and Alterations

Amendments and Riders to this Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law. Other than changes to Exhibit 2 stated in a *Notice of Change* to Exhibit 2, no change will be made to this Policy unless made by an Amendment or a Rider which is signed by one of our authorized executive officers, consistent with applicable notice requirements, and accepted in writing by the Group. No agent has authority to change this Policy or to waive any of its provisions.

6.5 Our Relationship with Providers and Groups

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.

The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided. The relationship between any Group and any Covered Person is that of employer and employee, Dependent, or any other category of Covered Person described in the Coverage Classifications shown in this Policy.

The Group is solely responsible for enrollment and Coverage Classification changes (including the end of a Covered Person's coverage) and for the timely payment of the Policy Charges.

6.6 Records

We may require information related to the Policy, from the Group. Upon request, the Group must provide us with the requested information and proofs which may include:

- All documents provided to the Group by an individual in connection with coverage.
- The Group's payroll.
- Any other records pertinent to the coverage under this Policy.

By accepting Benefits under this Policy, each Covered Person authorizes and directs any person or institution that has provided services to him or her, to provide us or our designees any and all information and records or copies of records relating to the health care services provided to the Covered Person. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are needed to administer the terms of this Policy including records for appropriate medical and quality review or as required by law or regulation.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy for research and analytic purposes.

6.7 Administrative Services

The services needed to administer this Policy and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee. If the Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Group must pay for such services or reports at the then current charges for such services or reports.

6.8 Employee Retirement Income Security Act (ERISA)

When this Policy is purchased by the Group to provide benefits under a health and welfare plan governed by the federal *Employee Retirement Income Security Act 29* U.S.C., 1001 et seq., we will not be named as, and will not be, the plan administrator or the named fiduciary of the health and welfare plan, as those terms are used in ERISA.

6.9 Do We Require Examination of Covered Persons?

In the event of a question or dispute concerning Benefits for Covered Health Care Services, we may require that a Network Physician, of our choice examine the Covered Person at our expense.

6.10 What Happens When There Is a Clerical Error?

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments is not a clerical error. We will not provide retroactive coverage for Eligible Persons when the Group fails to report enrollments. Failure to report the end of coverage will not continue the coverage for a Covered Person beyond the date it is scheduled to end. Upon discovery of a clerical error, any needed adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Group for more than 60 days of coverage prior to the date we received notification of the clerical error.

6.11 Is Workers' Compensation Affected?

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

6.12 Conformity with Law

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is deemed to be amended to follow the minimum requirements of those statutes and regulations.

6.13 Notice

We provide written notice regarding Policy administration to the Group's authorized representative. Once delivered, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to Covered Persons on a timely basis.

Any notice sent to us under this Policy and any notice sent to the Group must be addressed as described in Exhibit 1.

6.14 Continuation Coverage

We agree to provide Benefits under this Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in *Section 4: When Coverage Ends* of the *Certificate of Coverage*.

We will not provide any administrative duties with respect to the Group's compliance with federal or state law. All duties of the plan sponsor or plan administrator remain the sole responsibility of the Group, including but not limited to notification of COBRA and/or state law continuation rights and billing and collection of Premium.

6.15 Subscriber's Individual Certificate

We will issue *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments to the Group for delivery to each Subscriber. The *Certificate(s) of Coverage*, *Schedule(s) of Benefits*, and any attachments will show the Benefits and other provisions of this Policy. In addition, the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* may be available online at www.myuhc.com.

6.16 Summary of Benefits and Coverage

We will provide a *Summary of Benefits and Coverage* (*"SBC"*), as required by the *Affordable Care Act* and related regulations (*"ACA"*), to the Group for each benefit plan purchased. The Group is responsible for delivering the *SBC* to all Covered Persons and to other persons eligible for coverage in the manner and at the times required by the *ACA*.

6.17 System Access

The term "systems" as used in this provision means systems that we make available to the Group to facilitate the transfer of information in connection with this Policy.

System Access

We grant the Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms of this Policy. The Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. To access the systems, the Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Group, including any amendments to those requirements. The Group is responsible for obtaining internet access.

The Group will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or use systems, for purposes other than as expressly permitted under this Policy.

- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Policy.

The Group may designate a third party access to the systems on its behalf, provided the third party agrees to these terms and conditions. The Group remains responsible for the third party's compliance with the entire *System Access* provision.

Security Procedures

The Group will use commercially reasonable physical and software-based measures and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

End of System Access

We have the right to end the Group's system access:

- On the date the Group does not accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon the date this Policy ends, the Group agrees to cease all use of systems, and we will deactivate the Group's identification numbers and passwords and access to the system.

The Group may terminate electronic administration and elect paper communication at any time without affecting any other provision in the Policy.

Exhibit 1

1. **Parties.** The parties to this Policy are UnitedHealthcare Insurance Company and City of Manor, the Group.
2. **Effective Date.** The effective date of this Policy is 12:01 a.m. on September 1, 2024 in the time zone of the Group's location.
3. **Place of Issuance.** We are issuing this Policy in Texas and reserve the right to review place of issuance determinations. The Policy is subject to the laws of the state of Texas and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Texas law governs this Policy.
4. **Premiums.** We have the right to change the *Schedule of Premium Rates* shown in Exhibit 2, after a 31-day prior written notice at any time.
5. **Computation of Policy Charge.** A full calendar month's Premiums will be charged for Covered Persons whose effective date of coverage falls on or before the 15th day of that calendar month. No Premiums will be charged for Covered Persons whose effective date of coverage falls after the 15th day of that calendar month. For Texas residents, a full month's Premium will be charged until the last day of the calendar month in which the Group notifies us of a Covered Person's termination. For non-Texas residents, a full month's Premiums will be charged for Covered Persons whose coverage ends after the 15th day of the calendar month. For non-Texas residents, no Premiums will be charged for Covered Persons whose coverage ended on or before the 15th day of that calendar month.
6. **Payment of the Policy Charge.** The Policy Charge is payable to us in advance by the Group on a monthly basis.
7. **Minimum Participation Requirement.** 95% of Eligible Persons excluding spousal waivers but no less than 50% of all Eligible Persons must be enrolled for coverage under this Policy. Employees within their waiting period are not considered eligible employees.
8. **Minimum Contribution Requirement.** The Minimum Contribution Requirement does not apply.
9. **Notice.** Any notice sent to us under this Policy must be sent to:

   UnitedHealthcare Insurance Company

   185 Asylum Street

   Hartford, Connecticut 06103-0450

   Any notice sent to the Group under this Policy must be sent to:

   City of Manor

   105 E Eggleston Street

   Manor, Texas 78653
10. 935966: Group Number

Exhibit 2 Class 1

1. **Class Description.**

   All Employees enrolled in UnitedHealthcare Choice Plus Plan DQ6U.

2. **Eligibility.** The eligibility rules are applied by the Group. The eligibility rules are the requirements the Group must use to determine who is eligible for coverage under the Policy. In addition to the requirements below, the eligibility rules can be found in this Policy, Group *Application,* and within the *Certificate of Coverage*:

   A. The waiting or probationary period for newly Eligible Persons is as follows:

      None

   B. Notwithstanding the eligibility rules for health plan participation, continued coverage under this Policy for a Covered Person on a leave of absence (LOA) will be available in accordance with the following, unless state, local or federal law requires a longer period of time:

      - For a Covered Person on a non-medical LOA, coverage will be available for no longer than 13 consecutive weeks from the beginning of the LOA.
      - For a Covered Person on a medical LOA, coverage will be available for no longer than 26 consecutive weeks from the beginning of the LOA.

   C. Any required waiting period under this Section will not exceed 90 days from the date of employment.

   D. No waiting period or other eligibility requirement under this Section will be based on a health status related factor.

   E. Minimum required hours per week as outlined in the Group Application or as agreed to by the Group and us, and as required by applicable law.

   F. Other:

3. **Open Enrollment Period.** An Open Enrollment Period of at least 60 days will be provided by the Group when Eligible Persons may enroll for coverage. The Open Enrollment Period will occur on an annual basis.

4. **Effective Date for Eligible Persons**. The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is September 1, 2024.

   For an Eligible Person who becomes eligible after the effective date of this Policy, the effective date of coverage is the first day of the calendar month following the date the Eligible Person joins the Group. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates.**

   The *Schedule of Premium Rates* payable by or on behalf of this class of Covered Persons as of September 1, 2024 is shown below:

Coverage Classification	**Monthly Premium**
Subscriber only	$627.12
Subscriber and spouse	$1,312.86
Subscriber plus one child	$1,133.10
Subscriber plus family	$1,925.31

Exhibit 3 - Advocate4Me[SM]

The Group agrees to take part in an advocate-based consumer experience program. This program provides Subscribers and Enrolled Dependents with an additional level of support services.

For the purpose of this Exhibit, "advocate" means representatives that are a part of the Advocate4Me program.

Advocate4Me provides the following enhanced levels of support:

- **Expert Advocate Support** - Provides a point of contact to answer questions. This contact will address and resolve issues, and engage in clinical programs.
- **Integrated Financial Support** - The ability for the advocate to address simple financial questions in advance and in connection with *Optum Bank.* This includes questions on balances, last transactions and enrollment.
- **Elevated Issue Resolution** - Provide enhanced issue resolution. This includes escalation to experts to address issues in reduced timeframes.
- **Consumer Preference Communication** - Offer communication across technologies. This includes email, fax and telephone.

Exhibit 4

Policy Charge Credit for UnitedHealthcare Rewards Engagement

The Group may be eligible for a Policy Charge credit when both of the following are met:

- The Group renews their Policy with us; and
- The Group meets annual engagement requirements based on completion of activity targets which are described in the *UnitedHealthcare Rewards* Rider.

The Policy Charge credit will be applied to the Policy Charge, as applicable, administered by us.

Important Information About Coverage Under The Texas Life And Health Insurance Guaranty Association
(For Insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies that are members of the of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code, Chapter 463.)*

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court order or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas (**regardless of where the policyholder lived when the policy was issued)**
- Residents of other states, ONLY if the following conditions are met:
    1. The policyholder has a policy with the company domiciled in Texas;
    2. The policyholder's state of residence has a similar guaranty association; and
    3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limitation of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, or $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life polices.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contract on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agent are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance
Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin Texas 78714-9104
800-252-3439 or
www.tdi.texas.gov

AGENDA ITEM NO. _____

AGENDA ITEM SUMMARY FORM

PROPOSED MEETING DATE: August 7, 2024
PREPARED BY: Matt Woodard, Director
DEPARTMENT: Public Works

AGENDA ITEM DESCRIPTION:
Consideration, discussion, and possible action on approval of contractor and construction contract for the overlay of Lexington Street from Murray to US290.

BACKGROUND/SUMMARY:
The City Council is being asked to authorize the approval of the contractor and construction contract for milling, patchwork, pavement overlay, and stripping Lexington Street from Murray to US290. TXDOT has completed its pavement overlay project on Lexington Street from Murray to Parsons to Llano Street.

This maintenance work had been scheduled on TXDOT's project list for a couple of years, but it did not include the section of Lexington Street from Murray to US290 that needs to be upgraded to handle the 7,800 daily traffic volume. Completing this section of Lexington Street to match the other sections that TXDOT completed in July would illustrate the city's commitment to keeping our streets properly maintained in a timely manner. Attached are the quotes and photos of the proposed project.

LEGAL REVIEW: Yes
FISCAL IMPACT: No
PRESENTATION: No
ATTACHMENTS: Yes

- Contractor Quotes and Photos

STAFF RECOMMENDATION:
The city staff recommends that the City Council approve the proposal to complete the milling, patchwork, pavement overlay, and stripping of Lexington Street from Murray to US290 and authorize the City Manager to execute the contract after legal review.

PLANNING & ZONING COMMISSION: **Recommend Approval** **Disapproval** **None**

LONE STAR PAVING

11675 JOLLYVILLE RD, SUITE 150
AUSTIN, TX 78759

Phone #
(512)-906-5864

Estimate

Date	Estimate No.
7/29/2024	AW-24-7-074

Project

City of Manor- Lexington Street Paving

Alternate Bid Proposal

CONTRACT TIME: N/A

PRICING FOR PAVING IS VALID THROUGH 10/30/2024.

Item No.	Description	Qty	U/M	UNIT PRICE	Total
1	D-GR HMA TY-D PG64-22 (2")	1,931	SY	$33.00	$63,723.00
2	FLEXIBLE PAVEMENT STRUCTURE REPAIR (4")	289	SY	$68.00	$19,652.00
3	PLANE ASPH CONC PAV (2")	1,931	SY	$5.00	$9,655.00
4	BARRICADES, SIGNS, AND TRAFFIC HANDLING	1	DAY	$12,000.00	$12,000.00
5	REFL PAV MRK TY I (W) 8" (SLD)	280	LF	$2.25	$630.00
6	REFL PAV MRK TY I (W) 12" (SLD)	120	LF	$17.00	$2,040.00
7	REFL PAV MRK TY I (W) 24" (SLD)	30	LF	$34.00	$1,020.00
8	REFL PAV MRK TY I (W) (ARROW)	4	EA	$340.00	$1,360.00
9	REFL PAV MRK TY I (W) (DBL ARW)	2	EA	$450.00	$900.00
10	REFL PAV MRK TY I (W) (WORD)	4	EA	$425.00	$1,700.00
11	REFL PAV MRK TY I (Y) 4" (SLD)	700	LF	$2.25	$1,575.00
12	REFL PAV MRKR TY II-A-A	18	EA	$8.50	$153.00
13	REFL PAV MRKR TY I-C	14	EA	$8.50	$119.00
14	BONDING COURSE	174	GAL	$4.00	$696.00
	** All quoted work is based on TxDOT Specifications				

INCLUDES UP TO ONE (1) MOBILIZATION TO COMPLETE THE WORK.

PRICING BASED ON 0% RETAINAGE. BONDING AND SALES TAX EXCLUDED.

					Total
OPTIONAL					$115,223.00
500-BONDS	P & P BONDS	1.00	LS	$3,456.69	$3,456.69

Estimator
Andrew Warner
awarner@lspaving.com
512-906-5864

We acknowledge receipt of the following Addendum---->

ADDENDUM NO.
0

PRICING FOR THIS WORK EXPIRES IN 30-DAYS FROM BID DATE UNLESS THIS PROPOSAL/ESTIMATE IS ACCEPTED AND RETURNED SIGNED.

QUALIFICATIONS

EXCLUDES - BONDING, PERMITS, UTILITY ADJUSTMENTS, LAYOUT OR SURVEYING, ENGINEERED TRAFFIC CONTROL PLAN, LANE CLOSURE FEES OR PERMITS, TEMPORARY OR PERMANENT STRIPING (UNO), MESSAGE BOARDS (PCMS), LAW ENFORCEMENT FOR TRAFFIC CONTROL OPERATIONS.

Lone Star Paving will execute only those items of work listed in the "SCOPE OF WORK" above. Any additional items of work will require a written change order in adavance. Lone Star Paving is not responsible for drainage issues on slopes less than 2%. All quantity overruns will be verified in place upon completion and billed at the unit prices shown above. From time to time, the paving surface may have areas whereby additional hotmix must be applied to achieve desired results, the fees for these additional amounts of materials will be discussed and agreed to prior to commencement of work. All changes in the scope of the work must be agreed prior to the commencement of work.

TERMS & CONDITIONS

This quote will become part of the subcontract agreement, and shall supersede any other conflicting language in the subcontract agreement between the parties. All agreements must be made in writing. Asphalt paving standards for newly constructed areas are proposed to comply with the Texas Department of Transportation hot mix standards. Other paving specifications must be specifically outlined. All permits and fees are excluded unless otherwise noted. Customer/Owner is responsible for protecting the work site from tenants, customers, other work activities, and will bear any additional costs of repairing work. Lone Star Paving is not responsible for utility lines less than 12 inches deep. Lone Star Paving will carry Workers Compensation, General Liability and Auto Insurance for labor provided in the performance of this contract. The amounts included in this estimate are based on information provided and are subject to change if new information is provided or differing site conditions are encountered. LSP is only responsible for its asphalt work, and expressly excludes injury, warranty, damages, and remediation to business or property if there are deficiencies with the subgrade or base, which shall meet or exceed the governing specifications, and shall also meet or exceed the ride specifications. Testing for HMAC QCQA items only. LSP shall retain all production, ride, and placement bonus/penalty on HMAC item(s) according to specification where applicable. The bonus/penalty calculations shall be based on LSP's unit prices or the unit bid prices, whichever is greater. Maximum one (1) year warranty on materials and workmanship. Payments should be remitted to Asphalt Inc., LLC d/b/a Lone Star Paving, 11675 Jollyville Road, Suite 150, Austin, TX 78759. Fees for our services are due 10 days from the date of the invoice. Interest shall accrue for all amounts past due at the rate of eighteen percent (18%) compound interest per annum or highest legal limit. The Contractor agrees to pay reasonable attorney fees, expert fees, all costs of court, and any other expenses incurred by Asphalt Inc in the collection of any sums due under the performance of this contract. The venue for any legal action under this contract shall be Bexar County, Texas. The parties expressly agree to waive the right to a jury trial. Pricing based on (and subject to) a mutually agreeable contract being executed by both parties. LSP shall not be liable for any failure of or delay in the performance of its work for the period that such failure or delay is due to causes beyond its reasonable control, including but not limited to, acts of God, epidemic, pandemic, abnormal weather conditions, war, strikes or labor disputes, embargoes, government orders or any other force majeure event. If delayed by a force majeure event, LSP shall be entitled to an extension of time equal to the length of the delay and an increase in price if LSP's prices have been increased as a result of such force majeure event. Lone Star Paving Company cannot agree to an indemnity clause where it is responsible for the general contractor's or contractor's sole negligence.

The above prices, specifications, and conditions are satisfactory and are hereby accepted. Payment will be made as outlined above.

Accepted by: _____ Date: _____

Title: _____

Company Name: _____

LONE STAR PAVING

11675 JOLLYVILLE RD, SUITE 150
AUSTIN, TX 78759

Phone #
(512)-906-5864

Estimate

Date	Estimate No.
7/29/2024	AW-24-7-074

Project

City of Manor- Lexington Street Paving

Base Bid Proposal

PRICING FOR PAVING IS VALID THROUGH 10/30/2024.

CONTRACT TIME: N/A

Item No.	Description	Qty	U/M	UNIT PRICE	Total
1	TOM-C PG76-22 SAC-B (1")	1,931	SY	$29.00	$55,999.00
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14	BONDING COURSE	174	GAL	$4.00	$696.00
	** All quoted work is based on TxDOT Specifications				

INCLUDES UP TO ONE (1) MOBILIZATION TO COMPLETE THE WORK.

PRICING BASED ON 0% RETAINAGE. BONDING AND SALES TAX EXCLUDED.

					Total
OPTIONAL					$107,499.00
500-BONDS	P & P BONDS	1.00	LS	$3,224.97	$3,224.97

Estimator
Andrew Warner
awarner@lspaving.com
512-906-5864

We acknowledge receipt of the following Addendum---->

ADDENDUM NO.
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Lone Star Paving will execute only those items of work listed in the "SCOPE OF WORK" above. Any additional items of work will require a written change order in adavance. Lone Star Paving is not responsible for drainage issues on slopes less than 2%. All quantity overruns will be verified in place upon completion and billed at the unit prices shown above. From time to time, the paving surface may have areas whereby additional hotmix must be applied to achieve desired results, the fees for these additional amounts of materials will be discussed and agreed to prior to commencement of work. All changes in the scope of the work must be agreed prior to the commencement of work.

TERMS & CONDITIONS

This quote will become part of the subcontract agreement, and shall supersede any other conflicting language in the subcontract agreement between the parties. All agreements must be made in writing. Asphalt paving standards for newly constructed areas are proposed to comply with the Texas Department of Transportation hot mix standards. Other paving specifications must be specifically outlined. All permits and fees are excluded unless otherwise noted. Customer/Owner is responsible for protecting the work site from tenants, customers, other work activities, and will bear any additional costs of repairing work. Lone Star Paving is not responsible for utility lines less than 12 inches deep. Lone Star Paving will carry Workers Compensation, General Liability and Auto Insurance for labor provided in the performance of this contract. The amounts included in this estimate are based on information provided and are subject to change if new information is provided or differing site conditions are encountered. LSP is only responsible for its asphalt work, and expressly excludes injury, warranty, damages, and remediation to business or property if there are deficiencies with the subgrade or base, which shall meet or exceed the governing specifications, and shall also meet or exceed the ride specifications. Testing for HMAC QCQA items only. LSP shall retain all production, ride, and placement bonus/penalty on HMAC item(s) according to specification where applicable. The bonus/penalty calculations shall be based on LSP's unit prices or the unit bid prices, whichever is greater. Maximum one (1) year warranty on materials and workmanship. Payments should be remitted to Asphalt Inc., LLC d/b/a Lone Star Paving, 11675 Jollyville Road, Suite 150, Austin, TX 78759. Fees for our services are due 10 days from the date of the invoice. Interest shall accrue for all amounts past due at the rate of eighteen percent (18%) compound interest per annum or highest legal limit. The Contractor agrees to pay reasonable attorney fees, expert fees, all costs of court, and any other expenses incurred by Asphalt Inc in the collection of any sums due under the performance of this contract. The venue for any legal action under this contract shall be Bexar County, Texas. The parties expressly agree to waive the right to a jury trial. Pricing based on (and subject to) a mutually agreeable contract being executed by both parties. LSP shall not be liable for any failure of or delay in the performance of its work for the period that such failure or delay is due to causes beyond its reasonable control, including but not limited to, acts of God, epidemic, pandemic, abnormal weather conditions, war, strikes or labor disputes, embargoes, government orders or any other force majeure event. If delayed by a force majeure event, LSP shall be entitled to an extension of time equal to the length of the delay and an increase in price if LSP's prices have been increased as a result of such force majeure event. Lone Star Paving Company cannot agree to an indemnity clause where it is responsible for the general contractor's or contractor's sole negligence.

The above prices, specifications, and conditions are satisfactory and are hereby accepted. Payment will be made as outlined above.

Accepted by: _____ Date: _____

Title: _____

Company Name: _____

SMITH
Paving Inc.

July 31, 2024

Bid Proposal- City of Manor Lexington Street

We are pleased to quote all labor, materials, equipment, insurance, and incidentals necessary to complete the above reference project:

Scope of Work:

- 4” flexible pavement repairs 289 SY.
- 2” milling 1,931 Sy.
- 2” Type D HMAC Overlay 1,931 Sy.
- Stripe to match existing
- Provide necessary traffic control

Total: $110,000.00

Bid is based on all work being done at night and the road being open by 5:00 AM

Exclude: Traffic signal loop wiring

Respectfully,
Smith Paving Inc.
Casey Smith
512-917-1142 – Mobile
512-233-4444 – Office
512-280-5545 – Fax
Smithpaving99@yahoo.com

Austin
Elgin

RESTAURANT & CANTINA
US 290
ONLY

E MURRAY
LEXINGTON
UNEVEN
LANES
TACO

POST
OFFICE

AGENDA ITEM NO. _____

AGENDA ITEM SUMMARY FORM

PROPOSED MEETING DATE: August 7, 2024
PREPARED BY: Scott Jones, Economic Development Director
DEPARTMENT: Administration

AGENDA ITEM DESCRIPTION:

Consideration, discussion, and possible action on the City of Manor's Request for Proposals Solid Waste & Recycling Services RFP# 2024-07 and the submitted proposals.

BACKGROUND/SUMMARY:

The city issued a Request for Proposals ("RFP") for the collection, transportation, and disposal of solid waste and recyclable materials on April 26, 2024, with the assistance of the City's consultant, Solid Waste Specialists (SWS). After the RFP deadline for proposals and submission of proposals by solid waste providers, it was determined that information affecting the pricing of the proposals submitted was not included in the RFP. In order to provide the information to all solid waste providers a new RFP should be issued.

LEGAL REVIEW: Yes, Veronica Rivera, Assistant City Attorney
FISCAL IMPACT:
PRESENTATION: No
ATTACHMENTS: No

STAFF RECOMMENDATION:

Staff recommends that the City Council reject all proposals submitted under the City of Manor's Request for Proposals Solid Waste & Recycling Services RFP# 2024-07 and that a new Request for Proposals for the collection, transportation, and disposal of solid waste and recyclable materials be issued.

CITY COUNCIL: **Recommend Approval** **Disapproval** **None**

AGENDA ITEM NO. _____

AGENDA ITEM SUMMARY FORM

PROPOSED MEETING DATE: August 7, 2024
PREPARED BY: Yalondra M. Valderrama Santana, Heritage & Tourism Manager
DEPARTMENT: Community Development

AGENDA ITEM DESCRIPTION:

Consideration, discussion, and possible action on a resolution establishing a city sponsorship program; approving the policy and agreement; approving the application process; approving the amount of funding allocated for events and providing for related matters.

BACKGROUND/SUMMARY:

It is the City's policy to value and encourage events, programs, and services that benefit residents of the City. Historically, the City has supported various community events either with in-kind support or financial support based on citywide community needs and budgetary allocations. In order to ensure equitable opportunity for organizations to submit proposals, the City is formalizing the process in which organizations/groups receive City support. This policy will provide the basis for the City to enter into a (1) Formal City Sponsorship relationship, with monetary support; or 2) Informal Co-Sponsorship support for City sponsored special events. Requests for support will be approved in an equitable manner, ensuring a variety of programs, services, and community organizations receive the available support.

LEGAL REVIEW: Yes, Veronica Rivera, Assistant City Attorney
FISCAL IMPACT: Budget FY24-25
PRESENTATION: No
ATTACHMENTS: Yes

- Resolution No. 2024-26
- City of Manor Sponsorship Program Overview
- City of Manor Sponsorship Program Policy & Agreement
- City of Manor Sponsorship Program Application

STAFF RECOMMENDATION:

The city staff recommends that the City Council approve Resolution No. 2024-26 establishing the City of Manor Sponsorship Program; approving the policy and agreement; approving the application process; approving amount of funding allocated for events and providing for related matters.

CITY COUNCIL: **Recommend Approval** **Disapproval** **None**

RESOLUTION NO. 2024-26

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF MANOR, TEXAS ESTABLISHING A CITY SPONSORSHIP PROGRAM; APPROVING THE POLICY AND AGREEMENT; APPROVING AN APPLICATION PROCESS; APPROVING THE AMOUNT OF FUNDING ALLOCATED FOR EVENTS; AND PROVIDING FOR RELATED MATTERS.

WHEREAS, the City of Manor, Texas (the "City") is a home rule municipality; and

WHEREAS, the City Council of the City (the "City Council") desires to establish the City Sponsorship Program (the "Program") for the purpose of providing financial support to organizations and groups through formal and informal monetary sponsorship; and

WHEREAS, the City Council finds that the Program allows the opportunity for the City to provide Formal City Sponsorship via monetary funding and/or Informal Co-Sponsorship of in-kind services to support nonprofit entity events, programs, or services that benefit Manor residents; and

WHEREAS, the City Council has determined that the creation of the Program is in the best interest of City residents for the City to support community events in an equitable manner; and

WHEREAS, it is the intent of the City Council that the creation of the Program will attain the goals referenced above and will provide the City Council with valuable citizen input related thereto.

NOW THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF MANOR, TEXAS, THAT:

SECTION 1. The City Council hereby approves the recitals contained in the preamble of this Resolution and finds that all the recitals are true and correct and incorporate the same in the body of this Resolution as findings of fact.

SECTION 2. The City Council hereby establishes the City Sponsorship Program (the "Program") as further described in **Exhibit A**, attached hereto and incorporated herein as if fully set forth as a program of the City to provide financial support to organizations and groups through formal and informal monetary sponsorship.

SECTION 3. The City Council hereby approves the policy and agreement provided in **Exhibit B**, attached hereto and incorporated herein as if fully set forth.

SECTION 4. The City Council hereby approves the application provided in **Exhibit C**, attached hereto and incorporated herein as if fully set forth and the application process further described in the Program and the policy and agreement.

SECTION 5. The City Council hereby declares the following as eligible for the City Sponsorship Program:

- Incorporated nonprofit organizations with a 501(c)(3) designation;
- Texas certified tax-exempt nonprofit organizations;
- Public agencies, including public schools or school foundations in Manor's school districts;
- Committees formally established by the City Council;
- Established clubs from Manor; and
- Associations or organized groups that provide services and programs directly to Manor for the benefit of its residents.

SECTION 6. The City Council hereby declares that the Program will have a panel comprised of City staff, to be designated by the City Manager, shall review and recommend proposals to the City Council in accordance with proposed fiscal year budget based on proposals being submitted to the Community Development Department no later than June 30th of each fiscal year for staff to allocate upcoming resources accordingly; and the amount of funding allocated for an event shall be in the range of $1,000 to $10,000.

SECTION 7. If any section, article, paragraph, sentence, clause, phrase or word in this resolution or application thereof to any persons or circumstances is held invalid or unconstitutional by a court of competent jurisdiction, such holding shall not affect the validity of the remaining portions of this resolution; and the City Council hereby declares it would have passed such remaining portions of the resolution despite such invalidity, which remaining portions shall remain in full force and effect.

SECTION 8. This resolution shall take effect immediately from and after its passage, and it is duly resolved.

PASSED AND ADOPTED by the City Council of Manor, Texas, at a regular meeting on the 7th day of August 2024, at which a quorum was present, and for which due notice was given pursuant to Texas Government Code, Chapter 551.

CITY OF MANOR, TEXAS

_____
Dr. Christopher Harvey, Mayor

ATTEST:

_____
Lluvia Almaraz, City Secretary

Exhibit A
City Sponsorship Program
[attached]

City Sponsorship Program

The City values and encourages events, programs, and services that benefit Manor residents. Historically, Manor has supported various community events either with in-kind support or financial support based on citywide community needs and budgetary allowances. In order to ensure equal opportunity for organizations to submit their proposals for approval and obtain support, organizations will need to complete an application and follow certain guidelines.

Who is eligible to apply for the City Sponsorship Program?

- Incorporated nonprofit organizations with a 501(c)(3) designation
- Texas certified tax-exempt nonprofit organizations
- Public agencies, including public schools or school foundations in Manor's school districts
- Committees formally established by the City Council
- Established clubs from Manor
- Associations or organized groups that provide services and programs directly to Manor for the benefit of its residents

What kind of event is eligible for support?

Events that meet the following criteria are eligible:

- Enhances current City programs or core services by providing additional programming, financial and/or in-kind resources, community outreach, staffing, volunteers, or other tangible support to the City
- Is open to the public and does not require any entrance fees paid for admittance
- Provides significant citywide value, presented for the anticipated enjoyment and participation by a broad spectrum of the Manor community; the event shall not intentionally nor by design be presented for or intended to draw participation from a specific neighborhood area or region within the City and shall not exclude the participation of any segment of the community

What kind of support can I receive if my application is approved?

- The City may provide **Formal City Sponsorship** via monetary funding and/or **Informal Co-Sponsorship** of in-kind services to support nonprofit entity events, programs, or services that benefit Manor residents.

- **Informal Co-Sponsorship,** which does not provide monetary support, but may include:
    - waiving of facility rental fees
    - city staff support to provide advice and/or logistical guidance
    - permission to use the City logo on marketing materials

What is the maximum amount of support I can receive for my event or program?

- The amount of funding allocated for approved events may range from a minimum of $1,000 to a maximum of $10,000.
- The total value of City support shall not exceed $10,000 per organization per fiscal year and may not exceed the City approved budget. This includes but is not limited to the waiver of facility rental fees, staff costs, and/or equipment rental fees.
- The value of resources provided by the City in support of a partner event, program, or service shall not exceed the value of the partner's contribution.

How do I apply for support?

Applications for **Formal City Sponsorship** must be submitted no later than **June 30th** to apply for support for the following fiscal year (fiscal year runs October – September).

Informal Co-Sponsorship applications are due **60 days prior to the date of the event.**

- Complete the application with necessary and supportive documents
- Return the completed application to:

  Community Development Department
  City of Manor
  105 E. Eggleston St.
  Manor, Texas 78653
- Postmarks or incomplete application will not be accepted

Exhibit B
Policy and Agreement
[attached]

City Sponsorship Program
POLICY & AGREEMENT

It is the City policy to value and encourage events, programs, and services that benefit residents of the City. Historically, the City has supported various community events either with in-kind support or financial support based on citywide community needs and budgetary allocations. In order to ensure equitable opportunity for organizations to submit proposals, the City is formalizing the process in which organizations/groups receive City support. This policy will provide the basis for the City to enter into a (1) Formal City Sponsorship relationship, with monetary support; or 2) Informal Co-Sponsorship support for City sponsored special events. Requests for support will be approved in an equitable manner, ensuring a variety of programs, services, and community organizations receive the available support.

A. REQUIREMENTS

The City may provide Formal City Sponsorship via monetary funding and/or Informal Co-Sponsorship of in-kind services to support nonprofit entity events, programs or services that benefit Manor residents. City sponsorship for monetary assistance will be administered by means of written agreements ("Agreements") that set out what a community partner can expect of the City and what the City requires of its partners. All Agreements must comply with all applicable City regulations and policies. Agreements may not commit the City to additional operating and/or maintenance responsibilities, ongoing financial obligations, or program or service responsibilities beyond the current fiscal year.

Informal Co-Sponsorship relationships may be approved by the City Manager or designee. The City periodically provides support to an event or program through the use of Informal Co-Sponsorship which does not provide monetary support, but may include: waiving of facility rental fees, city staff support to provide advice and/or logistical guidance, or permission to use the City logo on marketing materials. The Community Development Director may approve the Informal Co-Sponsorship relationship with an organization or group that provides an event, program or service that is open to the public.

The amount of funding allocated for approved events may range from a minimum of $1,000 to a maximum of $10,000. Total value of City support shall not exceed $10,000 per

organization per fiscal year, and may not exceed the City approved budget (this inc
but is not limited to waiver of facility rental fees, staff costs and/or equipment rental fees). The value of resources provided by the City in support of a partner event, program or service shall not exceed the value of the partner's contribution.

The City Council has the sole discretion to determine whether an event benefits its residents and should, therefore, reserves the right to decline any request for Formal City Sponsorship or Informal Co-Sponsorship (in-kind support) if acceptance is determined not to be in the best interest of, or would create a conflict of interest for, the City. In addition, the City will not sponsor any event if doing so would cause the City to violate the First Amendment to the United States Constitution and/or any City regulations.

B. ELIGIBILITY

1. The requestor is an incorporated nonprofit organization with a 501(c)(3) designation; or a Texas-certified tax-exempt nonprofit organization; or a public agency, including public schools or school foundations in school districts; or a committee formally established by City Council or an established club, association or organized group that provides services and programs directly to Manor for the benefit of its residents. Preference and priority will be given to organizations based in Manor.
2. A requestor that is a commercial enterprise would not qualify unless the event, program, or service is open to the general public, benefits the greater Manor community, and provides no commercial benefit to the requestor.
3. The requestor's mission and goals in providing the event, service or program:
    a. Are compatible with the City's priorities; or
    b. Enhance current City programs or core services by providing additional programming, financial and/or in-kind resources, community outreach, staffing, volunteers or other tangible support to the City.
4. The requestor's event is open to the public and does not require any entrance fees paid for admittance.
5. The requestor's event provides significant citywide value, presented for the anticipated enjoyment and participation by a broad spectrum of the Manor community; the event shall not intentionally nor by design be presented for or intended to draw participation from a specific neighborhood area or region within the City and shall not exclude the participation of any segment of the community.
6. The requestor's prior relationships with the City have been successful (e.g., fees timely paid, documentation submitted complete and timely).
7. The requestor can provide verification of the availability of the City facility or capacity of programmatic function.
8. The requestor understands that City support is not for individual gain and is not intended to provide City support for business purposes or commercial enterprise.

9. The requestor may receive support once per fiscal year; any previous support does not guarantee any ongoing future support.

C. APPLICATION PROCESS

Application and Proposals - An application for Formal City Sponsorship of Community Events, Programs and Services must be submitted no later than June 30th to apply for support for the following fiscal year (fiscal year runs October – September respectively). Application and Agreement procedures described are administrative and may be modified by the City Council, City Mayor, City Manager, or designee, when appropriate.

1. Organizations must submit an application along with a written proposal to the Community Development Department for Formal City Sponsorship for Community Events;
2. Proposal must include:
    a. Description of organization;
    b. Include full legal name and address of the organizing group;
    c. Description of the organization, including its purpose, goals and/or mission;
    d. Copy of the organization 501(c)(3), if applicable;
    e. Full legal names, phone numbers, addresses, and emails of each person of interest in the organizing;
    f. Full legal name of the representative with the organizing group that is prepared to meet and work with a City representative;
    g. Full description of the event, including but not limited to name of event, date and time, location, financial breakdown, target audience, timeline, program or/and service providing, safety procedures, marketing plan, etc.;
    h. Descript how/where the city funds will be used; and
    i. Descript how it benefits the Manor community.
3. List of City funding and/or in-kind services requested (this includes but is not limited to waiver of facility rental fees, staff costs and/or equipment rental fees, plus any monetary funding; please note the combined total may not exceed $10,000 per organization, per fiscal year);
4. Description of how the City's sponsorship and funding will complement other in-kind and monetary support already attained or to be attained for successful event implementation;
5. Proposed event date(s), including dates for event load-in and load-out, location, event size and scope, and anticipated public attendance of Manor residents;
6. Summary of event organizer's experience planning and implementing the proposed event or an event of similar size and scope;
7. Description of the number of volunteers and volunteer hours anticipated for event coordination and implementation; and

8. Description of how the event will be marketed and indicate through what ve will the City have the opportunity to be recognized in marketing materials following the requirements provided below:
    a. Community organizations must adhere to the City's branding and logo guidelines and must seek permission prior to using the City logo.
    b. City has final approval of materials with City logo prior to distribution.
    c. Formal City Sponsorship requires that the City logo be added to all marketing materials, including but not limited to flyers, posters, banners, promotional items, maps, social media marketing, shirts, etc.
    d. City has final approval of marketing materials.

D. SELECTION PROCEDURE AND PROPOSAL ASSESSMENT

A panel comprised of city staff, to be designated by the City Manager, shall review and recommend proposals to the City Council in accordance with proposed fiscal year budget. Proposals must be submitted to the Community Development Department no later than June 30th of each fiscal year for staff to allocate upcoming resources accordingly. The amount of funding allocated to a proposed event will be determined based on need and overall benefit to the community. All proposals are contingent upon the approval of the City budget. In assessing proposals and the amount of funding that may be provided, the City will consider the following criteria, in no particular order of importance:

1. Production of measurable outcomes in alignment with City budget and priorities;
2. Ability to meet community needs;
3. Demonstrated public support for the service or program;
4. Level of community partner's contribution to the project;
5. Organizational capacity of the group or entity applying for the support;
6. Operational sustainability (ability of collaborator to offer the event in the absence of City support);
7. Commitment to ensuring ongoing public access;
8. Financial viability;
9. Project timelines;
10. Costs versus benefits of the event or program;
11. Impact on existing City operations, assets and facility resources;
12. Media exposure opportunities;
13. Involvement by other entities including partners, contractors and/or sponsors;
14. Event planning and execution history;
15. Proposal submitted by June 30th deadline;
16. Any other factors deemed relevant to the collaboration;
17. Number of Manor residents the program or event serves; and
18. Financial need of the group or entity applying for support.

E. AGREEMENT

An Agreement containing the material terms and obligations will be developed for approval by authorized representatives of the requesting party and the City. The Agreement will include a description of the contractual relationship, roles, post-event report details, and responsibilities of the City and the community group/organization. Indemnification and insurance will be required as part of the Agreement in accordance with City policy. Funds will not be released until proof of insurance is received by the City.

Exhibit C
City Sponsorship Program Application
[attached]

COMMUNITY DEVELOPMENT DEPARTMENT

City Sponsorship Program Application & Proposal

APPLICATION

NOTE

Formal City Sponsorship applications for events taking place between October 1st and September 30th will NOT BE ACCEPTED before April 1st and after June 30th.

SPONSORSHIP IS NOT GUARANTEED AND IS CONTINGENT UPON AVAILABLE CITY FUNDS

☐ **FORMAL CITY SPONSORSHIP** Due June 30th at 5:00 p.m. Postmarks will not be accepted.	☐ **INFORMAL CO-SPONSORSHIP** Due 60 days prior to event, program or service date.

Organization Name (Full Legal Name)			
Address (As Listed on Official Paperwork)	**City**	**State**	**Zip Code**
Contact Number	**Email**		

Type of Organization	
☐ Public Agency	☐ Club/Association/Organization Group
☐ Commercial Enterprise	☐ Tax Exempt Nonprofit Organization
☐ Committee	501 (c)(3) Tax ID _____

Summarize the organization's mission / purpose / goals.

Representative Name	**Title**		
Address	**City**	**Sate**	**Zip Code**
Contact Number	**Email**		

APPLICATION

Summarize the representative's experience in planning and implementing the proposed event, program or service or other project similar in size and scope.

List the names and contact information of each person involved in planning and implementation. Attach copies of this form to include additional names as needed.

Name		**Role**	
Address			
Phone		**Email**	
Name		**Role**	
Address			
Phone		**Email**	
Name		**Role**	
Address			
Phone		**Email**	
Name		**Role**	
Address			
Phone		**Email**	
Name		**Role**	
Address			
Phone		**Email**	
Name		**Role**	
Address			
Phone		**Email**	
Name		**Role**	
Address			
Phone		**Email**	

PROPOSAL

Name of Event, Program or Service			
Location		**Date(s)**	**Hours**
Load-In Date	**Load-Out Date**	**Anticipated Attendance**	

Target Audience	
☐ Citywide	☐ Other (describe):_____
☐ Neighborhood: _____	
_____	

Scope of Event		
☐ Open to the Public	☐ Entertainment	☐ Insurance
☐ Alcohol Service	☐ Admission/Fees	If approved, is the organization able to provide proof of insurance?
☐ Traffic Closures	☐ Parade/March /Procession	
☐ Carnival Rides	☐ Food / Merchandise / Crafts	☐ Yes ☐ No

How will the event, program or service meet a community need?

How will the event, program or service benefit the Manor community?

What percentage of the event, program or service's attendees are Manor residents?

How many years has this event, program or service taken place?	How many years has this event, program or service taken place in Manor?

Combined total support from the City may not exceed $10,000 per fiscal year and will not exceed the value of your organization's contributions.

Funding and/or In-Kind Services Requested Descriptions may be added in the space provided if necessary.	
☐ Monetary Request	☐ Police/Traffic support
☐ Facility Rental	☐ Electrician
☐ City Staffing	☐ City Equipment

How many volunteers, volunteer duties, and volunteer hours are anticipated for coordination and implementation?

PROPOSAL
Describe how the City's sponsorship and funding will complement other in-kind and monetary support already attained or to be attained for successful implementation.

List all other in-kind support	List all other sponsorship/income

Describe how the event, program or service will be advertised and indicate through what avenues will the City have the opportunity to be recognized on marketing materials. *Organizations must adhere to the City's branding and logo guidelines and must seek permission prior to using the City logo. The City has final approval of materials prior to distribution.*

APPLICANT AFFIDAVIT

The applicant and, if applicable, the professional event organizer, must complete, sign and date this application before submitting to:

Community Development Department
City of Manor
105 E. Eggleston St.
Manor, Texas 78653

*All requests for Formal City Sponsorship must be submitted by 5:00 p.m. on June 30th.

CERTIFICATION STATEMENT

I certify the information contained in the foregoing application is true and correct to the best of my knowledge and that I have read, understand and agree to abide by the rules and regulations governing the proposed Event under the Manor Municipal Code. I understand this application is made subject to the requirements, eligibility, application process and selection procedure established by the City Council Policy ("City Supported Event Policy & Agreement") adopted on August 7, 2024.
I certify I am authorized to submit this application on behalf of the Organization and to be bound by the information contained herein, and therefore, agree to be financially responsible for any costs and fees that may be incurred by or on behalf of the event to the City of Manor.

I acknowledge that sponsorship is not guaranteed and is contingent upon available City funds.

Organization (Full Legal Name)

_____

Organization's Representative (Full Legal Name) and Title

_____

Representative's Signature Date: _____

_____

Name of Professional Event Organizer (if applicable)

_____

Professional Event Organizer's Signature Date: _____

_____

AGENDA ITEM NO. _____

AGENDA ITEM SUMMARY FORM

PROPOSED MEETING DATE: August 7, 2024
PREPARED BY: Scott Moore, City Manager
DEPARTMENT: Administration

AGENDA ITEM DESCRIPTION:

Consideration, discussion, and possible action on a Website Services Agreement with CivicPlus.

BACKGROUND/SUMMARY:

On December 21, 2022, the City Council approved a website service agreement with CivicPlus to upgrade the functionality and appearance of our current website, making it easier to use and providing information to the public in a more accessible format. During the implementation process, staff recognized that an upgrade to the current contract was needed to add additional components to meet the City's goal.

The CivicPlus proposal includes an analysis of the current needs of the City, the implementation of the agreed-upon design, the development of the content to serve the needs of the various departments of the City, end-user training, and a new date to launch the website. The proposed agreement provides the Ultimate Design Package and Police Department Header Package for the City Website through CivicPlus with an initial investment of $32,042.25 and an annual recurring services payment of $9,054.75 with a yearly uplift of 5% to be applied in year two (2).

LEGAL REVIEW: Yes, Deron Henry, Associate Attorney
FISCAL IMPACT: Yes, FY24-25
PRESENTATION: Yes
ATTACHMENTS: Yes

- Ultimate Website Executive Summary Presentation
- Website Service Agreement
- Exhibit - CivicPlus Master Services Agreement and Statement of Work (Quote)

STAFF RECOMMENDATION:

The city staff recommends that the City Council approve a new website services agreement with CivicPlus as presented.

PLANNING & ZONING COMMISSION: **Recommend Approval** **Disapproval** **None**

City of Manor, TX

Executive Summary Presentation

HELPING LOCAL GOVERNMENT INFORM, ENGAGE & PROTECT THEIR CITIZENS

Powering and Empowering Local Governments

12,000+
Customers Inspire our Solutions

100,000+
Administrative Users

340+ Million
Resident Users in the U.S. and Canada Alone

CIVICPLUS

EngageCentral

Advanced Website Solution. Developed to be flexible, automated modules for various departments, online payment capable, and the ability to quickly update, quickly upload documents, while pushing and pulling information to/from 3rd party solutions with Zapier

- **40+ Website Modules**
  Integrations linking select modules together
- **Advanced Search with Predictive Capabilities**
- **Activities Module**
  Manage Registrations and Take Online Payments
- **WYSIWYG Editor**
  Live Editing Capabilities
- **Facilities Module**
  Allow Online Reservations, Payments Integrates with Calendar
- **NotifyMe**
  Subscription Tool. Send Notifications by Email & Text
- **Multiple Document, Pictures, & Files Upload**
- **Dashboard**
  View all website activity from one location

The Civic Experience

One Vendor, Multiple Software Options

Our Passion – Industry Recognitions

GovTech 100

AWARDED GOVTECH'S TOP 100 INNOVATOR LIST
9 YEARS IN A ROW 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024

Inc. 5000

GOVTECH 100 COMPANY 2024

GOLD 2023 STEVIE WINNER FOR SALES & CUSTOMER SERVICE

MOST PROMISING PUBLIC SECTOR SOLUTIONS PROVIDER 2022
Awarded by CIOReview

2024 – 5 Stevie Awards Nominations

- Best Customer Satisfaction Strategy – Finalist
- Customer Service Training of the Year – Finalist
- Customer Service Department of the Year –Finalist
- Best use of Technology in Customer Service – Finalist
- Best Achievement in Customer Experience - Finalist

CENTER FOR DIGITAL GOVERNMENT DIGITAL COUNTIES SURVEY 2018 WINNER

3CMA 2019 SAVVY AWARD SMALL POPULATION

NAGW PINNACLE AWARDS 2018 PINNACLE AWARD COUNTY SMALL POPULATION GROUP

3CMA 2019 SILVER CIRCLE AWARD SMALL POPULATION

PNWS-AWWA 2018 EXCELLENCE IN COMMUNICATIONS

NAGW PINNACLE AWARDS 2018 AWARD WINNER SMALL COUNTY GROUP

3CMA 2019 SAVVY AWARD SMALL POPULATION

IFEA 2019 GOLD: ORG WEB BUDGET $1 MILLION TO $3 MILLION

NAGW PINNACLE AWARDS 2019 PINNACLE AWARD & MEMBERS CHOICE COUNTY SMALL POPULATION GROUP

3CMA 2019 AWARD OF EXCELLENCE SMALL POPULATION

Typical Project Timeline

22 – 28 Weeks

1

Initiate

PROJECT KICKOFF MEETING

Review deliverables, outline process, assign action items

2

Analyze

DESIGN & ARCHITECTURE

Discuss design preferences and vision

3

Site Implementation

IMPLEMENT DESIGN

Design is created, reviewed and approved in JPG format

4

Content Development

DEPARTMENT SPECIFIC MODULES AND CONTENT

Migrate webpages, documents, and files

5

Educate

USER TRAINING

CivicCMS will provide system training to empower users with the skills needed to maintain the website.

6

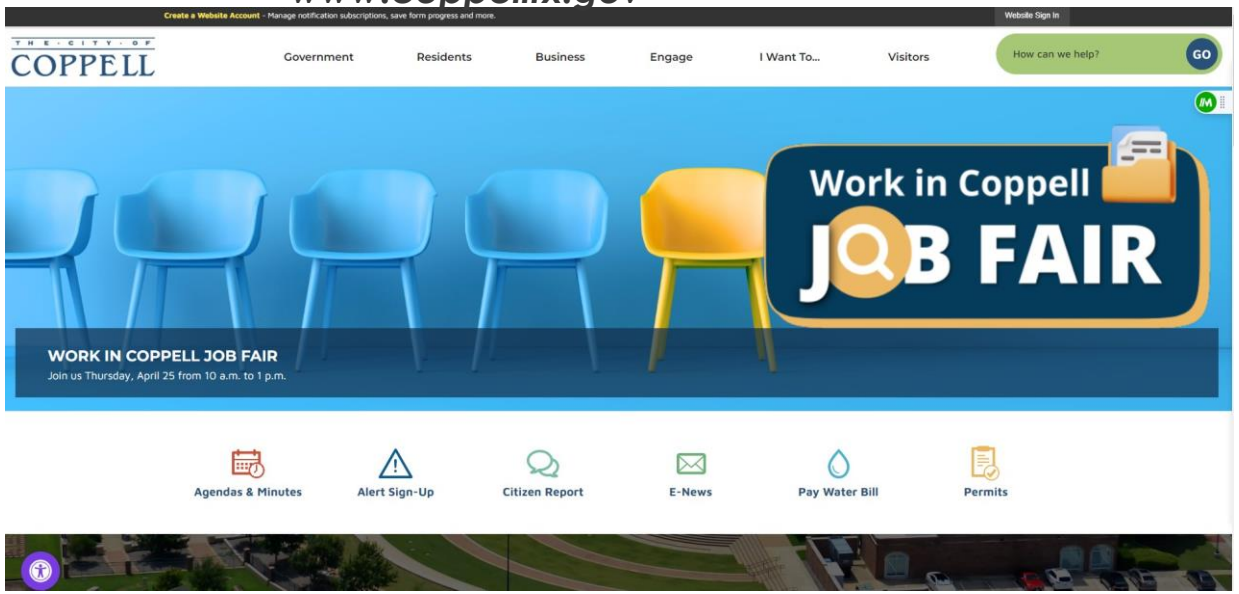
Launch

WEBSITE LAUNCH

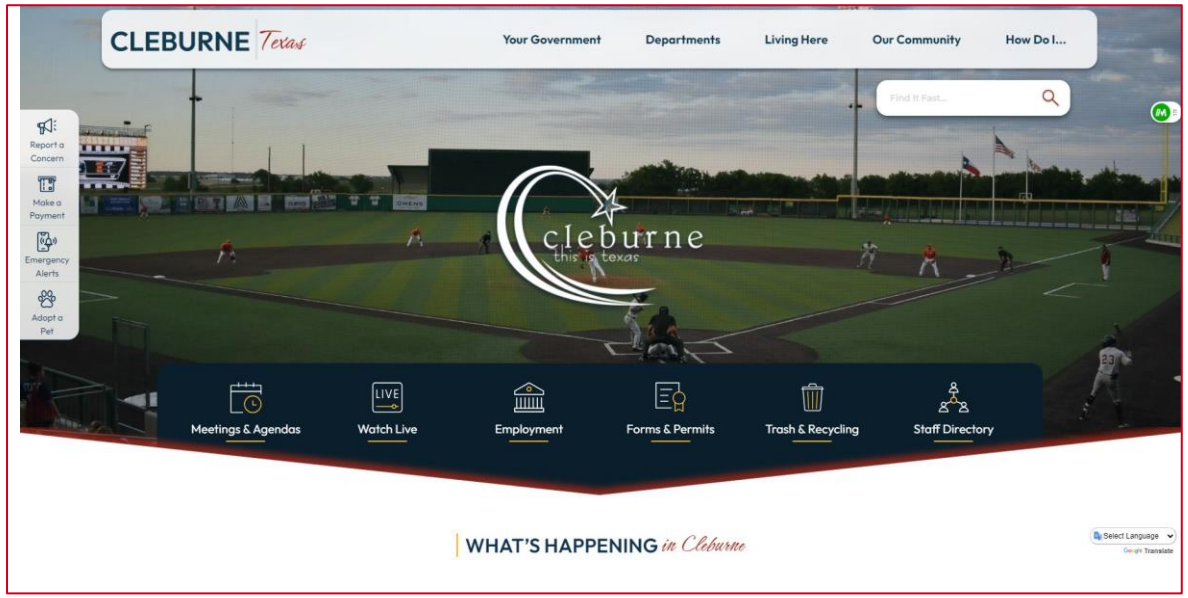
The new website is scheduled to be made available to the pu th live domain name.

Ultimate Design Example (Custom)

www.coppelltx.gov



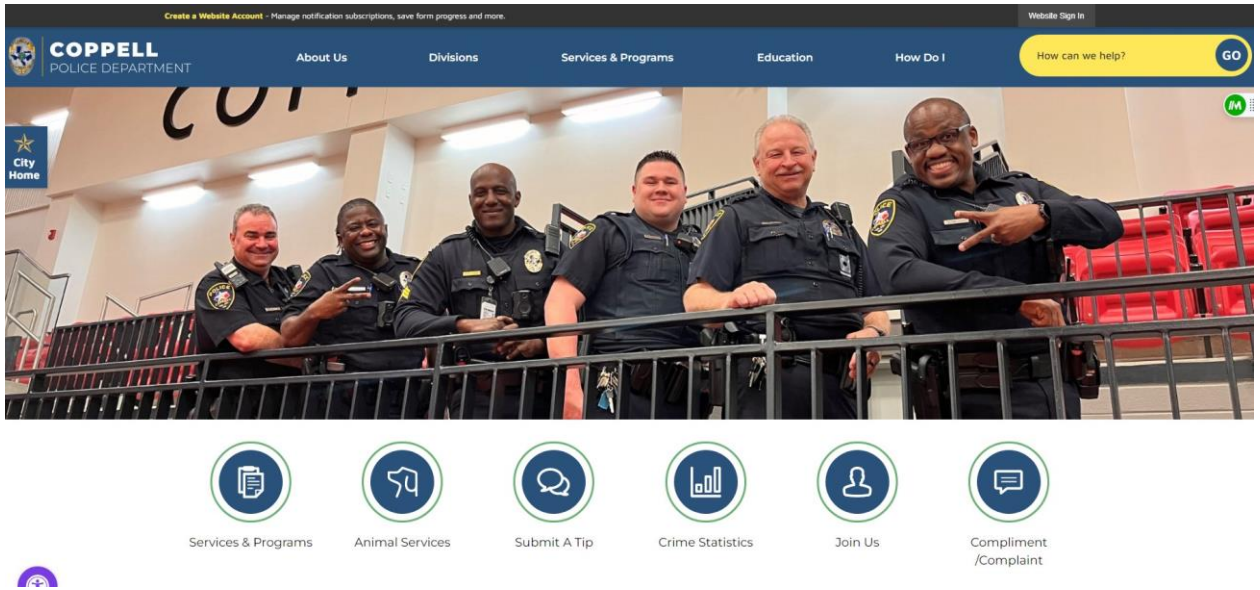
https://www.cleburne.net/



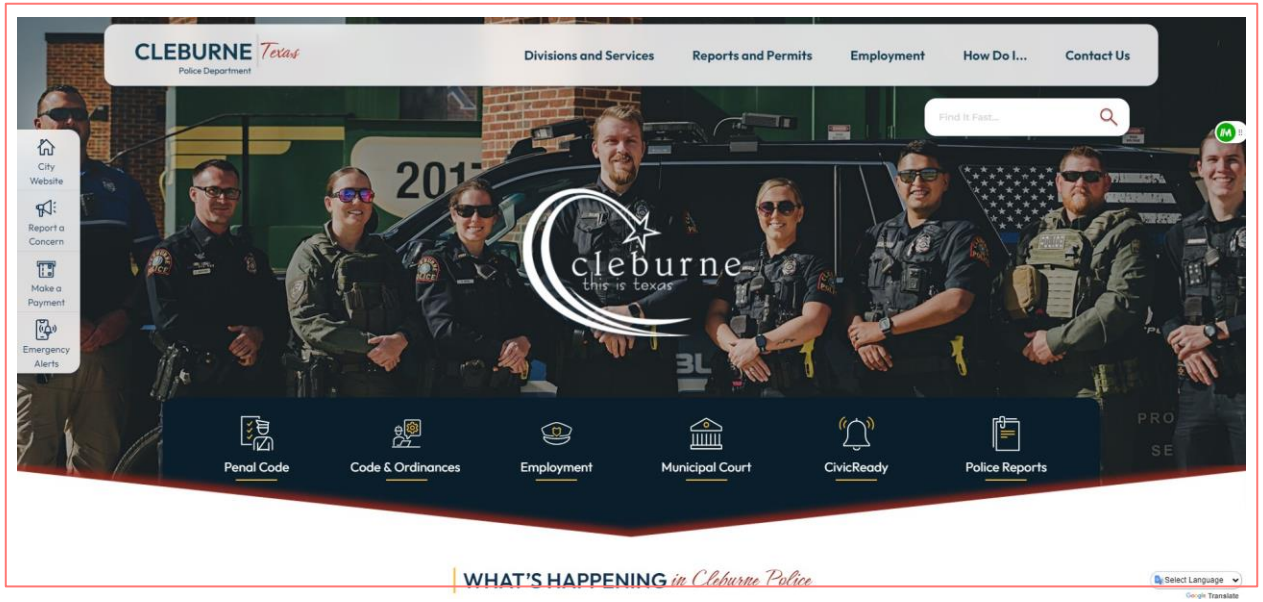
- Ultimate Design Configuration
- Hosting & Security
- 40+ Modules
- 150 Pages of Content Development
- 3 Days of Website Training
- CivicPlus Payment Module
- 4th year Website Redesign
- Police Department Header Package
- Online Helpdesk

Premium Design Example (Custom) Police Department Header Package

www.coppelltxtx.gov/165/Police-Department



https://www.cleburne.net/1494/Police



Ultimate Website Design

One-Time Development: $19,813.75

Annual Subscription: $8,351.25

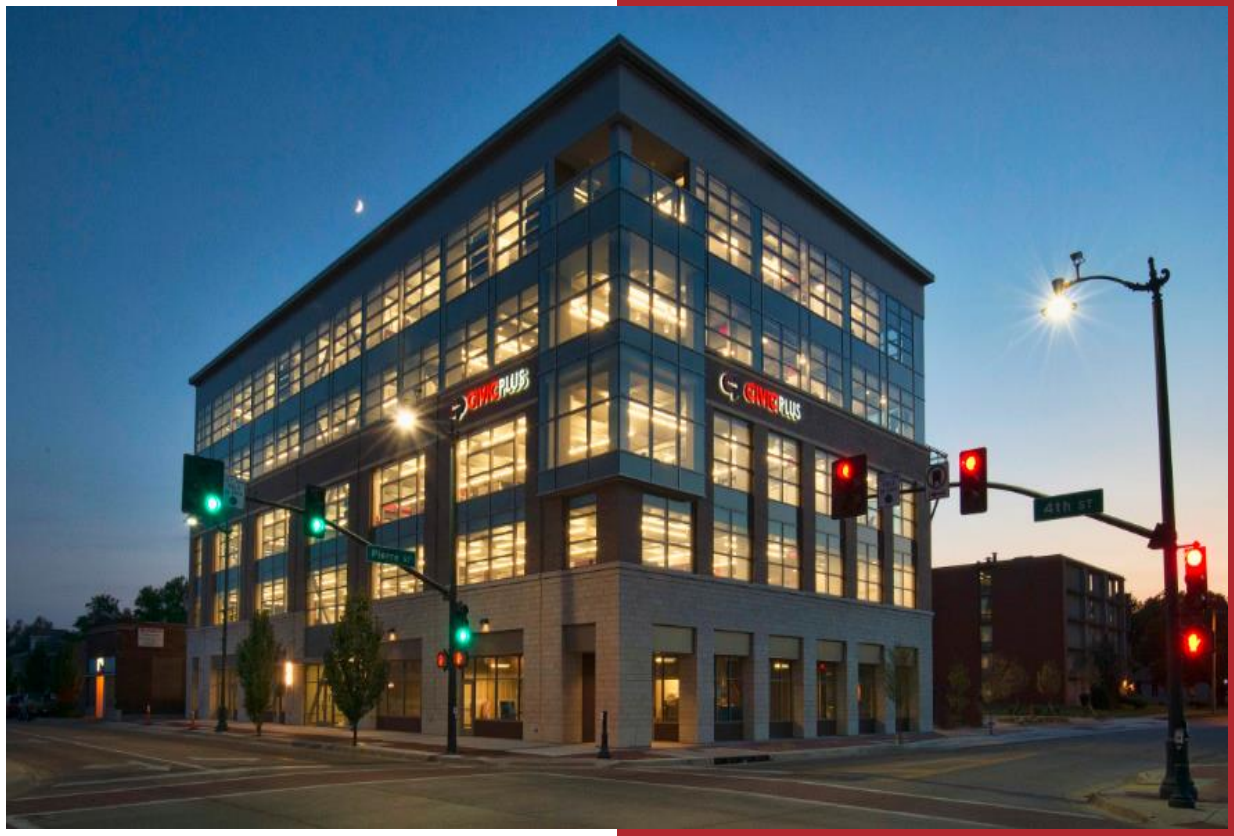
Premium Design
Police Department Header Package

One-Time Development: $4,515

Annual Subscription: $938

First Year Project Savings: - $13,680.75

Thank You



Richard L Jones
Solutions Consultant

785-323-4713

302 South 4th Street, Suite 500
Manhattan, Kansas 66502

www.civicplus.com

WEBSITE SERVICES AGREEMENT

This Website Services Agreement (hereinafter, the "Agreement") is made and entered into as of this _____ day of _____, 20____ (the "Effective Date"), by and between the City of Manor, Texas, a Texas home rule municipality (hereinafter, the "City" or "Client") and CivicPlus, LLC, a Kansas limited liability company (hereinafter the "Consultant" or "CivicPlus"), collectively, the Parties.

That, for and in consideration of the mutual terms, conditions and covenants of this Agreement and the accompanying document set forth therein, the Client and Consultant agree to the following:

I. Project and Employment.

Client agrees to employ Consultant to perform website redesign, hosting, and support services (hereinafter, the "Project"). Specifically, Consultant will provide the Ultimate Design package and Police Department Header Package as described and for the prices stated on the Statement of Work dated June 30, 2024 and attached hereto as **Exhibit A** and incorporated by reference herein (the, "SOW"). Should any term or condition of the SOW conflict with any term or condition in this Agreement, the terms and conditions in this Agreement shall control.

a.

The Parties acknowledge and agree that:

i. The Total Investment for the Initial Term is $32,042.25
ii. Annual Recurring Services : $9,054.75.

Subsequent Hosting and Support Annual Fees for renewal years shall be subject to a 5% annual increase beginning in year 2 of service.

b. Notwithstanding anything to the contrary contained in this Agreement, Client and Consultant agree and acknowledge that Client is entering into this Agreement in reliance on Consultant's special and unique abilities. Consultant accepts the relationship of trust and confidence established between it and Client by this Agreement. Consultant acknowledges that Consultant shall be solely responsible for determining the methods for performing the services and Statement of Work described in Exhibit A. Consultant covenants with Client to use its reasonable best efforts, skill, judgment, and abilities to perform the work required by this Agreement and to further the interests of Client in accordance with Client's requirements, in compliance with applicable federal, state, and local laws, regulations, codes, and orders and with those orders of any other body having jurisdiction. Consultant warrants, represents, covenants, and agrees that all of the work to be performed by Consultant under or pursuant to this Agreement shall be done (i) with the skill and care ordinarily provided by competent professionals practicing under the same or similar circumstances; and (ii) as expeditiously as is prudent.

c. The Consultant will be responsible for supplying all tools, supplies, and equipment necessary for the Consultant to provide the services set forth in this Agreement and in Exhibit A.

d. Client may, from time to time require changes in the scope of services of the Consultant to be performed hereunder. Such changes agreed upon by and between the Client and the Consultant, shall be incorporated in written amendment to this Agreement.

II. Work Product

a. Upon full and complete payment of amounts owed for the Project, Client will own the website graphic designs, webpage or services content, module content, importable/exportable data, and archived information ("Client Content") created by CivicPlus on behalf of Client pursuant to this Agreement. "Client Content" also includes any elements of text, graphics, images, photos, designs, artworks, logos, trademarks, services marks, and other materials or content which Client provides or inputs into any website, software or module in connection with the services. Client Content excludes any content in the public domain and any content owned or licensed by CivicPlus, whether in connection with providing services or otherwise.

b. Upon completion of the project development, Client will assume full responsibility for Client Content maintenance and administration. Client, not CivicPlus, shall have sole responsibility for the accuracy, quality, integrity, legality, reliability, appropriateness, and intellectual property ownership or right to use of all Client Content. Client hereby grants CivicPlus a worldwide, non-exclusive right and license to reproduce, distribute and display the Client Content as necessary to provide the services. Client represents and warrants that Client owns all Client Content or that Client has permission from the rightful owner to use each of the elements of Client Content; and that Client has all rights necessary for CivicPlus to use the Client Content in connection with providing the services.

c. At any time during the term of this Agreement, Client will have the ability to download the Client Content and export the Client data through the services. **Client may request CivicPlus to perform the export of Client data and provide the Client data to Client in a commonly used format at any time, for a fee to be quoted at time of request and approved by Client.** Upon termination for any reason, whether or not Client has retrieved or requested the Client data, CivicPlus reserves the right to permanently and definitively delete the Client Content and Client data held in the Services thirty (30) days following termination. During the thirty (30) day period following termination, regardless of the reason for its termination, Client will not have access to the services.

d. Intellectual Property in the software or other original works created by or licensed to CivicPlus, including all source code, documents, and materials used in the services ("CivicPlus Property") will remain the property of CivicPlus. CivicPlus Property specifically excludes Client Content. Client shall not:

(i) license, sublicense, sell, resell, reproduce, transfer, assign, distribute or otherwise commercially exploit or make available to any third party any CivicPlus Property in any way, except as specifically provided in the applicable SOW;

(ii) adapt, alter, modify or make derivative works based upon any CivicPlus Property;

(iii) create internet "links" to the CivicPlus Property software or "frame" or "mirror" any CivicPlus Property administrative access on any other server or

wireless or internet-based device that may allow third party entities, other than Client, to use the services;

(iv) reverse engineer, decompile, disassemble or otherwise attempt to obtain the source code to all or any portion of the services; or

(v) access any CivicPlus Property in order to:

(1) build a competitive product or service,

(2) build a product using similar ideas, features, functions or graphics of any CivicPlus Property, or

(3) copy any ideas, features, functions or graphics of any CivicPlus Property.

The CivicPlus name, the CivicPlus logo, and the product and module names associated with any CivicPlus Property are trademarks of CivicPlus, and no right or license is granted to use them outside of the licenses set forth in this Agreement.

e. Provided Client complies with the terms and conditions herein, and license restrictions set forth in this section, CivicPlus hereby grants Client a limited, nontransferable, nonexclusive, license to access and use the CivicPlus Property associated with this Agreement for the term of this Agreement.

III. Term of Agreement and Payment

a. This Agreement will begin on the Effective Date and shall remain in effect for a period of 12 months. This Agreement shall renew automatically, for an addition 12 month period ("Renewal Term") upon the expiration of the initial term unless terminated by either Party with thirty (30) days' advance written notice before the end of the current term.

b. The Consultant will perform the tasks described in the scope of work as described in Exhibit A. In performing the services under this Agreement, the Consultant is acting as an independent contractor. No term or provision herein will be construed as making the Consultant the agent, servant, or employee of the Client or as creating a partnership or joint venture relationship between the Client and the Consultant.

c. The cost of the first year of the Project will not exceed $32,042.25, unless additional services are obtained through written amendment to this Agreement signed by both Parties. The Client shall be invoiced for the Total Investment – Year 1 fees upon signing and submission of this agreement. Subsequent annual fees shall be invoiced on the start date of the Renewal Term, and shall be subject to a 5% annual increase beginning in year 2 of service. Invoices will be payable in accordance with the provisions of the Texas Prompt Payment Act, Government Code Chapter 2252.

d. Any additional professional services or other expenses must be approved by the Client and those amounts amended to this Agreement.

e. The Consultant will begin work on the Project on the Effective Date or on a date acceptable to the parties.

IV. Termination

a. Client may terminate this Agreement for convenience upon thirty (30) days advance written notice to Consultant prior to the end of the current term.

b. This Agreement may be terminated by either Party upon thirty (30) days written notice to the other Party in the event that the Project is abandoned or indefinitely postponed in which event, Consultant shall be compensated for all services performed to termination date.

c. Client may terminate the whole or any part of this Agreement for cause in the following circumstances:

(i). If Consultant fails to perform services by the agreed upon time or any extension thereof granted by Client in writing;

(ii) If Consultant materially breaches any of the terms or conditions set forth in this Agreement or fails to perform any of the other provisions of this Agreement or so fails to make progress as to endanger performance of this Agreement in accordance with its terms, and in any of these circumstances does not cure such breach or failure to Client's reasonable satisfaction within a period of thirty (30) calendar days after receipt of notice from Client specifying such breach or failure.

d. Upon termination of this Agreement, Client shall compensate Consultant for those services which were provided under this Agreement prior to its termination and which have not been previously invoiced to Client. Consultant's final invoice for said services will be presented to Client in the same manner set forth in Section 2 above.

e. If Client terminates this Agreement as provided in this Section, no fees of any type, other than fees due and payable at the Termination Date, shall thereafter be paid to Consultant.

f. If Client terminates this agreement for cause, Client shall be entitled a pro-rated refund of any pre-paid fees covering the remainder of the term after the date of termination.

V. Insurance.

a. Prior to commencement of the services, Consultant shall furnish Client with properly executed certificates of insurance which shall evidence all insurance required and provide that such insurance shall not be canceled, except on 30 days' prior written notice to Client. Consultant shall provide certified copies of insurance endorsements and/or policies if requested by Client. Consultant shall maintain such insurance coverage from the time services commence until services are completed and provide replacement certificates, policies and/or endorsements for any such insurance expiring prior to completion of services. Consultant shall obtain such insurance written on an Occurrence form from such companies licensed or approved to transact business in the State of Texas, and shall obtain such insurance of the following types and minimum limits:

(i) Workers' Compensation in accordance with the laws of the State of Texas. Substitutes to genuine Workers' Compensation Insurance are not allowed.

(ii) Employers' Liability insurance with limits of not less than $1,000,000 per injury by accident.

(iii) Commercial general liability insurance with a limit of not less than $1,000,000 each occurrence and $2,000,000 in the annual aggregate. Policy shall cover liability for bodily injury, personal injury, and property damage and products/completed operations arising out of the business operations of the policyholder.

(iv) Business Automobile Liability coverage applying to owned, non-owned and hired automobiles with limits not less than $1,000,000 each occurrence combined single limit for Bodily Injury and Property Damage combined.

(v) Cyber Liability insurance for errors and omissions with a limit of not less than $1,000,000 each occurrence and $1,000,000 in the annual aggregate.

b. Client shall be named as additional insured to all required coverage except for Workers' Compensation and Cyber Liability (if required). All Liability policies written on behalf of Consultant shall contain a waiver of subrogation in favor of Client.

c. If required coverage is written on a claims-made basis, Consultant warrants that any retroactive date applicable to coverage under the policy precedes the effective date of the Contract.

d. Consultant shall not commence any portion of the work under this Contract until it has obtained the insurance required herein and certificates of such insurance have been filed with and approved by Client.

e. No cancellation of or changes to the certificates, or the policies, may be made without thirty (30) days prior, written notification to Client.

f. Approval of the insurance by Client shall not relieve or decrease the liability of Consultant.

VI. Responsibilities and Liability

a. CivicPlus will not be liable for any act, omission of act, negligence or defect in the quality of service of any underlying carrier, licensor or other third-party service provider whose facilities or services are used in furnishing any portion of the service received by the Client.

b. CivicPlus will not be liable for any failure of performance that is caused by or the result of any act or omission by Client or any entity employed/contracted on the Client's behalf. During project development, Client will be responsive and cooperative with CivicPlus to ensure the project development is completed in a timely manner.

c. CivicPlus will not be liable for any failure of performance that is caused by or the result of any act or omission by Client or any entity employed/contracted on the Client's behalf. During Project Development, Client will be responsive and cooperative with CivicPlus to ensure the Project Development is completed in a timely manner.

d. Client agrees that it is solely responsible for any solicitation, collection, storage, or other use of end-user's personal data on any service provided by CivicPlus. Client further agrees that CivicPlus has no responsibility for the use or storage of end-users' personal data in connection with the services or the consequences of the solicitation, collection, storage, or other use by Client or by any third party of personal data.

e. CivicPlus shall, at all times, comply with the terms and conditions of its Privacy Policy (the "Privacy Policy" found at https://www.civicplus.com/privacy-policy"). CivicPlus will maintain commercially reasonable administrative, physical, and technical safeguards designed to protect the security and confidentiality of Client data. Except (a) in order to provide the services; (b) to prevent or address service or technical problems in connection

with support matters; (c) as expressly permitted in writing by Client; or (d) in compliance with our Privacy Policy, CivicPlus will not modify Client data or disclose Client data, unless specifically directed by Client or compelled by law. Notwithstanding the foregoing, CivicPlus reserves the right to delete known malicious accounts without Client authorization. CivicPlus' liability arising out of or related to this Agreement will not exceed the Annual Recurring Services amounts paid by Client in the year prior to such claim of liability.

f. CivicPlus warrants that the services will perform substantially in accordance with documentation and marketing proposals, and free of any material defect. CivicPlus warrants to the Client that, upon notice given to CivicPlus of any defect in design or fault or improper workmanship, CivicPlus will remedy any such defect. CivicPlus makes no warranty regarding, and will have no responsibility for, any claim arising out of: (i) a modification of the Services made by anyone other than CivicPlus, even in a situation where CivicPlus approves of such modification in writing; or (ii) use of the Services in combination with a third party service, web hosting service, or server not authorized by CivicPlus.

g. CivicPlus agrees that it is an agent of a governmental entity as defined by the Texas Open Records Act, Texas Government Code Chapter 552, and will comply with all applicable standards and obligations of this Act.

VII. Statutory Verifications.

a. To the extent this Agreement constitutes a contract for goods or services within the meaning of Section 2271.002 of the Texas Government Code, as amended, solely for purposes of compliance with Chapter 2270 of the Texas Government Code, and subject to applicable Federal law, the Consultant represents that neither the Consultant nor any wholly owned subsidiary, majority-owned subsidiary, parent company or affiliate of Consultant (i) boycotts Israel or (ii) will boycott Israel through the term of this Agreement. The terms "boycotts Israel" and "boycott Israel" as used in this paragraph have the meanings assigned to the term "boycott Israel" in Section 808.001 of the Texas Government Code, as amended.

b. To the extent the Agreement constitutes a governmental contract within the meaning of Section 2252.151 of the Texas Governmental Code, as amended, solely for the purposes of compliance with Chapter 2252 of the Texas Governmental Code, and except to the extent otherwise required by applicable federal law, Consultant represents that the Consultant nor any wholly owned subsidiary, majority-owned subsidiary, parent company or affiliate of Consultant is a company listed by the Texas Comptroller Public Accounts under Sections 2270.0201, or 2252.153 of the Texas Government Code.

c. The Consultant hereby verifies that it and its parent company, wholly or majority-owned subsidiaries, and other affiliates, if any, do not boycott energy companies and will not boycott energy companies during the term of this Agreement. The foregoing verification is made solely to comply with Section 2274.002, Texas Government Code, and to the extent such section is not inconsistent, to comply with a governmental entity's constitutional or statutory duties related to the issuance, incurrence, or management of debt obligations or the deposit, custody, management, borrowing or investment of funds. As used in the foregoing verification, "boycott energy company" means, without an ordinary business purpose, refusing to deal with, terminating business activities with, or otherwise

taking any action that is intended to penalize, inflict economic harm, or limit commercial relations with a company because the company: (A) engages in the exploration, production, utilization, transportation, sale, or manufacturing of fossil-based energy and does not commit or pledge to meet environmental standards beyond federal and state law: or (B) does business with a company described as by the preceding statement in (A).

d. The Consultant hereby verifies that it and its parent company, wholly- or majority-owned subsidiaries, and other affiliates, if any, do not have a practice, policy, guidance, or directive that discriminates against a firearm entity or firearm trade association and will not have a practice, policy, guidance, or directive that discriminates against a firearm entity or firearm trade association during the term of this Agreement. The foregoing verification is made solely to comply with Section 2274.002, Texas Government Code. As used in the foregoing verification, "discriminate against a firearm entity or firearm trade association" means: (i) refuse to engage in the trade of any goods or services with the entity or association based solely on its status as a firearm entity or firearm trade association; (ii) refrain from continuing an existing business relationship with the entity or association based solely on its status as a firearm entity or firearm trade association; or (iii) terminate an existing business relationship with the entity or association based solely on its status as a firearm entity or firearm trade association; but does not include (a) the established policies of a merchant, retail seller, or platform that restrict or prohibit the listing or selling of ammunition, firearms, or firearm accessories; or (b) a company's refusal to engage in the trade of any goods or services, decision to refrain from continuing an existing business relationship, or decision to terminate an existing business relationship to comply with federal, state, or local law, policy, or regulations or a directive by a regulatory agency; or for any traditional business reason that is specific to the customer or potential customer and not based solely on an entity's or association's status as a firearm entity or firearm trade association.

e. Form 1295. Texas law and the Client requires that business entities, as defined in Texas Government Code, Section 2252.908, who contract with the Client complete the on-line Form 1295 "Certificate of Interested Parties" as promulgated by the Texas Ethics Commission (https://www.ethics.state.tx.us/filinginfo/1295/). Form 1295 is also required for any and all contract amendments, extensions or renewals. Prior to any payment to Consultant hereunder, Consultant shall provide proof of submission to the City Secretary that the appropriate Form 1295 documentation has been submitted.

VIII. General Provisions

a. Choice of Law. It is contemplated that this Agreement shall be performed in Travis County, Texas, and the venue and jurisdiction of any suit, right, or cause of action arising out of or in connection with this Agreement shall lie exclusively in Travis County, Texas. This Agreement shall be governed by and construed in accordance with the laws of the State of Texas.

b. **Indemnification. Consultant hereby expressly agrees to indemnify, protect and hold harmless the Client, its officials and employees and its agents and agents' employees, from and against all third party claims, suits, demands, costs, causes of action, loss, damage and liability of every kind and nature, including reasonable attorney's fees, costs and expenses (including, but not limited to expenses related to expert witnesses) of any kind whatsoever, to the extent that is caused by or results from any act of negligence, intentional tort, intellectual property infringement, failure to pay a**

subprofessional, or supplier, error or omission of Consultant or any of its subconsultants and/or subcontractors in connection with the performance of services under this Agreement, or failure to pay a subcontractor or supplier committed by Consultant or Consultant's agent, subconsultant under contract, or another entity over which Consultant exercises control; provided, however, Consultant shall not be responsible for the negligence of any other party, other than its subconsultants and/or subcontractors. The Consultant's obligations under this section shall not be limited to the limits of coverage of insurance maintained or required to be maintained under this Agreement. This Section (Indemnification) shall survive termination and/or completion of this Agreement.

c. Notices. Any and all notices under this Agreement shall be in writing and shall be delivered to the party entitled to receive the same by electronic mail, national courier services or U.S. Certified Mail, return receipt requested, addressed as follows (or as amended in writing in the future), or by other commercially reasonable means.

Notice to Client:	Notice to Consultant:
City of Manor Attn: Scott Moore 105 E. Eggleston St. Manor, TX 78653	CivicPlus, LLC Attn: Legal Department 302 S. 4th St. Ste. 500 Manhattan, KS 66502
With a copy to : The Knight Law Firm, LLP Attn: Paige Saenz 223 West Anderson Lane, Suite A-105 Austin, Texas 78752	With a copy to: _____ _____

d. Successors and Assigns. This Agreement shall be binding upon and inure to the benefit of the Client and Consultant and their respective successors, executors, administrators, and assigns. Neither the Client nor Consultant may assign, sublet, or transfer the parties' interest in or obligations under this Agreement without prior written consent of the other party hereto. Notwithstanding the foregoing, CivicPlus may assign and transfer all of its rights under this Agreement by a sale of all of its assets or merger. However, within 10 days of such asset sale or merger, CivicPlus shall notify the City of the transaction.

e. Compliance with Laws. Consultant shall comply with all applicable federal, state, and local laws, statutes, ordinances, rules and regulations, and the orders and decrees of any courts or administrative bodies or tribunals in any matter affecting the performance of this Agreement, including, without limitation, Workers' Compensation laws, minimum and maximum salary and wage statutes and regulations, licensing laws and regulations. When required, Consultant shall furnish the Client with certification of compliance with said laws, statutes, ordinances, rules, regulations, orders, and decrees above specified.

f. This Agreement and exhibits represent the entire and integrated Agreement between the Client and Consultant and supersedes all prior negotiations, representations, or agreements, either oral or written. This Agreement may be amended only by written instrument signed by both the Client and Consultant. NO OFFICIAL, EMPLOYEE, AGENT, OR REPRESENTATIVE OF CLIENT HAS ANY AUTHORITY, EITHER EXPRESS OR

IMPLIED, TO AMEND THIS CONTRACT, EXCEPT PURSUANT TO SUCH EXPRESS AUTHORITY AS MAY BE GRANTED BY THE CLIENT's GOVERNING BODY, THE MANOR CITY COUNCIL.

g. Entity Status. By the signature below, Consultant certifies that it is a Kansas limited liability corporation duly authorized to transact and do business in the State of Texas, and the individual executing this agreement on behalf of the Consultant is vested with the authority to bind the Consultant to this Agreement.

h. No failure or delay in exercising any right or remedy or requiring the satisfaction of any condition under this Agreement, and no course of dealing between the parties, operates as a waiver or estoppel of any right, remedy, or condition.

i. The rights and remedies of the parties set forth in this Agreement are not exclusive of, but are cumulative to, any rights or remedies now or subsequently existing at law, in equity, or by statute.

j. Counterparts. This Agreement may be executed in any number of counterparts, including, without limitation, facsimile counterparts, with the same effect as if the parties had signed the same document, and all counterparts will constitute one and the same agreement.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the Parties hereto hereby execute this Agreement as of the Effective Date.

CITY OF MANOR,
a Texas municipal corporation

By: _____
Dr. Christopher Harvey, Mayor

Attest:

By: _____
Lluvia T. Almaraz, City Secretary

CIVICPLUS, LLC:
a Kansas limited liability company

By: _____

Name: Amy Vikander

Title: Senior VP of Customer Success

EXHIBIT A

CivicPlus Master Services Agreement

and

Statement of Work
(06/30/2024)

CivicPlus Master Services Agreement

This Master Services Agreement (this "Agreement") governs all Statements of Work ("SOW") entered into by and between CivicPlus, LLC ("CivicPlus") and the customer entity identified on the SOW ("Customer"). This Agreement governs the use and provision of any Services purchased by Customer, as described in any signed SOW, and the effective date of this Agreement shall commence on the date of signature of the SOW ("Effective Date"). If a SOW has not been executed, then the Effective Date shall be determined as the start date of implementation of any software solution by CivicPlus for Customer. CivicPlus and Customer referred to herein individually as "Party" and jointly as "Parties".

Recitals

I. WHEREAS, CivicPlus is engaged in the business of developing and providing access to proprietary community engagement and government content, workflow, and general management software solutions, platforms and associated services (the "Services"); and

II. WHEREAS, Customer wishes to engage CivicPlus for the procurement of the Services and/or receive a license subscription for the ongoing use of the Services, as set forth in the SOW;

NOW, THEREFORE, Customer and CivicPlus agree as follows:

Agreement

Term & Termination

1. This Agreement shall commence on the Effective Date and shall remain in full force and effect for as long as any SOW is in effect between CivicPlus and Customer, or Services are being provided by CivicPlus to Customer, unless terminated in accordance with this §1 or as otherwise provided in this Agreement (the "Term"). Either Party may terminate this Agreement or any SOW as set forth in such SOW, or at its discretion, effective immediately upon written notice to the other Party, if the other Party materially breaches any provision of this Agreement and does not substantially cure the breach within thirty (30) days after receiving notice of such breach. A delinquent Customer account remaining past due for longer than 90 days is a material breach by Customer and is grounds for CivicPlus termination. CivicPlus reserves the right to withhold, remove and/or discard Customer Data without notice for any breach, including, without limitation, Customer's non-payment. Upon termination for Customer's breach, Customer's right to access or use Customer Data immediately ceases, and CivicPlus shall have no obligation to maintain or forward any Customer Data.

2. Upon termination of this Agreement or any SOW for any reason, (a) the licenses granted for such relevant SOW by §11 below will terminate and Customer shall cease all use of the CivicPlus Property and Services associated with the terminated SOW and (b) any amounts owed to CivicPlus for work performed prior to termination shall immediately become due in full and payable. If Customer has paid in advance for the Services, and this Agreement terminates due to material breach of this Agreement by CivicPlus, CivicPlus shall refund Customer a prorated amount of any amount already paid. Upon termination by Customer for convenience or due to material breach by Customer, in addition to any remedy

provided in this Agreement or provided in law or equity, CivicPlus shall be entitled to retain any amounts already paid. Sections 7, 8, 10, 14, 15, 18, 32 -34, 40, and 42 will survive any expiration or termination of this Agreement.

3. At any time during the Term, CivicPlus may, immediately upon notice to Customer, suspend Customer and any of its Users access to any Service due to a threat to the technical security or technical integrity of the Services.

Invoicing & Payment Terms

4. Customer will pay the amounts owed to CivicPlus for the development and implementation of the Customer's Services, as defined in the SOW ("Project Development"), subscription and licensing, and annual hosting, support and maintenance services ("Annual Recurring Services") in accordance with the payment schedule set forth on the applicable SOW. Invoices shall be sent electronically to the individual/entity designated in the SOW's contact sheet that is required to be filled out and submitted by Customer (the "Contact Sheet"). Customer shall provide accurate, current and complete information of Customer's legal business name, address, email address, and phone number in the Contact Sheet upon submission of a signed SOW. Customer will maintain and promptly update the Contact Sheet information if it should change. Upon Customer's request, CivicPlus will mail hard-copy invoices for a $5.00 convenience fee to be added to the mailed invoice.

5. Each SOW will state the amount of days from date of invoice payment is due. Unless otherwise limited by law, a finance charge of 1.5 percent (%) per month or the maximum rate permitted by applicable law, whichever is less, will be added to past due accounts from due date until paid. Payments received will be applied first to finance charges, then to the oldest outstanding invoice(s). If the Customer's account exceeds 60 days past due, support will be discontinued until the Customer's account is made current. If the Customer's account exceeds 90 days past due, CivicPlus may suspend in progress Project Development and Annual Recurring Services will be discontinued, and the Customer will no longer have access to the Services until the Customer's account is made current. Customer will be given 15 days' notice prior to discontinuation of Services for non-payment.

6. During the performance of Project Development, if Customer requests a change that requires repeated efforts to previously approved work product and such change causes CivicPlus to incur additional expenses (i.e. airline change fees, resource hours, consultant fees, Customer does not show up for scheduled meetings or trainings), Customer agrees to reimburse CivicPlus for such additional expenses. CivicPlus shall notify Customer prior to incurring such expenses and shall only incur those expenses which are approved by Customer.

Ownership & Content Responsibility

7. Upon full and complete payment of amounts owed for Project Development under the applicable SOW, Customer will own any website graphic designs, Services content, module content, importable/exportable data, and archived information ("Customer Content") created by CivicPlus on behalf of Customer pursuant to this Agreement. "Customer Content" also includes, without limitation, any elements of text, graphics, images, photos, audio, video, designs, artworks, logos, trademarks, services marks, and other materials or content which Customer provides to CivicPlus for processing, transmission, storage, or inputs into any website, software or module in connection with any Services. Customer Content excludes any content in the public domain and any content owned or licensed by CivicPlus, whether in connection with providing Services or otherwise.

8. Upon completion of the Project Development, Customer will take over the management and control of the Services and Customer will assume full responsibility for Customer Content maintenance and administration. Customer, not CivicPlus, shall have sole responsibility for the accuracy, quality, integrity, legality, reliability, appropriateness, and

intellectual property ownership or right to use of all Customer Content. Customer hereby grants CivicPlus a worldwide, non-exclusive right and license to reproduce, distribute and display the Customer Content as necessary to provide the Services. Customer represents and warrants that Customer owns all Customer Content or that Customer has permission from the rightful owner to use each of the elements of Customer Content and that Customer has all rights necessary for CivicPlus to use the Customer Content in connection with providing the Services. Customer agrees that CivicPlus shall not be responsible or liable for the content of messages created by Customer or by Customer's Users or end-users who access Service. Notwithstanding the foregoing, CivicPlus retains the right, but not the obligation, to remove any Customer Content that is libelous, harassing, abusive, fraudulent, defamatory, excessively profane, obscene, abusive, hate related, violent, harmful to minors, that advocates racial or ethnic intolerance, intended to advocate or advance computer hacking or cracking, or other material, products or services that violate or encourage conduct that would violate any laws or third-party rights.

9. At any time during the term of the applicable SOW, Customer will have the ability to download the Customer Content and export the data that is processed through the Services ("Customer Data"). Customer may request CivicPlus to perform the export of Customer Data and provide the Customer Data to Customer in a commonly used format, at any time, for a fee to be quoted at time of request and approved by Customer. Upon termination of the applicable SOW for any reason, whether or not Customer has retrieved or requested the Customer Data, CivicPlus reserves the right to permanently and definitively delete the Customer Content and Customer Data held in the Services thirty (30) days following termination of the applicable SOW. During the thirty (30) day period following termination of the SOW, regardless of the reason for its termination, Customer will not have access to the Services.

10. Intellectual Property in the software or other original works created by or licensed to CivicPlus, including all software source code, documents, and materials used in performing the Services ("CivicPlus Property") will remain the property of CivicPlus. CivicPlus Property specifically excludes Customer Content. Customer shall not (i) license, sublicense, sell, resell, reproduce, transfer, assign, distribute or otherwise commercially exploit or make available to any third party any CivicPlus Property in any way, except as specifically provided in the applicable SOW; (ii) adapt, alter, modify or make derivative works based upon any CivicPlus Property; (iii) create internet "links" to the CivicPlus Property software or "frame" or "mirror" any CivicPlus Property administrative access on any other server or wireless or internet-based device that may allow third party entities, other than Customer, to use the Services; (iv) reverse engineer, decompile, disassemble or otherwise attempt to obtain the software source code to all or any portion of the Services; (v) make any attempt to gain unauthorized access to the Services and/or any of CivicPlus' systems or networks; or (vi) access any CivicPlus Property in order to: (a) build a competitive product or service, (b) build a product using similar ideas, features, functions or graphics of any CivicPlus Property, or (c) copy any ideas, features, functions or graphics of any CivicPlus Property. The CivicPlus name, the CivicPlus logo, and the product and module names associated with any CivicPlus Property are trademarks of CivicPlus, and no right or license is granted to use them outside of the licenses set forth in this Agreement.

11. Provided Customer complies with the terms and conditions herein, the relevant SOW, and license restrictions set forth in §10, CivicPlus hereby grants Customer a limited, nontransferable, nonexclusive, non-assignable license to access and use the CivicPlus Property associated with any valid and effective SOW, for the term of the respective SOW. The license set forth herein, shall only apply to the extent that Customer is using the Services for legitimate business use as intended by the purpose of the Services and not for the purpose of comparing the Services to a competitor or similar product of CivicPlus. Customer hereby warrants and affirms its purpose in accessing or otherwise using the Services is for their intended purpose only and understands and agrees that any other use shall be considered fraud.

12. All CivicPlus helpful information and user's guides for the Services ("Documentation") are maintained and updated electronically by CivicPlus and can be accessed through the CivicPlus "Help Center". CivicPlus does not provide paper copies of its Documentation. Customer and its Users are granted a limited license to access Documentation as needed. Customer shall not copy, download, distribute, or make derivatives of the Documentation.

13. Customer acknowledges that CivicPlus may continually develop, alter, deliver, and provide to the Customer ongoing

innovation to the Services, in the form of new features and functionalities. CivicPlus reserves the right to modify the Services from time to time. Any modifications or improvements to the Services listed on the SOW will be provided to the Customer at no additional charge. In the event that CivicPlus creates new products or significant enhancements to the Services ("New Services"), and Customer desires these New Services, then Customer will have to pay CivicPlus the appropriate fee for the access to and use of the New Services. CivicPlus shall use its reasonable best efforts to provide workarounds in the event any modification to the Services causes Customer to lose substantial functionality of the Services.

14. CivicPlus in its sole discretion, may utilize all comments and suggestions, whether written or oral, furnished by Customer to CivicPlus in connection with its access to and use of the Services (all reports, comments and suggestions provided by Customer hereunder constitute, collectively, the "Feedback"). Customer hereby grants to CivicPlus a worldwide, non-exclusive, irrevocable, perpetual, royalty-free right and license to incorporate the Feedback in the CivicPlus products and services.

Indemnification

15. CivicPlus will defend at its expense or settle any third-party claim against Customer alleging that the Services provided under this Agreement infringe intellectual property rights. CivicPlus will pay infringement claim defense costs, CivicPlus–negotiated settlement amounts, and damages finally awarded by a court. CivicPlus has no obligation for any claim of infringement arising from Customer's use of the Services for purposes not contemplated by this Agreement. CivicPlus's indemnification obligations under this Section 15 are conditioned upon the Customer (i) promptly notifying the CivicPlus of any claim in writing; (ii) cooperating with CivicPlus in the defense of the claim; and (iii) granting CivicPlus sole control of the defense or settlement of the claim. The indemnification obligations of CivicPlus herein shall not apply to any claims of intellectual property infringement related to Customer Content.

Responsibilities of the Parties

16. CivicPlus will not be liable for any act, omission of act, negligence or defect in the quality of service of any underlying carrier, licensor or other third-party service provider whose facilities or services are used in furnishing any portion of the Service received by the Customer.

17. CivicPlus will not be liable for any failure of performance that is caused by or the result of any act or omission by Customer or any entity employed/contracted on the Customer's behalf. During Project Development, Customer will be responsive and cooperative with CivicPlus to ensure the Project Development is completed in a timely manner.

18. Customer agrees that it is solely responsible for the end-user's personal data that Customer decides to solicit, collect, store, or otherwise use in connection with any Service provided by CivicPlus. Customer understands and agrees that CivicPlus provides certain solutions with increased security measures for the solicitation and storage of any sensitive data, and it is Customer's responsibility to determine whether the data it solicits and collects should be stored in such solutions. Customer understands and agrees that CivicPlus does not have knowledge or control over what type of data Customer solicits therefore CivicPlus has no responsibility for the use or storage of end-users' personal data in connection with the Services or the consequences of the solicitation, collection, storage, or other use by Customer or by any third party of any personal data. Customer has the sole control and responsibility over the determination of which data and information shall be included in the content that is to be transmitted and stored by CivicPlus. Customer shall not provide to CivicPlus or allow to be provided to CivicPlus any content that (a) infringes or violates any 3rd party's intellectual property rights, rights of publicity or rights of privacy, (b) contains any defamatory material, or (c) violates any federal, state, local, or foreign laws, regulations, or statutes.

19. Customer is responsible for all activity that occurs under Customer's accounts by or on behalf of Customer. Customer agrees to (a) be solely responsible for all designated and authorized individuals chosen by Customer ("User") activity, which must be in accordance with this Agreement and the CivicPlus Terms of Use; (b) be solely responsible for Customer Data; (c) obtain and maintain during the term all necessary consents, agreements and approvals from end-users, individuals or any other third parties for all actual or intended uses of information, data or other content Customer will use in connection with the Services; (d) use commercially reasonable efforts to prevent unauthorized access to, or use of, any User's log-in information and the Services, and notify CivicPlus promptly of any known unauthorized access or use of the foregoing; (e) use commercially reasonable efforts to prevent unauthorized access to or use of the Services and CivicPlus Property and shall promptly notify CivicPlus of any unauthorized access or use of the Services and/or CivicPlus Property and any loss or theft or unauthorized use of any n User's password or username and/or personal information; and (f) use the Services only in accordance with applicable laws and regulations.

20. The Parties shall comply with all applicable local, state, and federal laws, treaties, regulations, and conventions in connection with its use and provision of any of the Services or CivicPlus Property.

21. CivicPlus shall not be responsible for any act or omission of any third-party vendor or service provider that Customer has selected to integrate any of its Services with.

22. Customer understands that CivicPlus must fastidiously allocate resources across all of its customers and specifically reserves necessary resources for Customer's Project Development. If any professional services, such as consulting or training, purchased by Customer are not used during the Project Development phase solely due to the inaction or unresponsiveness of Customer, then these services shall expire 30 days after completion of Project Development. The Customer may re-schedule any unused professional services during this 30-day period as mutually agreed upon by the Parties. Any professional services that have not been used or rescheduled shall be marked as complete and closed upon the expiration of the 30-day period.

Data Security

23. CivicPlus shall, at all times, comply with the terms and conditions of its Privacy Policy. CivicPlus will maintain commercially reasonable administrative, physical, and technical safeguards designed to protect the security and confidentiality of Customer Data. CivicPlus will not modify Customer Data or disclose Customer Data, except (a) in order to provide the Services; (b) to prevent or address service or technical problems in connection with support matters; (c) as specifically directed or expressly permitted in writing by Customer, (d) in compliance with our Privacy Policy; or (f) if compelled by law. Notwithstanding the foregoing, CivicPlus reserves the right to delete, suspend, or block known malicious accounts without Customer authorization. Customer understands that CivicPlus has no obligation to provide the Services or maintain the Customer Data, information or other material if Customer's accounts are past due and unpaid as set forth in this Agreement.

24. Customer acknowledges and agrees that CivicPlus utilizes third-party service providers to host and provide the Services and store Customer Data and the protection of such data will be in accordance with such third party's safeguards for the protection and the security and confidentiality of Customer's Data. Notwithstanding anything to the contrary, CivicPlus shall have the right to collect and analyze data and other information relating to the provision, use and performance of various aspects of the Services and related systems and technologies (including, without limitation, information concerning Customer Data and data derived therefrom), and CivicPlus will be free (during and after the term hereof) to use such information and data to improve and enhance the Services and for other development, diagnostic and corrective purposes in connection with the Services and other CivicPlus offerings.

25. CivicPlus may offer Customer the ability to use third-party applications in combination with the Services. Any such third-party application will be subject to acceptance by Customer. In connection with any such third-party application

agreed to by Customer, Customer acknowledges and agrees that CivicPlus may allow the third-party providers access to Customer Data as required for the interoperation of such third-party application with the Services. The use of a third-party application with the Services may also require Customer to agree to a separate agreement or terms and conditions with the provider of the third-party application, which will govern Customer's use of such third-party application.

26. In the event of a security breach due to the sole negligence, malicious actions, omissions, or misconduct of CivicPlus, CivicPlus, as the data custodian, will comply will all remediation efforts as required by applicable federal and state law.

CivicPlus Support

27. CivicPlus will use commercially reasonable efforts to perform the Services in a manner consistent with applicable industry standards, including maintaining Services availability 24 hours a day, 7 days a week with 99.9% uptime. Customer will have 24/7 access to the online CivicPlus Help Center (civicplus.help) to review use articles, software best practices, receive maintenance release notes, as well as submit and monitor omni-channel support tickets and access solution specific support contact methods (https://www.civicplus.help/hc/en-us/requests/new).

28. CivicPlus provides live support engineers based in the domestic United States to respond to basic questions concerning use and configuration, to diagnose software code-related errors, and proactively identify potential systems issues. CivicPlus support engineers serve a preliminary function in the agile development process and escalate defects to software developers or architects for remediation. For security purposes, CivicPlus support engineers are not permitted to modify user accounts, and permissions nor distribute access outside of accounts established by means of a support interaction for testing. Customer delegated Users may receive tutorials and guidance on account modifications but will perform the action themselves.

29. CivicPlus support hours span between the hours of 7 am to 7 pm CST, but may vary by product. Customer may access the CivicPlus Help Center (civicplus.help) to obtain each product's support hours. After hours support is available by toll- free phone call only. Non-emergency support requested outside of support hours will be subject to additional fees, such fees will be quoted to Customer at the time of the request and will be subject to Customer acceptance and invoiced the next business day following the non-emergency support. CivicPlus shall have the sole discretion to determine in good faith whether support requests qualify as an emergency, exceed reasonable use or are outside the scope of services outlined in any SOW.

30. If a reported problem cannot be solved during the first support interaction, Customer will be provided a ticket number that will be used as communication method throughout ticket escalation until a solution is provided. Support service does not include support for errors caused by third party products or applications for which CivicPlus is not responsible.

Marketing

31. Customer hereby authorizes CivicPlus to include CivicPlus's name and logo inconspicuously within the Customer's instance of the Services. Customer may publicly refer to itself as a customer of the CivicPlus Services, including on Customer's website and in sales presentations. Notwithstanding the foregoing, each Party hereby grants the other a limited, worldwide, license to use the other's logo in conformance with such Party's trademark usage guidelines and solely for the purposes of providing the Services. In no event will either Party issue a press release publicly announcing this relationship without the approval of the other Party, such approval not to be unreasonably withheld.

Limitation of Liability

32. CivicPlus' liability arising out of or related to this Agreement, or any associated SOW, will not exceed the amounts paid by Customer for the Annual Recurring Services in the year prior to such claim of liability.

33. In no event will CivicPlus be liable to Customer for any consequential, indirect, special, incidental, or punitive damages arising out of or related to this Agreement.

34. The liabilities limited by Section 32 and 33 apply: (a) to liability for negligence; (b) regardless of the form of action, whether in contract, tort, strict product liability, or otherwise; (c) even if Customer is advised in advance of the possibility of the damages in question and even if such damages were foreseeable; and (d) even if Customer's remedies fail of their essential purposes. If applicable law limits the application of the provisions of this Limitation of Liability section, CivicPlus' liability will be limited to the maximum extent permissible.

Warranties and Disclaimer

35. Each person signing the SOW, or otherwise agreeing to the terms of this Agreement, represents and warrants that he or she is duly authorized and has legal capacity to execute and bind the respective Party to the terms and conditions of the SOW and this Agreement. Each Party represents and warrants to the other that the execution and delivery of the SOW and the performance of such Party's obligations thereunder have been duly authorized and that this Agreement is a valid and legal agreement binding on such Party and enforceable in accordance with its terms. Customer represents and warrants that Customer has not provided any false information to gain access to the Service and that Customer's billing information provided on the Contact Sheet is correct; and it has all necessary rights in the Customer Content to permit Customer's use of the Service and to grant the licenses contained in this Agreement without infringing the intellectual property or other rights of any third parties, violating any applicable laws, or violating the terms of any license or agreement to which it is bound.

36. CivicPlus warrants that the Services will perform substantially in accordance with documentation and marketing proposals, and free of any material defect. CivicPlus warrants to the Customer that, upon notice given to CivicPlus of any defect in design or fault or improper workmanship, CivicPlus will remedy any such defect. CivicPlus makes no warranty regarding, and will have no responsibility for, any claim arising out of: (i) a modification of the Services made by anyone other than CivicPlus, even in a situation where CivicPlus approves of such modification in writing; or (ii) use of the Services in combination with a third-party service, web hosting service, or server not authorized by CivicPlus.

37. The Services may be temporarily unavailable for scheduled maintenance or for unscheduled emergency maintenance, either by CivicPlus or by third-party providers, or because of other causes beyond CivicPlus's reasonable control, but CivicPlus shall use reasonable efforts to provide advance notice in writing or by e-mail of any scheduled service disruption. HOWEVER, SERVICE PROVIDER DOES NOT WARRANT THAT THE SERVICES WILL BE UNINTERRUPTED OR ERROR FREE; NOR DOES IT MAKE ANY WARRANTY AS TO THE RESULTS THAT MAY BE OBTAINED FROM USE OF THE SERVICES.EXCEPT FOR THE EXPRESS WARRANTIES IN THIS AGREEMENT, THE SERVICES ARE PROVIDED "AS IS AND CIVICPLUS HEREBY DISCLAIMS ALL WARRANTIES, WHETHER EXPRESS, IMPLIED, STATUTORY OR OTHERWISE, INCLUDING ANY IMPLIED WARRANTY OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, OR ARISING FROM A PRIOR COURSE OF DEALING.

38. EACH PROVISION OF THIS AGREEMENT THAT PROVIDES FOR A LIMITATION OF LIABILITY, DISCLAIMER OF WARRANTIES, OR EXCLUSION OF DAMAGES IS TO ALLOCATE THE RISKS OF THIS AGREEMENT BETWEEN THE PARTIES. THIS ALLOCATION IS REFLECTED IN THE PRICING OFFERED BY CIVICPLUS TO CUSTOMER AND IS AN ESSENTIAL ELEMENT OF THE BASIS OF THE BARGAIN BETWEEN

THE PARTIES. EACH OF THESE PROVISIONS IS SEVERABLE AND INDEPENDENT OF ALL OTHER PROVISIONS OF THIS AGREEMENT.

Force Majeure

39. No party shall have any liability to the other hereunder by reason of any delay or failure to perform any obligation or covenant if the delay or failure to perform is occasioned by force majeure, meaning any act of God, storm, pandemic, fire, casualty, unanticipated work stoppage, strike, lockout, labor dispute, civil disturbance, riot, war, national emergency, act of public enemy, internet service provider failure or delay, third party application failure, denial of service attack, or other cause of similar or dissimilar nature beyond its control.

Taxes

40. The amounts owed for the Services exclude, and Customer will be responsible for, all sales, use, excise, withholding and any other similar taxes, duties and charges of any kind imposed by any federal, state or local governmental entity in connection with the Services (excluding taxes based solely on CivicPlus's income). If the Customer is tax-exempt, the Customer must provide CivicPlus proof of their tax-exempt status, within fifteen (15) days of contract signing, and the fees owed by Customer under this Agreement will not be taxed. If such exemption certificate is challenged or held invalid by a taxing authority then Customer agrees to pay for all resulting fines, penalties and expenses.

Other Documents

41. This Agreement, including all exhibits, amendments, and addenda hereto and all SOWs, constitutes the entire agreement between the Parties and supersedes all prior and contemporaneous agreements, proposals or representations, written or oral, concerning its subject matter. No modification, amendment, or waiver of any provision of this Agreement or any SOW will be effective unless in writing and signed by each Party. However, to the extent of any conflict or inconsistency between the provision in the body of this Agreement and any exhibit, amendment, or addenda hereto or any SOW, the terms of such exhibit, amendment, addenda or SOW will prevail. Notwithstanding any language to the contrary therein, no terms or conditions stated in a Customer purchase order or other order documentation (excluding SOWs) will be incorporated into or form any part of this Agreement, all such terms or conditions will be null and void, unless such term is to refer and agree to this Agreement.

Interlocal Purchasing Consent/ Cooperative Purchasing

42. With the prior approval of CivicPlus, which may be withheld for any or no reason within CivicPlus's sole discretion, this Agreement and any SOW may be extended to any public entity in Customer's home-state to purchase at the SOW prices and specifications in accordance with the terms stated herein.

43. To the extent permitted by law, the terms of this Agreement and set forth in one or more SOW(s) may be extended for use by other local government entities upon execution of a separate agreement, SOW, or other duly signed writing by and between CivicPlus and such entity, setting forth all of the terms and conditions for such use, including applicable fees and billing terms.

Miscellaneous Provisions

44. The invalidity or unenforceability, in whole or in part, of any provision of this Agreement shall not void, affect the validity or enforceability of any other provision of this Agreement.

45. The Parties negotiated this Agreement with the opportunity to receive the aid of counsel and, accordingly, intend this Agreement to be construed fairly, according to its terms, in plain English, without constructive presumptions against the drafting Party. The headings of Sections of this Agreement are for convenience and are not to be used in interpreting this Agreement. As used in this Agreement, the word "including" means "including but not limited to."

46. The Parties will use reasonable, good faith efforts to resolve any dispute between them in good faith prior to initiating legal action.

47. This Agreement and any SOW, to the extent signed and delivered by means of a facsimile machine or electronic mail, shall be treated in all manner and respects as an original agreement or instrument and shall be considered to have the same binding legal effect as if it were the original signed version thereof delivered in person. The Parties agree that an electronic signature is the legal equivalent of its manual signature on this Agreement and any SOW. The Parties agree that no certification authority or other third party verification is necessary to validate its electronic signature and that the lack of such certification of third party verification will not in any way affect the enforceability of the Parties' electronic signature or any resulting agreement between CivicPlus and Customer.

48. Due to the rapidly changing nature of software as a service and digital communications, CivicPlus may unilaterally update this Agreement from time to time. In the event CivicPlus believes such change is a material alteration of the terms herein, CivicPlus will provide Customer with written notice describing such change via email or through its website. Customer's continued use of the Services following such updates constitutes Customer's acceptance of the same. In the event Customer rejects the update to the terms herein, Customer must notify CivicPlus of its objection within ten (10) days receipt of notice of such update.

CivicPlus
302 South 4th St. Suite 500
Manhattan, KS 66502
US

Statement of Work

Quote #: Q-78801-1
Date: 6/30/2024 9:16 PM
Expires On: 8/29/2024

Client:
Manor TX - CivicEngage

Bill To:

SALESPERSON	Phone	EMAIL	DELIVERY METHOD	PAYMENT METHOD
Richard Jones	785.323.4713	rjones@civicplus.com		Net 30

ULTIMATE WEBSITE DESIGN

QTY	PRODUCT NAME	DESCRIPTION	DISCOUNT %	TOTAL
1.00	Annual - CivicEngage Central	Annual - CivicEngage Central	25	USD 2,889.75
1.00	Hosting & Security Annual Fee - CivicEngage Central	Hosting & Security Annual Fee - CivicEngage Central	25	USD 891.00
1.00	Guardian Security (Cloudflare WAF/CDN)	Cloudflare Tier 1 WAF/CDN security protection	25	USD 450.00
1.00	SSL Management – CP Provided Only	SSL Management – CP Provided Only 1 per domain (Annually Renews)	25	USD 66.75
1.00	DNS and Domain Hosting Setup (http://URL)	DNS and Domain Hosting Setup (http://URL)	25	USD 118.50
1.00	DNS and Domain Hosting Annual Fee (http://URL)	DNS and Domain Hosting Annual Fee (http://URL)	25	USD 141.75
1.00	Ultimate Implementation - CivicEngage Central	Ultimate Implementation - CivicEngage Central	25	USD 10,970.25
1.00	48 Month Redesign Ultimate Annual - CivicEngage Central	48 Month Redesign Ultimate Annual - CivicEngage Central	25	USD 2,573.25
150.00	Content Development - 1 Page - CivicEngage	Content Development - 1 Page - CivicEngage	25	USD 4,500.00
6.00	New Customer System Training (3h, virtual) - Web Central	CivicEngage System Training - Virtual, Up to 3 Hours, up to 12 Attendees	25	USD 3,375.00
1.00	Agendas & Minutes Migration - PDF - 100 Meetings - CivicEngage	Content Migration : Agendas & Minutes - Per 100 Meetings (Approx. 1 year)	25	USD 637.50

QTY	PRODUCT NAME	DESCRIPTION	DISCOUNT %	TOTAL
1.00	Pay - Forte	Pay - Forte	0	USD 0.00
1.00	Pay Annual Fee - Forte	Pay Annual maintenance and support fee	25	USD 1,338.75
1.00	Pay Implementation - Forte	Includes setting CivicPlus Pay configuration, configuring CivicPlus products for accepting payments, advanced troubleshooting with our partner's support.	100	USD 0.00

POLICE DEPARTMENT HEADER PACKAGE

QTY	PRODUCT NAME	DESCRIPTION	DISCOUNT %	TOTAL
1.00	Premium Department Header Package - CivicEngage	Page specific Site ID, Navigation, Banner, Graphic Links, Colors; follows main site layout.	0	USD 0.00
1.00	Premium Department Header Annual Fee - CivicEngage	Premium Department Header Annual Fee: Police Department	25	USD 703.50
1.00	Premium Department Header Implementation - CivicEngage	Premium Department Header Implementation	25	USD 3,386.25

~~List Price - Initial Term Total~~	~~USD 45,723.00~~
Total Investment - Initial Term	USD 32,042.25
Annual Recurring Services (Subject to Uplift)	USD 9,054.75

Initial Term	12 Months
Initial Term Invoice Schedule	100% Invoiced upon Signature Date

Renewal Procedure	Automatic 1 year renewal term, unless 60 days notice provided prior to renewal date
Annual Uplift	5% to be applied in year 2

This Statement of Work ("SOW") shall be subject to the terms and conditions of the CivicPlus Master Services Agreement and the applicable Solution and Services terms and conditions located at https://www.civicplus.help/hc/en-us/p/legal-stuff (collectively, the "Binding Terms"), By signing this SOW, Client expressly agrees to the terms and conditions of the Binding Terms throughout the term of this SOW.

Acceptance

The undersigned has read and agrees to the following Binding Terms, which are incorporated into this SOW, and have caused this SOW to be executed as of the date signed by the Customer which will be the Effective Date:

For CivicPlus Billing Information, please visit https://www.civicplus.com/verify/

Authorized Client Signature	CivicPlus
By (please sign):	By (please sign):
_____	_____
Printed Name:	Printed Name:
_____	Amy Vikander
Title:	Title:
_____	Senior VP of Customer Success
Date:	Date:
_____	8/1/24

Organization Legal Name:

_____
Billing Contact:

_____
Title:

_____
Billing Phone Number:

_____
Billing Email:

_____
Billing Address:

_____

_____
Mailing Address: (If different from above)

_____

_____
PO Number: (Info needed on Invoice (PO or Job#) if required)

_____

AGENDA ITEM NO. _____

AGENDA ITEM SUMMARY FORM

PROPOSED MEETING DATE: August 7, 2024
PREPARED BY: Scott Dunlop, Director
DEPARTMENT: Development Services

AGENDA ITEM DESCRIPTION:

Second and Final Reading: Consideration, discussion, and possible action on an Ordinance rezoning the Monarch Ranch Subdivision, being 134.53 acres, more or less, and located at the southwest corner of the intersection at Gregg Lane and FM 973, Manor, TX from Planned Unit Development (PUD) to Planned Unit Development (PUD).
Applicant: SEC Planning
Owner: Blackburn Group LLC

BACKGROUND/SUMMARY:

The Monarch Ranch PUD was first approved by Ordinance 636 on January 19, 2022. It was amended by Ordinance 681 on December 7, 2022. This amendment was to update the roadway and lot layout to accommodate the city's new thoroughfare plan.

This second amendment to the PUD proposes reducing the minimum dwelling unit size from 1,700 square feet to 1,300 square feet. No other additional PUD changes are proposed.

Limits have been set on the range of home sizes so as to provide multiple options as well as having enough home elevations/designs to satisfy our zoning code's requirement for elevation differentiation. The development is approved for 400 homes, so 20% would represent 80 homes. Each size range is limited to 20% of the overall development, except for units 1,701 or larger, which are not limited.

Minimum dwelling unit size:

Dwelling Unit Size (conditioned space)	Maximum Percentage
1,300 - 1,400 sq. ft.	20%
1,401 - 1,500 sq. ft.	20%
1,501 - 1,600 sq. ft	20%
1,601 - 1,700 sq. ft.	20%
1,701 + sq. ft.	Unlimited

The second amendment to the PUD is being considered concurrently with the Third Amendment to the Development Agreement. The Development Agreement amendment is to update the masonry requirements based on the proposed dwelling unit sizes in this second PUD amendment.

Under our zoning code, the minimum dwelling unit size (conditioned space) for properties not in the Historic District is 2,000 square feet for SF-1 and 1,700 for SF-2. If the homes are 50% masonry (stone, brick, or cement stucco), these can be reduced to 1,500 sf and 1,200 sf, respectively, with the approval of a Development Agreement. For unconditioned space, a two-car enclosed garage and a minimum 100 sf covered or uncovered patio are also required. Enclosed garages typically are 350 sf – 400 sf, so with these, the overall structure could be 2,500 sf – 2,200 sf, if no masonry is included.

The original Monarch Ranch PUD followed the SF-2 standard and set the minimum dwelling unit size to 1,700 sf. Through the Development Agreement, they were approved to have 30% front façade masonry, with corner and double-frontage lots also having a minimum of 30% of masonry on the side or rear. Had they been zoned SF-2 rather than PUD, the dwelling units would have required 0% masonry, so the Development Agreement requiring 30% front façade masonry was higher than code standards.

Our zoning code allows for each 10% increment of masonry applied to the entire structure, the conditioned space can be reduced by 100 square feet. So a home in an SF-2 district is required to have 1,700 sf of conditioned space, but if 50% of the structure is masonry, the minimum dwelling size can be 1,200 sf.

A modified version of this code is being applied to the Monarch Ranch PUD with the Development Agreement amendment. Since the current Development Agreement only requires front façade masonry and not an overall structure percentage, the amendment maintains that exception but increases the amount of masonry on the front façade consistent with our zoning code. So for each 100 sf the dwelling unit is reduced the front façade masonry is increased by 10%. The table below is what is proposed in the Development Agreement amendment to be considered by the City Council when the PUD amendment comes back for the second and final reading on August 7th, should the first reading be approved.

A. **Masonry and Dwelling Unit Size Table**

Dwelling Unit Size (conditioned space)	Minimum Front Façade* Masonry Percentage
1,300 – 1,400 sq. ft.	70%
1,401 – 1,500 sq. ft.	60%
1,501 – 1,600 sq. ft.	50%
1,600 – 1,700 sq. ft.	40%
1,701 + sq. ft.	30%

* Collector Road and Corner Lots shall have side and rear masonry percentages equal to the minimum front façade percentage.

The Planning and Zoning Commission at their July 10th meeting voted 4-1 to recommend approval with the table modified to be:

Dwelling Unit Size (conditioned space)	**Maximum Percentage**
1,300 -1,400 sq. ft.	15%
1,401 – 1,500 sq. ft.	15%

1,501 – 1,600 sq. ft.	20%
1,601 – 1,700 sq. ft.	20%
1,701 + sq. ft.	Unlimited

The Planning and Zoning Commission discussed at length the need to balance housing affordability/attainability and long-term property values/neighborhood character. The Developer promoted the smaller unit sizes to be at a more attainable price while also providing additional choices and designs for buyers.

Commissioner Orion spoke from recent personal experience that smaller units do not always mean the cost of the home becomes that much more affordable as she shared her experience looking for a new home in Elgin prior to moving to Manor where the homes were 900 sq. ft to 1,760 sq ft., and the smaller ones were still around $350,000+. She further spoke that under the proposed maximum percentages, 80% of the entire development could be below the code minimum of 1,700 sq. ft., which does not meet a PUD's intent to be a superior zoning designation. Commissioner Stensland spoke of his experience in Austin, which tries to provide all types of homes, for all types of people, in all parts of town; so by approving this PUD amendment, it would introduce a larger variation of home sizes and help achieve a more diverse community. However, Commissioner Stensland agreed with Commissioner Orion that the number of units below the current 1,700 sq. ft. should be limited further as a PUD is intended to be a superior zoning classification above standard zoning.

Vice-Chair Chavis and Commissioner Meyer spoke of their concern that the smaller units could be clustered in one phase or area of the development as the PUD does not restrict the number of unit sizes within each phase. The Developer said that shouldn't be a concern as they plan to disperse the housing types throughout the development. The developer additionally added that they have homes that go up to 2,800 sq. ft. of conditioned space (3,200 sq. ft. total), so the 1,700 sq. ft. minimum doesn't represent the maximum home size they intend to offer to buyers. Based on the lot size mix, the larger 60' lots would have the larger homes, and as currently planned and approved on the Preliminary Plat, the development has 25.2% 60' lots and 74.8% 50' lots. Within Phase 1 the unit mix is 98 50' lots and 36 60' lots, Phase 2 has 109 50' lots and 20 60' lots, and Phase 3 has 81 50' lots and 41 60's. In total that is 288 50' lots and 97 60' lots for a total of 385 lots.

The developer said his goal is not to put in 20% 1,300 sq. ft. homes, as this PUD amendment would allow, but to offer a variety of products and price points and let the market decide demand.

Commissioner Orion motioned to reduce the proposed 20% limits to 10% each, which would have allowed 40% of the total units to be below 1,700 sq. ft and Commission Meyer seconded it. That motion failed 2 – 3, with Vice Chair Chavis, Commissioner Stensland, and Commissioner Nila voting against it. Commissioner Stensland put forward a new motion to reduce units 1,300 – 1,500 to 15% each, 1,500 – 1,700 to 20% each, and 1,700 + unlimited. That motion was approved 4-1, with Commissioner Orion voting against it. Commissioner Stensland said this allows 30% the development to be above 1,700 sq. ft., which provides enough space for growing families, and 70% below, which provides people with additional choices that suit their needs and budgets. Commissioner Orion objected as she spoke that to maintain superiority, the development should be primarily above the code minimum of 1,700 sq. ft. with only 20-30% of the entire project below the 1,700 sq. ft. limit. Commissioner Orion said that a better way to achieve affordability is to reduce lot sizes in future developments and not dwelling unit sizes.

The City Council approved the first reading at the July 17th meeting 5-1 with Councilmember Deja Hill opposing. A discussion was held to clarify the updated masonry requirement in the draft development agreement, why the developer was making this request, and how many homes would fall under the current 1,700 sf requirement. Michael Burrell provided that with the recommended percentages, the PUD is approved for 400 homes, so there could be 60 1,300 – 1,400 homes, 60 1,401 – 1,500 homes, 80 1,501-1,600 homes, 80 1,601-1,700 homes, and 120 1,701+ homes. He further included the developer thought the minimum square footage was all enclosed

space, but later learned the city only counts conditioned space so the garage was not included in the current 1,700 sq ft. minimum. The developer added they are making the request to have a variety of home types, sizes, and prices to provide the most number of homes to the largest group of potential buyers.

LEGAL REVIEW: Yes, Veronica Rivera
FISCAL IMPACT: No
PRESENTATION: No
ATTACHMENTS: Yes

- Ordinance No. 755
- Rezoning Map
- Aerial Image
- Monarch Ranch PUD
- PUD Comparison
- Draft 3rd DA Amendment
- Public Notice
- Mailing Labels

STAFF RECOMMENDATION:
The City Staff recommends that the City Council approve the second and final reading of Ordinance No. 755 rezoning the Monarch Ranch Subdivision, being 134.53 acres, more or less, and located at the southwest corner of the intersection at Gregg Lane and FM 973, Manor, TX from Planned Unit Development (PUD) to Planned Unit Development (PUD).

PLANNING & ZONING COMMISSION:	**Recommend Approval**	**Disapproval**	**None**
	X – with modifications		

ORDINANCE NO. 755

AN ORDINANCE OF THE CITY OF MANOR, TEXAS, AMENDING ORDINANCES Nos. 636 and 681 TO MODIFY THE PLANNED UNIT DEVELOPMENT SITE PLAN FOR THE MONARCH RANCH FINAL PLANNED UNIT DEVELOPMENT; REZONING FROM PLANNED UNIT DEVELOPMENT (PUD) TO PLANNED UNIT DEVELOPMENT (PUD); MAKING FINDINGS OF FACT; AND PROVIDING FOR RELATED MATTERS.

Whereas, the owner of the property described hereinafter (the "Property") has requested that the Property be rezoned;

Whereas, Ordinance No. 636 was adopted by the City of Manor City Council (the "City Council") on January 19, 2022;

Whereas, Ordinance No. 681, being the first amendment to the Monarch Ranch Planned Unit Development was adopted by the City Council on December 7th, 2022 and amended Ordinance No. 636 to include the Planned Unit Development Site Plan for the Monarch Ranch Final Planned Unit Development as part of Exhibit "A";

Whereas, the owner of the Property is requesting to amend Ordinances Nos. 636 and 681in order to modify the Planned Unit Development Site Plan for the Monarch Ranch Final Planned Unit Development;

Whereas, after giving ten days written notice to the owners of land within three hundred feet of the Property, the Planning & Zoning Commission held a public hearing on the proposed rezoning and forwarded its recommendation on the rezoning to the City Council; and

Whereas, after publishing notice of the public hearing at least fifteen days prior to the date of such hearing, the City Council at a public hearing has reviewed the request and the circumstances of the Property and finds that a substantial change in circumstances of the Property, sufficient to warrant a change in the zoning of the Property, has transpired;

NOW, THEREFORE, BE IT ORDAINED BY THE CITY COUNCIL OF THE CITY OF MANOR, TEXAS, THAT:

Section 1. Findings. The foregoing recitals are hereby found to be true and correct and are hereby adopted by the City Council and made a part hereof for all purposes as findings of fact.

Section 2. Amendment of Ordinances. Ordinances Nos. 636 and 681 are hereby modified and amended by deleting Exhibit "A" in its entirety, and replacing it with a new Exhibit "A" to include the modified planned unit development site plan for the Monarch Ranch Final PUD, attached hereto and incorporated herein as if fully set forth.

Section 3. Severability. Any provision of this Ordinance or the application of any provision to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the Ordinance which can be given effect without the invalid provision or application, and to this end the provisions of this Ordinance are declared to be severable.

Section 4. Amendment of Conflicting Ordinances. Exhibit "A" of the City's Ordinances

No. 636 and 681, are hereby amended as provided in this Ordinance. All ordinances and parts of ordinances in conflict with this Ordinance are amended only to the extent of such conflict otherwise remaining in full force and effect. In the event of a conflict or inconsistency between this Ordinance and any code or ordinance of the city, the terms and provisions of this Ordinance shall govern.

Section 5. Open Meetings. It is hereby officially found and determined that the meeting at which this ordinance is passed was open to the public as required and that public notice of the time, place, and purpose of said meeting was given as required by the Open Meetings Act, Chapter 551, Texas Government Code.

PASSED AND APPROVED FIRST READING on this the 17th day of July 2024.

PASSED AND APPROVED SECOND AND FINAL READING on this the 7th day of August 2024.

THE CITY OF MANOR, TEXAS

_____
Dr. Christopher Harvey,
Mayor

ATTEST:

_____
Lluvia T. Almaraz, TRMC
City Secretary

EXHIBIT "A"

Property Legal Description:

Being all that certain tract or parcel of land situated in the S. Bacon Survey, Abstract No. 63, Travis County, Texas, being all of that certain called 146 3/4 acre tract of land described in the deed to Janice Thurman White Trust, Martin Payne, John Thurman Payne add Enfield Partners, LLC, recorded in Document No. 2019013312, Official Public Records, Travis County, Texas and being more particularly described by metes and bounds and follows:

BEGINNING at the South corner of the tract being described herein at a 1/2-inch iron rod found in the Northwesterly right-of-way line of F.M. 973 for the East corner of that certain called 136.342 acre tract of land described in the deed to H. Dalton Wallace, recorded in Document No. 2013210018, Official Public Records, Travis County, Texas and the South corner of said 146 3/4 acre tract of land, from which a 1/2-inch iron rod found on the Northwesterly right-of-way line of said F.M. 973 and the Southeasterly line of said 136.342 acre tract of land bears S13°18'28"W, a distance of 389.02 feet;

THENCE with the common line of said 136.342 acre tract of land said 146 3/4 acre tract of land, the following courses and distances:

N62°14'30"W, a distance of 3199.28 feet to a capped iron rod stamped "Chapparal" found for corner;

N88°59'54"W, a distance of 788.38 feet to a 1/2-inch iron rod found for the South corner of that certain called 59.072 acre tract of land described in the deed to Danny K. Fuchs and Diane F. Swanson, recorded in Document No. 2020081497, Official Public Records, Travis County, Texas and the West corner of said tract herein described;

THENCE with the East line of said 59.072 acre tract of land, the following courses and distances:

N12°37'38"E, a distance of 546.74 feet to a 4-inch wood fence corner post found for corner;

N71°31'15"E, a distance of 218.24 feet to a 5/8-inch iron rod with plastic cap stamped "Landpoint" set (herein referred to as capped iron rod set) for corner;

N53°03'35"E, a distance of 273.85 feet to a capped iron rod set for corner;

N26°39'39"E, a distance of 230.33 feet to a 1/2-inch iron rod found for corner;

N79°38'13"W, a distance of 59.13 feet to a 1/2-inch iron rod found for corner;

N06°31'39"E, passing at a distance of 649.99 feet a capped iron rod stamped "McGray"

found for corner and continuing on said course for a total distance of 724.90 feet to a 1/2-inch iron rod found in the Southwesterly line of Gregg Lane for the East corner of said 59.072 acre tract of land and the North corner of said tract herein described;

THENCE S62°19'23"E, with the Southwesterly line of said Gregg Lane, a distance of 4059.00 feet to a capped iron rod set in the Northwesterly right-of-way line of said F.M. 973 for the East corner of said tract herein described, from which a concrete monument found on the Northeasterly line of said Gregg Lane for the South corner of that certain called 36.14 acre tract of land described in the deed to the United States of America, recorded in Document No. 2014113251, Official Public Records, Travis County, Texas bears N27°21'28"E, a distance of 32.41 feet;

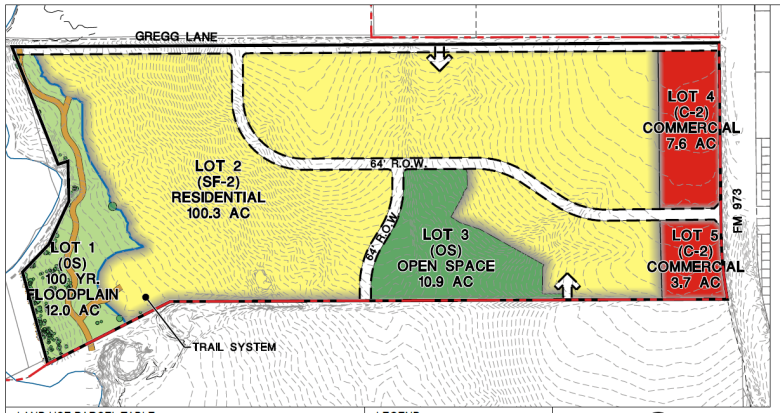
THENCE with the Northwesterly right-of-way line of said F.M. 973, the following courses and distances:

S27°21'28" W for a distance of 1082.34 feet to a 1/2-inch iron rod found for the beginning of a curve to the left;

With said curve to the left, an arc length of 391.80 feet, a central angle of 09° 23'08", a radius of 2391.83 feet and a chord that bears S22°39'54"W, a distance of 391.36 feet to the POINT OF BEGINNING and containing 134.529 acres of land.

The herein referenced tract is referenced to State Plane Coordinates, Texas Central Zone, 4203.

Planned Unit Development Site Plan for the Monarch Ranch Final Planned Unit Development
[attached]



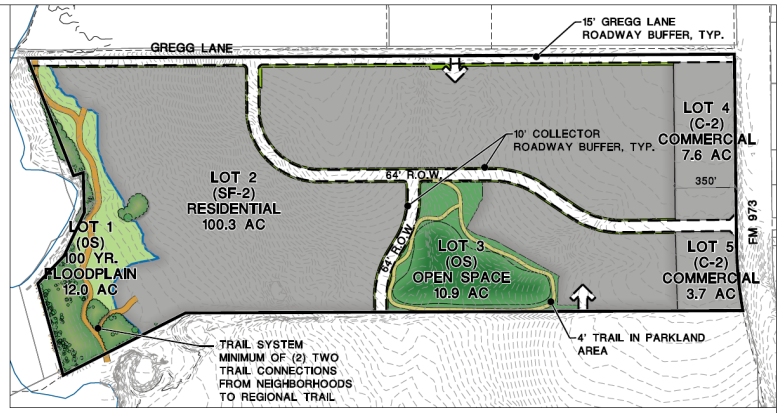
LAND USE PARCEL TABLE			
LAND USE	ACREAGE	LOTS	DENSITY
(SF-2) RESIDENTIAL	101.9 ACRES	400 LOTS	4.0 DU/AC
(C-2) MEDIUM COMMERCIAL	11.3 ACRES	2 LOTS	
(OS) FLOODPLAIN	12.0 ACRES	1 LOTS	
(OS) OPEN SPACE	9.3 ACRES	1 LOTS	
TOTAL	134.5 ACRES		3.0 DU/AC

LEGEND
- PLAN BOUNDARY
- PROPOSED RIGHT-OF-WAY
- CITY LIMITS
- 4' WALKS
- 8' TRAILS

North

0 300' 600' 900'

Scale: 1" = 300'



PARK PLAN

PARK LAND DEDICATION:

North

0 300' 600' 900'

Scale: 1" = 300'

400 (number of dwelling units) /66 x 1 = 6.1 (required park acreage) 22.9 (proposed park acreage)

8' CONCRETE TRAIL (2,400 L.F.)

A. Purpose and Intent

1. The Monarch Ranch Planned Unit Development (PUD) is comprised of approximately 134.5 acres. The development of this Property is a combination of light commercial along FM 973 at the Eastern edge of the Property and a single-family detached residential community on the remainder of the Property.

B. Applicability and Base Zoning

1. All aspects regarding the development of this PUD shall comply with the City of Manor Code of Ordinances, except as established in this exhibit, titled Final PUD Site Plan.

2. For the purpose of establishing development standards for the PUD, the following base zoning districts have been selected from the Manor Code of Ordinances:

SF-2 (Single-Family Standard)
C-2 (Medium Commercial)

C. Conceptual Site Layout and Land Use Plan

1. The Land Use Plan has been attached to this PUD to illustrate the design intent for the Property. The Final PUD Site Plan is intended to serve as a guide to illustrate the general community vision and design concept and is not intended to serve as a final document.

D. Allowable/Prohibited Uses

1. The allowable residential use shall be detached single-family dwellings on individually platted lots. The maximum residential lot count shall be four hundred (400). Commercial uses shall be consistent with allowable C-2 (Medium Commercial) land uses as defined in Division 3, Section 14.02.017 of City of Manor Code of Ordinances except as modified herein.

2. The following uses shall be prohibited within the C-2 area of the PUD:

- Amusement (outdoor)
- Automobile Repair (minor)
- Automobile Repair (major)
- Commercial Off-Street Parking
- Contractor's Shop
- Financial Services (alternative)
- Funeral Services
- Kennel
- Laundry Services
- Mini-Storage Warehouse
- Off-Site Accessory Parking
- Pawnshop
- Recreational Vehicle Sales and Rental
- Truck and Trailer Sales and Rental
- Veterinary Service, Large

E. Residential Development Standards:

1. To ensure product diversity, the following single-family detached residential percentages shall apply to the residential district within this PUD:
   a. A maximum of 80 percent (80%) of the total lots may have a width of less than sixty feet (60').
   b. A minimum of 20 percent (20%) of the total shall have a width of sixty feet (60') or wider.

2. The Monarch Ranch residential development will comply with the Development Standards set forth below:

RESIDENTIAL USES

Lot Area: 6,000 s.f. Minimum (fronted loaded garage)
Lot Width: (minimum)50 ft.
Front Setback: (minimum)25 ft.
Side Setback: (minimum)5 ft.
Street Side Setback: (minimum)15 ft.
Rear Setback to residential:(minimum)10 ft.
Rear Setback to commercial: 15 ft
Minimum dwelling unit size:

Dwelling Unit Size (conditioned space)	Maximum Percentage
1,300 - 1,400 sq. ft.	20%
1,401 - 1,500 sq. ft.	20%
1,501 - 1,600 sq. ft	20%
1,601 - 1,700 sq. ft.	20%
1,701 + sq. ft.	Unlimited

Maximum building coverage: 50%
Maximum building coverage plus accessory structures: 60%

3. Standards not listed follow code, as amended

F. Commercial Development Standards:

1. The Monarch Ranch commercial development shall comply with the C-2 (Medium Commercial) development standards set forth in the City of Manor Code of Ordinances, as amended.

G. Drainage Dedication and Facilities

1. Residential drainage facilities shall utilize earthen berms and be designed with a curvilinear shape where possible. If concrete retaining walls are required in the design of detention facilities, such areas shall be limited to not more than forty percent (40%) of the perimeter of the pond.

H. Parkland and Open Space

1. This Final PUD Site Plan provides approximately 22.9 acres of park and open space with the dedication of two (2) tracts of land as illustrated on the Parks Plan on this sheet. The parks and open space will include detention facilities for the project, tree preservation areas, 100 year floodplain, trail corridor and active programmed parkland.

2. An eight-foot (8') concrete trail shall provide pedestrian/bike access along the parkland corridor connecting from the north property boundary to the south property boundary, as depicted on Park Plan. Trees shall be planted parallel to the concrete trail at a spacing of one (1) tree for every forty (40) linear feet. Trees shall be a minimum of three (3) inch caliper and selected from the Type A/B tree list of the City of Manor Code of Ordinances.

3. Parkland amenities located within the Enfield PUD shall include a minimum of the following recreational elements: playground, parking area, dog park, picnic areas, picnic pavilion and open lawn/gaming area.

   a. Age 5-12 playground
   b. Age 2-5 playground
   c. Parking area with a minimum of 20 parking spaces
   d. Minimum 10,000 square foot dog park (may be allowed within detention area)
   e. Minimum 20 foot by 30 foot picnic pavilion

4. A portion of the parkland may be utilized for a private amenity pool and associated restroom facility. This lot defined for the private amenity will not be dedicated to the City and final boundary will be determined at the platting stage of development. The private amenity portion of the overall parkland will be a maximum of 2 acres.

5. A minimum 4 foot wide, concrete sidewalk shall be provided parallel to the Gregg Lane Landscape Buffer.

6. The proposed parkland shall be dedicated to the City of Manor and privately maintained by the Monarch Ranch Homeowner's Association.

I. Landscaping

1. Gregg Lane Landscape Buffer

   a. A minimum fifteen (15) foot landscape buffer, measured from the edge of the Gregg Lane right of way, shall be provided. Four (4), minimum three (3) inch caliper, Type A large or Type B medium native trees (as defined by the Manor Code of Ordinances) and fifteen (15), minimum three (3) gallon, shrubs shall be planted per 200 linear feet of landscape buffer. A minimum four (4) foot wide, concrete sidewalk shall be provided within the Gregg Lane Landscape Buffer or the expanded right of way for Gregg Lane. Location and alignment of the sidewalk shall be coordinated during the Preliminary Plan stage of development.

2. Unloaded Collector Landscape Buffer.

   a. For internal, unloaded collector roadways, a minimum ten (10) foot landscape buffer, measured from the edge of the collector right of way, shall be provided. One (1), minimum three (3) inch caliper, Type A large or Type B medium native tree (as defined by the Manor Code of Ordinances) and five (5), minimum three (3) gallon, shrubs shall be planted per 50 linear feet of landscape buffer.

3. Storm Water Detention

   a. Storm water detention facilities shall be screened according to the requirements outlined in the City of Manor Code of Ordinances, Section 15.03.021 (f).

4. Masonry wall shall be provided along the rear and side lotlines of lots that back up to an unloaded collector and Gregg Lane. Masonry shall include brick, stone, stucco or concrete panel fencing. Stone or brick columns shall be provided a minimum of every 300 feet. Walls should be minimized and varied whenever possible to avoid a tunnel effect along the collector roadway.

5. All landscape buffers and walls shall be privately maintained by the Monarch Ranch Homeowners Association.

Approval and authorized for record by the City Council for the City of Manor, Texas.

Dated this ____ Day of _____, 20___

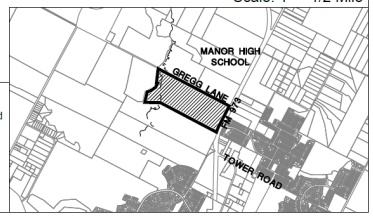
By:_____
Honorable Mayor Dr. Christopher Harvey
Mayor of the City of Manor, Texas

This Final PUD Site Plan has been submitted to and considered by the Planning and Zoning Commission of the City of Manor, Texas, and is hereby recommended for approval by the City Council.

Dated this ____ Day of _____, 20___

By:_____
Felix Paiz, Chairperson

VICINITY MAP
Scale: 1" = 1/2 Mile



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Email: info@secplanning.com

BLACKBURN HOMES

MONARCH RANCH
FINAL PUD SITE PLAN
MANOR, TEXAS

Z:\210038-BBGR\Cadfiles\PLANNING\Submittals\PUD Amendment_05.2023\PUD Site Plan_Notes Monarch Ranch Amendment.dwg

Issued:
1. PUD Submittal 5/24/2021
2.
3.
4.
5.

Revisions:
1. PUD Submittal 7/29/2021
2. PUD Submittal 8/30/2021
3. PUD Submittal 11/11/2021
4. PUD Amend Submittal 10/13/2022
5. PUD Amend 2 4/15/2024
Issue Date:

Drawn By:
Reviewed By: MB

Project No.
210038 - BBGR

SHEET 1 of 1

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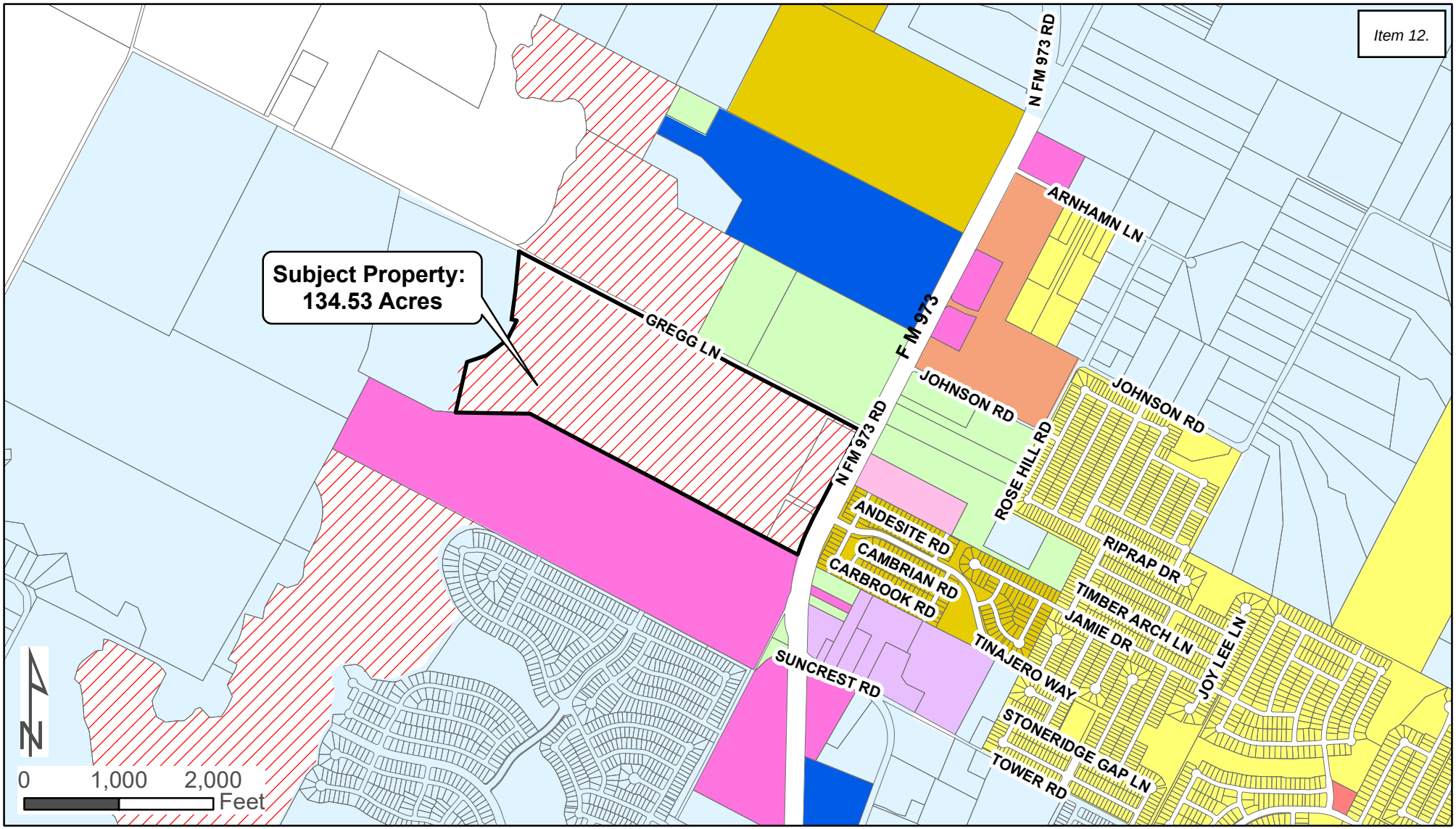


MANOR
EST. TEXAS 1872

Current:
(PUD) Planned Unit Development

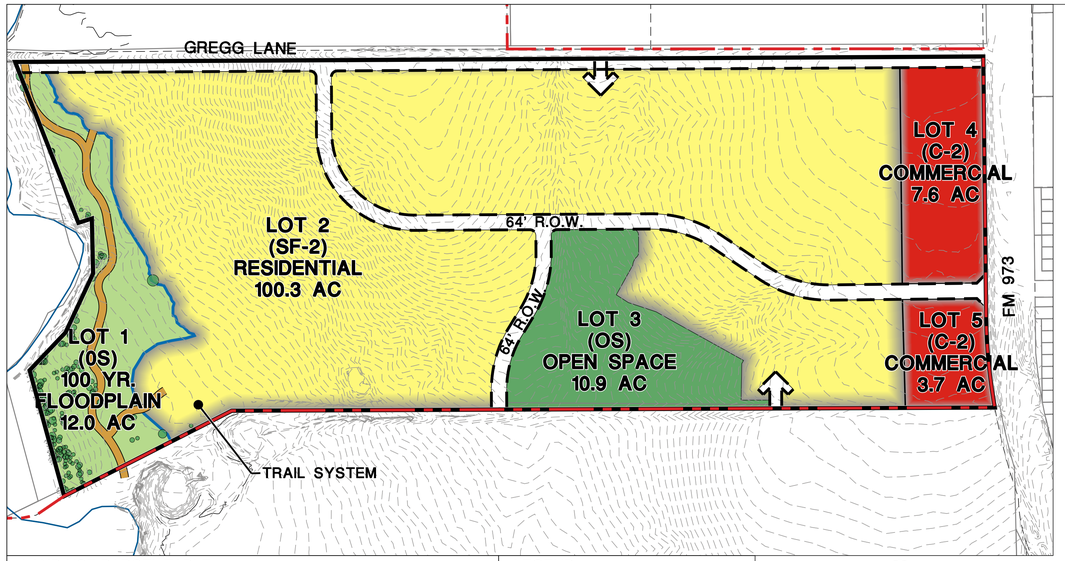
Proposed:
(PUD) Planned Unit Development

Zone

- A - Agricultural
- SF-1 - Single Family Suburban
- SF-2 - Single Family Standard
- TF - Two Family
- TH - Townhome
- MF-1 - Multi-Family 15
- MF-2 - Multi-Family 25
- MH-1 - Manufactured Home
- I-1 - Institutional Small
- I-2 - Institutional Large
- GO - General Office
- C-1 - Light Commercial
- C-2 - Medium Commercial
- C-3 - Heavy Commercial
- NB - Neighborhood Business
- DB - Downtown Business
- IN-1 - Light Industrial
- IN-2 - Heavy Industrial
- PUD - Planned Unit Development
- ETJ

Kimbro Creek
Estates
978
Stonewater
Shadowglen
Greenbury
Presidential
Meadows

Gregg Ln
Johnson Rd
Suncrest Rd



LAND USE PARCEL TABLE			
LAND USE	ACREAGE	LOTS	DENSITY
(SF-2) RESIDENTIAL	101.9 ACRES	400 LOTS	4.0 DU/AC
(C-2) MEDIUM COMMERCIAL	11.3 ACRES	2 LOTS	
(OS) FLOODPLAIN	12.0 ACRES	1 LOTS	
(OS) OPEN SPACE	9.3 ACRES	1 LOTS	
TOTAL	134.5 ACRES		3.0 DU/AC

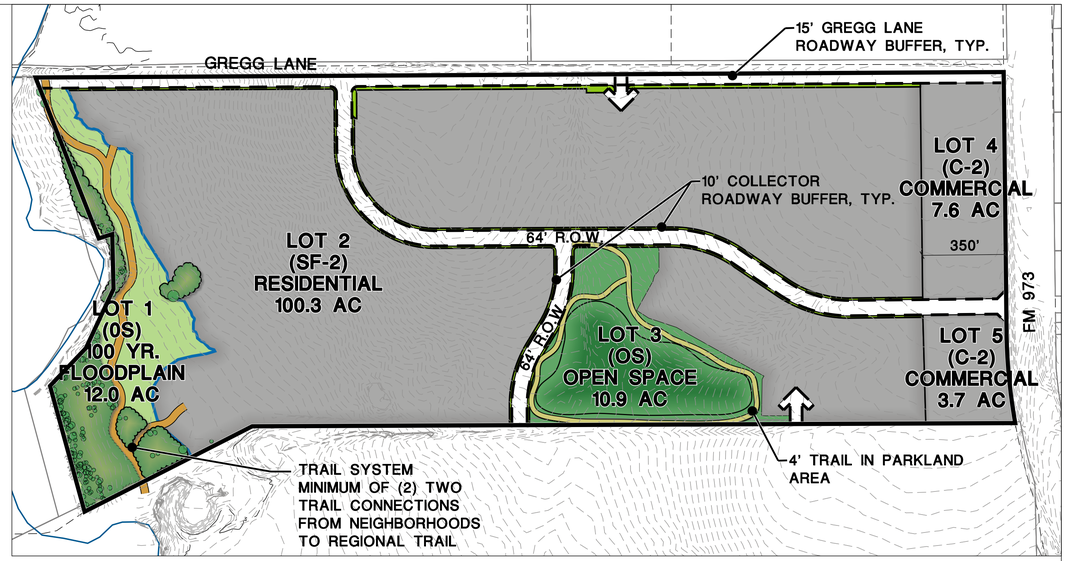
LEGEND

- PLAN BOUNDARY
- PROPOSED RIGHT-OF-WAY
- CITY LIMITS
- 4' WALKS
- 8' TRAILS

North

0 300' 600' 900'

Scale: 1" = 300'



PARK PLAN

PARK LAND DEDICATION:

North

0 300' 600' 900'

Scale: 1" = 300'

400 (number of dwelling units) /66 x 1 = 6.1 (required park acreage) 22.9 (proposed park acreage)

8' CONCRETE TRAIL (2,400 L.F.)

A. Purpose and Intent

1. The Monarch Ranch Planned Unit Development (PUD) is comprised of approximately 134.5 acres. The development of this Property is a combination of light commercial along FM 973 at the Eastern edge of the Property and a single-family detached residential community on the remainder of the Property.

B. Applicability and Base Zoning

1. All aspects regarding the development of this PUD shall comply with the City of Manor Code of Ordinances, except as established in this exhibit, titled Final PUD Site Plan.

2. For the purpose of establishing development standards for the PUD, the following base zoning districts have been selected from the Manor Code of Ordinances:

   SF-2 (Single-Family Standard)
   C-2 (Medium Commercial)

C. Conceptual Site Layout and Land Use Plan

1. The Land Use Plan has been attached to this PUD to illustrate the design intent for the Property. The Final PUD Site Plan is intended to serve as a guide to illustrate the general community vision and design concept and is not intended to serve as a final document.

D. Allowable/Prohibited Uses

1. The allowable residential use shall be detached single-family dwellings on individually platted lots. The maximum residential lot count shall be four hundred (400). Commercial uses shall be consistent with allowable C-2 (Medium Commercial) land uses as defined in Division 3, Section 14.02.017 of City of Manor Code of Ordinances except as modified herein.

2. The following uses shall be prohibited within the C-2 area of the PUD:
   - Amusement (outdoor)
   - Automobile Repair (minor)
   - Automobile Repair (major)
   - Commercial Off-Street Parking
   - Contractor's Shop
   - Financial Services (alternative)
   - Funeral Services
   - Kennel
   - Laundry Services
   - Mini-Storage Warehouse
   - Off-Site Accessory Parking
   - Pawnshop
   - Recreational Vehicle Sales and Rental
   - Truck and Trailer Sales and Rental
   - Veterinary Service, Large

E. Residential Development Standards

1. To ensure product diversity, the following single-family detached residential percentages shall apply to the residential district within this PUD:
   a. A maximum of 80 percent (80%) of the total lots may have a width of less than sixty feet (60').
   b. A minimum of 20 percent (20%) of the total shall have a width of sixty feet (60') or wider.

2. The Monarch Ranch residential development will comply with the Development Standards set forth below:

RESIDENTIAL USES

Lot Area: 6,000 s.f. Minimum (fronted loaded garage)
Lot Width: (minimum)50 ft.
Front Setback: (minimum)25 ft.
Side Setback: (minimum)5 ft.
Street Side Setback: (minimum)15 ft.
Rear Setback to residential:(minimum)10 ft.
Rear Setback to commercial: 15 ft
Minimum dwelling unit size:

Dwelling Unit Size (conditioned space)	Maximum Percentage
1,300 - 1,400 sq. ft.	20%
1,401 - 1,500 sq. ft.	20%
1,501 - 1,600 sq. ft	20%
1,601 - 1,700 sq. ft.	20%
1,701 + sq. ft.	Unlimited

Maximum building coverage: 50%
Maximum building coverage plus accessory structures: 60%

3. Standards not listed follow code, as amended

F. Commercial Development Standards

1. The Monarch Ranch commercial development shall comply with the C-2 (Medium Commercial) development standards set forth in the City of Manor Code of Ordinances, as amended.

G. Drainage Dedication and Facilities

1. Residential drainage facilities shall utilize earthen berms and be designed with a curvilinear shape where possible. If concrete retaining walls are required in the design of detention facilities, such areas shall be limited to not more than forty percent (40%) of the perimeter of the pond.

H. Parkland and Open Space

1. This Final PUD Site Plan provides approximately 22.9 acres of park and open space with the dedication of two (2) tracts of land as illustrated on the Parks Plan on this sheet. The parks and open space will include detention facilities for the project, tree preservation areas, 100 year floodplain, trail corridor and active programmed parkland.

2. An eight-foot (8') concrete trail shall provide pedestrian/bike access along the parkland corridor connecting from the north property boundary to the south property boundary, as depicted on Park Plan. Trees shall be planted parallel to the concrete trail at a spacing of one (1) tree for every forty (40) linear feet. Trees shall be a minimum of three (3) inch caliper and selected from the Type A/B tree list of the City of Manor Code of Ordinances.

3. Parkland amenities located within the Enfield PUD shall include a minimum of the following recreational elements: playground, parking area, dog park, picnic areas, picnic pavilion and open lawn/gaming area.
   a. Age 5-12 playground
   b. Age 2-5 playground
   c. Parking area with a minimum of 20 parking spaces
   d. Minimum 10,000 square foot dog park (may be allowed within detention area)
   e. Minimum 20 foot by 30 foot picnic pavilion

4. A portion of the parkland may be utilized for a private amenity pool and associated restroom facility. This lot defined for the private amenity will not be dedicated to the City and final boundary will be determined at the platting stage of development. The private amenity portion of the overall parkland will be a maximum of 2 acres.

5. A minimum 4 foot wide, concrete sidewalk shall be provided parallel to the Gregg Lane Landscape Buffer.

6. The proposed parkland shall be dedicated to the City of Manor and privately maintained by the Monarch Ranch Homeowner's Association.

I. Landscaping

1. Gregg Lane Landscape Buffer
   a. A minimum fifteen (15) foot landscape buffer, measured from the edge of the Gregg Lane right of way, shall be provided. Four (4), minimum three (3) inch caliper, Type A large or Type B medium native trees (as defined by the Manor Code of Ordinances) and fifteen (15), minimum three (3) gallon, shrubs shall be planted per 200 linear feet of landscape buffer. A minimum four (4) foot wide, concrete sidewalk shall be provided within the Gregg Lane Landscape Buffer or the expanded right of way for Gregg Lane. Location and alignment of the sidewalk shall be coordinated during the Preliminary Plan stage of development.

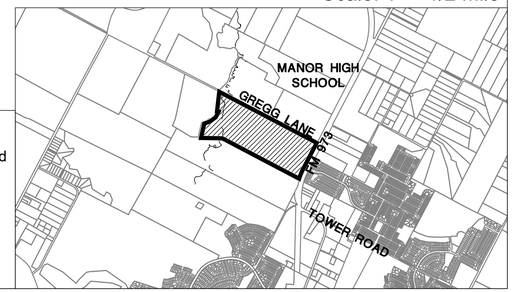
2. Unloaded Collector Landscape Buffer.
   a. For internal, unloaded collector roadways, a minimum ten (10) foot landscape buffer, measured from the edge of the collector right of way, shall be provided. One (1), minimum three (3) inch caliper, Type A large or Type B medium native tree (as defined by the Manor Code of Ordinances) and five (5), minimum three (3) gallon, shrubs shall be planted per 50 linear feet of landscape buffer.

3. Storm Water Detention
   a. Storm water detention facilities shall be screened according to the requirements outlined in the City of Manor Code of Ordinances, Section 15.03.021 (f).

4. Masonry wall shall be provided along the rear and side lotlines of lots that back up to an unloaded collector and Gregg Lane. Masonry shall include brick, stone, stucco or concrete panel fencing. Stone or brick columns shall be provided a minimum of every 300 feet. Walls should be minimized and varied whenever possible to avoid a tunnel effect along the collector roadway.

5. All landscape buffers and walls shall be privately maintained by the Monarch Ranch Homeowners Association.

VICINITY MAP
Scale: 1" = 1/2 Mile



Approval and authorized for record by the City Council for the City of Manor, Texas.

Dated this ____ Day of _____, 20___

By:_____
Honorable Mayor Dr. Christopher Harvey
Mayor of the City of Manor, Texas

This Final PUD Site Plan has been submitted to and considered by the Planning and Zoning Commission of the City of Manor, Texas, and is hereby recommended for approval by the City Council.

Dated this ____ Day of _____, 20___

By:_____
Felix Paiz, Chairperson

SEC Planning, LLC
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BLACKBURN HOMES

MONARCH RANCH
FINAL PUD SITE PLAN
MANOR, TEXAS

Z:\210038-BBGR\Cadfiles\PLANNING\Submittals\PUD Amendment_10-2022\PUD Site Plan_Notes Monarch Ranch Amendment.dwg

Issued:
1. PUD Submittal 5/24/2021
2. _____
3. _____
4. _____
5. _____

Revisions:
1. PUD Submittal 7/29/2021
2. PUD Submittal 8/30/2021
3. PUD Submittal 11/11/2021
4. PUD Amend Submittal 10/13/2022
5. PUD Amend 2 4/15/2024

Issue Date: _____

Drawn By:
Reviewed By: MB

Project No.
210038 - BBGR

SHEET 1 of 1

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Proposed PUD Amendment:

E. Residential Development Standards

1. To ensure product diversity, the following single-family detached residential percentages shall apply to the residential district within this PUD:
   a. A maximum of 80 percent (80%) of the total lots may have a width of less than sixty feet (60').
   b. A minimum of 20 percent (20%) of the total shall have a width of sixty feet (60') or wider.

2. The Monarch Ranch residential development will comply with the Development Standards set forth below:

RESIDENTIAL USES

Lot Area: 6,000 s.f. Minimum (fronted loaded garage)
Lot Width: (minimum)50 ft.
Front Setback: (minimum)25 ft.
Side Setback: (minimum)5 ft.
Street Side Setback: (minimum)15 ft.
Rear Setback to residential:(minimum)10 ft.
Rear Setback to commercial: 15 ft
Minimum dwelling unit size:

Dwelling Unit Size (conditioned space)	Maximum Percentage
1,300 - 1,400 sq. ft.	20%
1,401 - 1,500 sq. ft.	20%
1,501 - 1,600 sq. ft	20%
1,601 - 1,700 sq. ft.	20%
1,701 + sq. ft.	Unlimited

Maximum building coverage: 50%
Maximum building coverage plus accessory structures: 60%

3. Standards not listed follow code, as amended

Current PUD:

E. Residential Development Standards

1. To ensure product diversity, the following single-family detached residential percentages shall apply to the residential district within this PUD:
   a. A maximum of 80 percent (80%) of the total lots may have a width of less than sixty feet (60').
   b. A minimum of 20 percent (20%) of the total shall have a width of sixty feet (60') or wider.

2. The Monarch Ranch residential development will comply with the Development Standards set forth below:

RESIDENTIAL USES

Lot Area: 6,000 s.f. Minimum (fronted loaded garage)
Lot Width: (minimum)50 ft.
Front Setback: (minimum)25 ft.
Side Setback: (minimum)5 ft.
Street Side Setback: (minimum)15 ft.
Rear Setback to residential:(minimum)10 ft.
Rear Setback to commercial: 15 ft
Minimum dwelling unit size: 1,700 sq. ft.
Maximum building coverage: 50%
Maximum building coverage plus accessory structures: 60%

3. Standards not listed follow code, as amended

THIRD AMENDMENT TO DEVELOPMENT AGREEMENT ESTABLISHING DEVELOPMENT STANDARDS FOR MONARCH RANCH

This Third Amendment to the Development Agreement Establishing Development Standards for Monarch Ranch (this "**Third Amendment**") is dated effective ~~April~~ August ____, 2024 (the "**Third Amendment Effective Date**") and is entered into between the **City of Manor**, a Texas home-rule municipal corporation (the "**City**"), **Monarch Ranch at Manor, LLC**, a Texas limited liability company ("**Monarch Developer**"), **Enfield Partners LLC**, a Texas limited liability company, as to a 40% undivided ownership interest, **Birdview LLC**, a Texas limited liability company, as to a 10% undivided ownership interest, **MP 973, LLC**, a Texas limited liability company, as to a 25% undivided ownership interest, and **Payne Travis LLC**, a Texas limited liability company, as to a 25% undivided ownership interest (collectively "**Enfield Developer**") (collectively referred to as the "**Developers**"), and **Gregg Lane Dev LLC**, a Texas limited liability company ("**Gregg Lane Dev LLC**") hereby joins and consents to this Third Amendment for the limited purposes described herein. Enfield Developer and Monarch Developer are sometimes referred to, collectively, herein as the "**Developers**." The City and the Developer are sometimes referred to as a "**Party**" and collectively herein as the "**Parties**."

RECITALS:

A. City and Developers previously entered into that certain Development Agreement Establishing Development Standards for Monarch Ranch dated effective May 4, 2022, ~~and~~ that certain First Amendment to Development Agreement Establishing Development Standards for Monarch Ranch dated effective December 21, 2022 and that certain Second Amendment to Development Agreement Establishing Development Standards for Monarch Ranch dated effective February 21, 2024 (collectively the "**Agreement**"), for that certain residential and commercial project located in the City of Manor, Travis County, Texas, as more particularly described in the Agreement.

B. The Agreement provides, among other things, provisions related to residential development requirements.

C. The City and Developers desire to modify and amend the Agreement in certain respects, as more particularly set forth in this Third Amendment to address the residential development requirements as applied to the number of square feet in the structure.

AGREEMENT:

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, City and Developers hereby agree as follows:

1. Incorporation of Recitals. The recitals set forth above are incorporated herein and made a part of this Third Amendment to the same extent as if set forth herein in full.

2. Capitalized Terms. All capitalized terms in this Third Amendment shall have the same meanings as in the Agreement unless expressly provided otherwise herein.

3. Development Standards. Section 3 (a) Residential Development Requirement of the Agreement is hereby deleted in its entirety and replaced with the following:

" **Section 3. Development Standards**

~~**(a) Residential Development Requirement.** The exterior wall standards set forth in this section shall apply to the structures located on the Monarch Property, including any amenity building structures:~~

~~**1. Front Elevations for Dwelling Units 1,700 square feet and larger.** At least thirty (30%) of the exterior façade of the front elevations must be constructed of clay brick, natural stone, cultured stone, cast stone, cement stucco or natural stone panels or similar material approved by the Development Services Director, exclusive of roofs, eaves, soffits, windows, balconies, gables, doors and trim work as outlined in **Exhibit F, Section A**;~~

~~i. All street facing exterior walls of primary buildings / structures must include at least three (3) variations of architectural accents that break the wall plane, as outlined in **Exhibit F, Section A.** Architectural features may include:~~

~~1. Cantilevered overhangs;~~
~~2. Cedar brackets / details;~~
~~3. Awnings (with optional metal roofs);~~
~~4. Shutters;~~
~~5. Gable Vents; or~~
~~6. Dormers.~~

~~**2. Front Elevations for Dwelling Units Less Than 1,700 Square Feet to a Minimum of 1,300 Square Feet.** At least fifty (50%) of the exterior façade of the front elevations must be constructed of clay brick, natural stone, cultured stone, cast stone, cement stucco or natural stone panels or similar material approved by the Development Services Director, exclusive of roofs, eaves, soffits, windows, balconies, gables, doors and trim work as outlined in **Exhibit F, Section A.**~~

~~i. All street facing exterior walls of primary buildings / structures must include at least three (3) variations of architectural accents that break the wall plane, as outlined in **Exhibit F, Section A.** Architectural features may include:~~

~~1. Cantilevered overhangs;~~
~~2. Cedar brackets / details;~~
~~3. Awnings (with optional metal roofs);~~
~~4. Shutters;~~
~~5. Gable Vents; or~~
~~6. Dormers.~~

~~**3. Collector Road and Corner Lots.**~~

~~For Dwelling Units of 1,700 square feet and larger, at least thirty (30%) of the exterior façade of the side and rear elevations must be constructed of clay brick, natural stone, cultured stone, cast stone, cement stucco or natural stone panels or similar material approved by the Development Services Director, exclusive of roofs, eaves, soffits, windows, balconies, gables, doors and trim work as outlined in **Exhibit F, Section B**.~~

~~For Dwelling Units less than 1,700 square feet to a minimum of 1,300 square feet, at least fifty (50%) of the exterior façade of the side and rear elevations must be constructed of clay brick, natural stone, cultured stone, cast stone, cement stucco or natural stone panels or similar material approved by the Development Services Director, exclusive of roofs, eaves, soffits, windows, balconies, gables, doors and trim work as outlined in **Exhibit F, Section B**.~~

~~i. All exterior walls of primary buildings / structures that face public R.O.W. shall include at least one (1) variation of an architectural accent that breaks the wall plane, as outlined in **Exhibit F, Section B.** Architectural features may include:~~

~~1. Cantilevered overhangs;~~
~~2. Cedar brackets / details;~~
~~3. Awnings (with optional metal roofs);~~
~~4. Shutters;~~
~~5. Gable Vents; or~~
~~6. Dormers.~~

~~**4. Interior Lots.** At least thirty percent (30%) of the exterior façade of the side and rear elevations on interior lots will consist of cementitious fiber siding with at least a 2' masonry return as outlined in **Exhibit F, Section C**.~~

~~**5. Amenity Building**. Architectural split-faced, integrally colored limestone CMU block shall be an acceptable masonry material for the residential amenity building(s) and picnic pavilion structures."~~

(a) **Residential Development Requirement.** The exterior wall standards set forth in this section shall apply to the structures located on the Monarch Property, including any amenity building structures:

1. Front Elevations. The exterior façade of the front elevations shall be constructed to the following minimum standards:

i. All street facing, exterior walls of primary buildings / structures shall include at least three (3) variations of architectural accents that break the wall plane, as outlined in **Exhibit F**, Section A. Architectural features may include:

1. Cantilevered overhangs;
2. Cedar brackets / details;
3. Awnings (with option metal roofs);
4. Shutters;

5. Gable vents; or
6. Dormers.

2. **Collector Road and Corner Lots**. The exterior façade of the side and rear elevations, when adjacent to a collector road or on a corner lot, shall be constructed to the following minimum standards:

i. All exterior walls of primary buildings / structures that face public R.O.W shall include at least one (1) variation of an architectural accent that breaks the wall plane, as outlined in **Exhibit F**, Section B. Architectural features may include:

1. Cantilevered overhangs;
2. Cedar brackets / details;
3. Awnings (with option metal roofs);
4. Shutters;
5. Gable vents; or
6. Dormers.

3. **Interior Lots.** The exterior façade of the side and rear elevations on interior lots will consist of cementitious fiber siding with at least a 2' masonry return, as outlined in **Exhibit F**, Section C.

4. **Amenity Building.** Architectural split-faced, integrally colored limestone CMU block shall be an acceptable masonry material for the residential amenity building(s) and picnic pavilion structures.

5. **Masonry Requirement and Dwelling Unit Size.** The Monarch Developer agrees to provide a minimum percentage of the total exterior facade area constructed of Masonry as provided for in **Exhibit F**, Section D. "Masonry" is considered clay brick, natural stone, cultured stone, cast stone, stucco or natural stone panels or similar material approved by the Development Services Director, exclusive of roofs, eaves, soffits, windows, balconies, gables, doors and trim work. Masonry excludes cementitious planking."

4. Ratification of Agreement/Conflict. Except as expressly amended hereby, the Agreement and all rights and obligations created thereby or thereunder are in all respects ratified and confirmed and remain in full force and effect. Where any section, subsection or clause of the Agreement is modified or deleted by this Third Amendment, any unaltered provision of such section, subsection or clause of the Agreement shall remain in full force and effect. However, where any provision of this Third Amendment conflicts or is inconsistent with the Agreement, the provisions of this Third Amendment shall control.

5. No Waiver. Neither City's nor Developer's execution of this Third Amendment shall (a) constitute a waiver of any of its rights and remedies under the Agreement or at law with respect to the other party's obligations under the Agreement or (b) be construed as a bar to any subsequent enforcement of any of its rights or remedies against the other party.

6. Governing Law. This Third Amendment shall be governed by and construed in accordance with the laws of the State of Texas and shall be performable in Travis County, Texas. Venue shall lie exclusively in Travis County, Texas.

7. Entire Agreement. This Third Amendment, together with any exhibits attached hereto, and the Agreement, as amended by this Third Amendment, constitute the entire agreement between the Parties with respect to the subject matter stated therein, supersedes all prior agreements relating to such subject matter and may not be amended except by a writing signed by the Parties and dated subsequent to the date hereof. The Parties hereto agree and understand that this Third Amendment shall be binding upon and inure to the benefit of the parties hereto and their respective representatives, heirs, successors and assigns.

8. Covenant Running with the Land. The Agreement, as amended by this Third Amendment, shall continue to constitute a binding covenant on the Property (as defined and detailed in the Agreement) and shall run with the land. A copy of this Third Amendment shall be recorded in the Official Public Records of Travis County, Texas. The Owner and the City acknowledge and agree that this Third Amendment is binding upon the City and the Owner and their respective successors, executors, heirs, and assigns, as applicable, for the term of this Third Amendment.

9. Captions. The captions preceding the text of each section and paragraph hereof, if any, are included only for convenience of reference and shall be disregarded in the construction and interpretation of this Third Amendment.

10. Interpretation. This Third Amendment has been jointly negotiated by the Parties and shall not be construed against a party because that Party may have primarily assumed responsibility for the drafting of this Third Amendment.

11. Authority. Each party hereto warrants that each has the full legal authority to execute and deliver this Third Amendment. In addition, the individual who executes this Third Amendment on behalf of each party hereto is authorized to act for and on behalf of such party and to bind such party to the terms and provisions hereof.

12. Severability. If any provision of this Third Amendment shall be held to be invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable, unless enforcement of this Third Amendment as so invalidated would be unreasonable or grossly inequitable under the circumstances or would frustrate the purpose of this Third Amendment.

13. Anti-Boycott Verification. To the extent this Third Amendment constitutes a contract for goods or services within the meaning of Section 2271.002 of the Texas Government Code, as amended, solely for purposes of compliance with Chapter 2271 of the Texas Government Code, and subject to applicable Federal law, Developers and Gregg Lane Dev LLC represent that neither Developers, Gregg Lane Dev LLC nor any wholly owned subsidiary, majority-owned subsidiary, parent company or affiliate of Developers or Gregg Lane Dev LLC (i) boycotts Israel or (ii) will boycott Israel through the term of this Third Amendment. The terms “boycotts Israel”

and "boycott Israel" as used in this paragraph have the meanings assigned to the term "boycott Israel" in Section 808.001 of the Texas Government Code, as amended.

14. Iran, Sudan and Foreign Terrorist Organizations. To the extent this Third Amendment constitutes a governmental contract within the meaning of Section 2252.151 of the Texas Government Code, as amended, solely for purposes of compliance with Chapter 2252 of the Texas Government Code, and except to the extent otherwise required by applicable federal law, Developers and Gregg Lane Dev LLC represent that Developers and Gregg Lane Dev LLC nor any wholly owned subsidiary, majority-owned subsidiary, parent company or affiliate of Developers or Gregg Lane Dev LLC is a company listed by the Texas Comptroller of Public Accounts under Sections 2270.0201, or 2252.153 of the Texas Government Code.

15. Anti-Boycott Verification – Energy Companies. The Developers and Gregg Lane Dev LLC hereby verify that they and their parent company, wholly- or majority-owned subsidiaries, and other affiliates, if any, do not boycott energy companies and will not boycott energy companies during the term of this Third Amendment. The foregoing verification is made solely to comply with Section 2274.002, Texas Government Code, and to the extent such Section is not inconsistent with a governmental entity's constitutional or statutory duties related to the issuance, incurrence, or management of debt obligations or the deposit, custody, management, borrowing, or investment of funds. As used in the foregoing verification, "boycott energy company" means, without an ordinary business purpose, refusing to deal with, terminating business activities with, or otherwise taking any action that is intended to penalize, inflict economic harm on, or limit commercial relations with a company because the company: (A) engages in the exploration, production, utilization, transportation, sale, or manufacturing of fossil fuel-based energy and does not commit or pledge to meet environmental standards beyond applicable federal and state law; or (B) does business with a company described by the preceding statement in (A).

16. Anti-Discrimination Verification – Firearm Entities and Firearm Trade Associations. The Developers and Gregg Lane Dev LLC hereby verify that they and their parent company, wholly- or majority-owned subsidiaries, and other affiliates, if any, do not have a practice, policy, guidance, or directive that discriminates against a firearm entity or firearm trade association and will not have a practice, policy, guidance, or directive that discriminates against a firearm entity or firearm trade association during the term of this Third Amendment. The foregoing verification is made solely to comply with Section 2274.002, Texas Government Code. As used in the foregoing verification, "discriminate against a firearm entity or firearm trade association" means: (i) refuse to engage in the trade of any goods or services with the entity or association based solely on its status as a firearm entity or firearm trade association; (ii) refrain from continuing an existing business relationship with the entity or association based solely on its status as a firearm entity or firearm trade association; or (iii) terminate an existing business relationship with the entity or association based solely on its status as a firearm entity or firearm trade association; but does not include (a) the established policies of a merchant, retail seller, or platform that restrict or prohibit the listing or selling of ammunition, firearms, or firearm accessories; or (b) a company's refusal to engage in the trade of any goods or services, decision to refrain from continuing an existing business relationship, or decision to terminate an existing business relationship to comply with federal, state, or local law, policy, or regulations or a directive by a regulatory agency; or for any traditional business reason that is specific to the customer or potential

customer and not based solely on an entity's or association's status as a firearm entity or firearm trade association.

17. Counterparts. This Third Amendment may be executed in multiple counterparts, each of which will be deemed original, and all of which will constitute one and the same agreement. Each such executed copy shall have the full force and effect of an original executed instrument.

[SIGNATURES ON FOLLOWING PAGES]

EXECUTED in multiple originals, and in full force and effect as of the Third Amendment Effective Date.

CITY:

CITY OF MANOR, TEXAS
A Texas Home Rule Municipal Corporation

By: _____
Dr. Christopher Harvey, Mayor

ATTEST:

_____
Lluvia T. Alvaraz, City Secretary

STATE OF TEXAS
COUNTY OF TRAVIS

This instrument was acknowledged before me on the _____ day of _____, 2024 by Dr. Christopher Harvey, Mayor of Manor, Texas, a Texas home rule municipality on behalf of the City.

_____
Notary Public for Texas

DEVELOPER:

MONARCH RANCH AT MANOR LLC

By: _____
David B. Blackburn, Manager

STATE OF MISSISSIPPI
COUNTY OF LAFAYETTE

This instrument was acknowledged before me on the ___ day of _____, 2024 by David B. Blackburn, Manager of Monarch Ranch at Manor LLC on behalf of the entity.

_____
Notary Public for Texas

ENFIELD DEVELOPER:

ENFIELD PARTNERS LLC

By: _____
Russell T. Thurman
Manager/Member

STATE OF TEXAS
COUNTY OF TRAVIS

This instrument was acknowledged before me on the ___ day of _____, 2024 by Russell T. Thurman, manager of Enfield Partners LLC on behalf of the entity.

_____
Notary Public for Texas

BIRDVIEW LLC

By: _____
Bryan White, Manager

STATE OF TEXAS
COUNTY OF TRAVIS

This instrument was acknowledged before me on the ___ day of _____, 2024 by Bryan White, manager of Birdview LLC on behalf of the entity.

_____
Notary Public for Texas

MP 973 LLC

By: _____
Martin B. Payne, Manager/Member

STATE OF TEXAS
COUNTY OF FAYETTE

This instrument was acknowledged before me on the ___ day of _____, 2024 by Martin B. Payne manager of MP 973 LLC on behalf of the entity.

_____
Notary Public for Texas

PAYNE TRAVIS LLC

By: _____
John Thurman Payne

STATE OF TEXAS
COUNTY OF LLANO

This instrument was acknowledged before me on the ___ day of _____, 2024 by John Thurman Payne, manager of Payne Travis LLC on behalf of the entity.

_____
Notary Public for Texas

CONSENTING PARTY

Gregg Lane Dev LLC, a Texas limited liability company, hereby joins and consents to the execution of this Third Amendment solely for the purpose of agreeing to the terms, obligations and provisions outlined in this Third Amendment expressly applicable to Gregg Lane Dev LLC.

GREGG LANE DEV LLC,
a Texas limited liability company

By: _____
Name: _____
Title: _____

STATE OF TEXAS
COUNTY OF _____

This instrument was acknowledged before me on the _____ day of _____, 2024 by _____, _____ of Gregg Lane Dev LLC, a Texas limited liability company on behalf of the entity.

_____
Notary Public for Texas

EXHIBIT F
RESIDENTIAL EXTERIOR STANDARDS

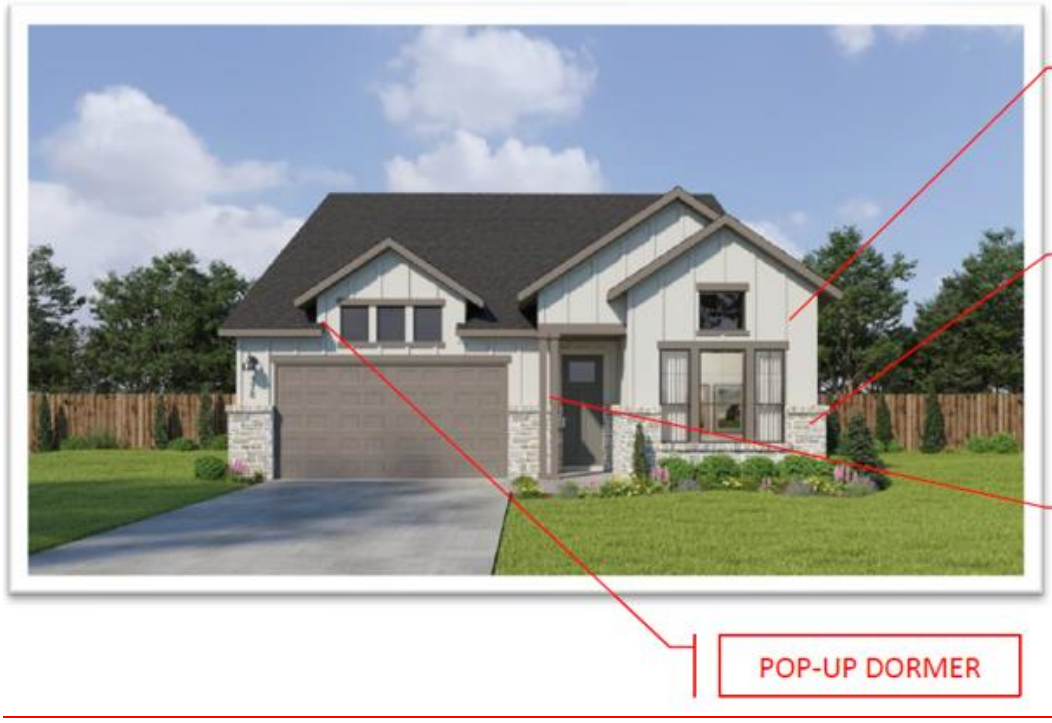
A. All **Front elevations shall** consist of:

a. Minimum masonry percentage (cement stucco, stone, or brick) from the table in subsection "D"

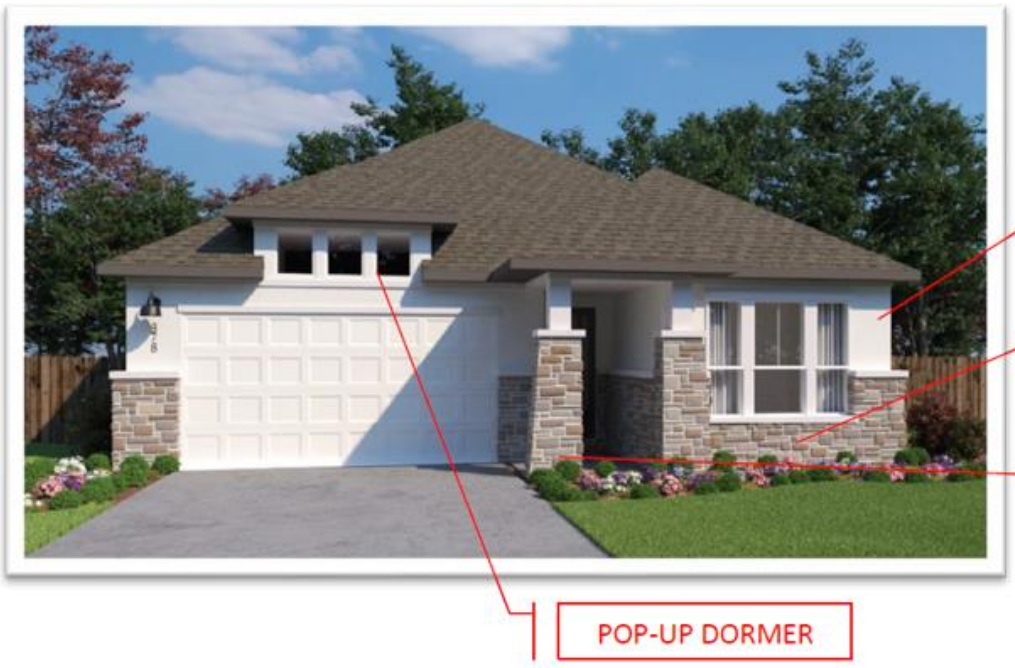
b. At least three (3) variations of architectural accents.

1. Cantilevered Overhangs
2. Cedar Brackets / Details
3. Awnings (with optional metal roofs)
4. Shutters
5. Gable Vents
6. Dormers

DECORATIVE CEDAR TRUSS
CEMENTITIOUS, PAINT GRADE, BOARD & BATTEN
MASONRY
DORMER


CEMENTITIOUS, PAINT GRADE, BOARD & BATTEN
MASONRY WAINSCOT
WRAPPED POST
POP-UP DORMER

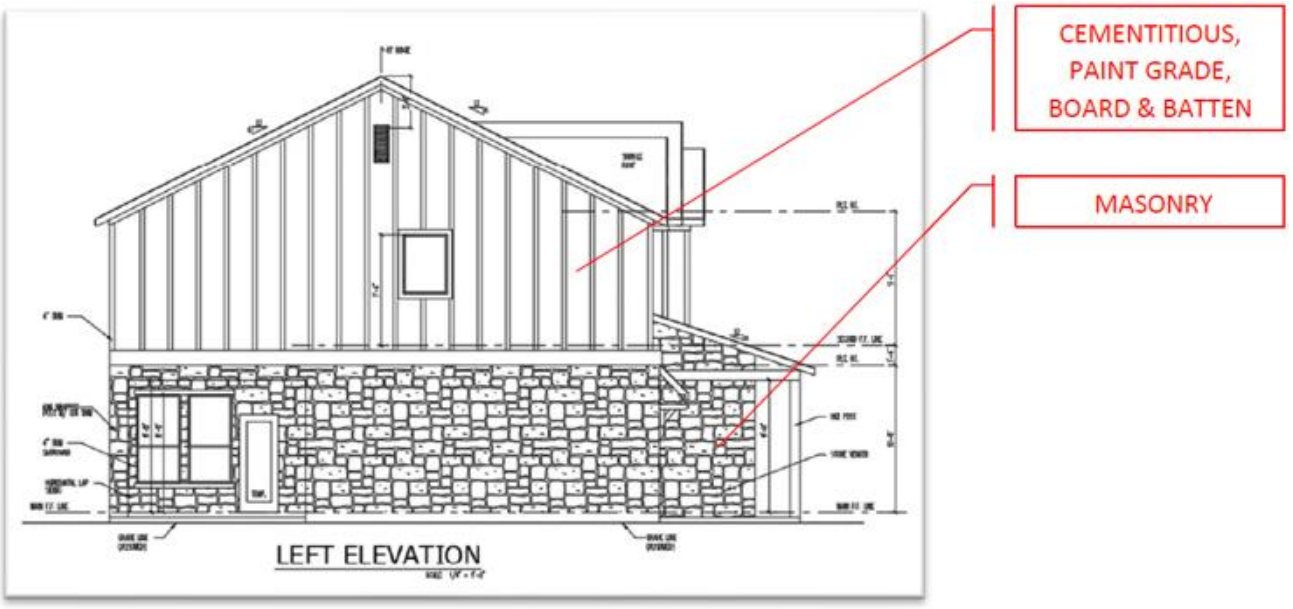
DECORATIVE CEDAR TRUSS
PAINTED STUCCO
MASONRY
CANTILVERED OVERHANG

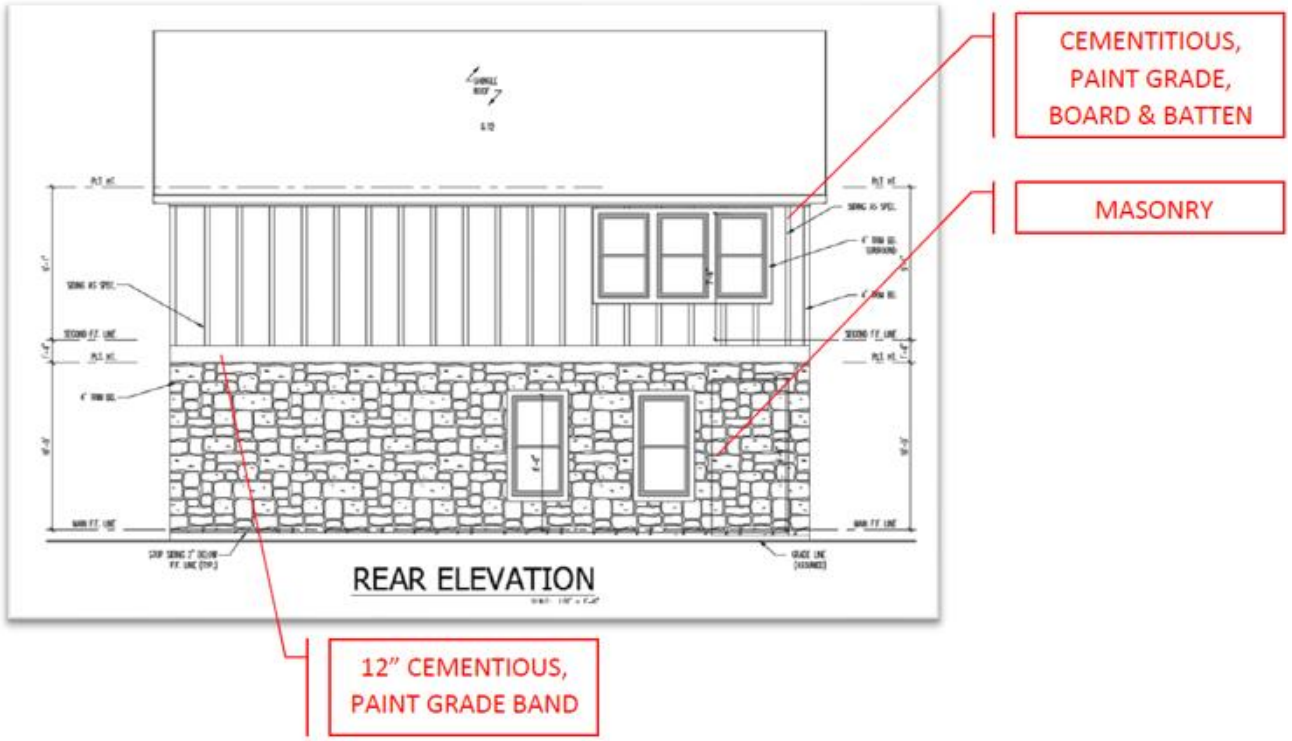

PAINTED STUCCO
MASONRY WAINSCOT
ANGLED COLUMN
POP-UP DORMER

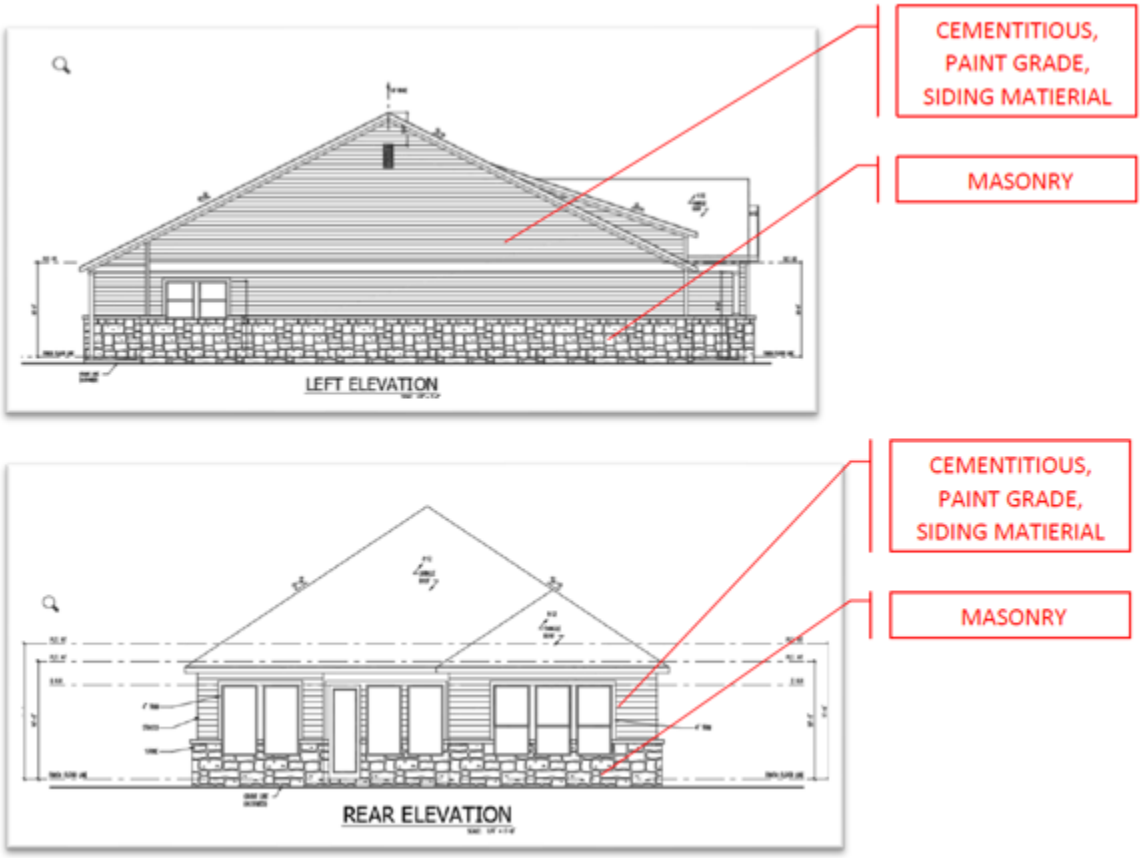
DECORATIVE CEDAR TRUSS
PAINTED STUCCO
MASONRY
SHUTTERS

DECORATIVE CEDAR TRUSS
CEMENTITIOUS, PAINT GRADE, BOARD & BATTEN
MASONRY
METAL ACCENT ROOF

B. **Collector Road & Corner Lots shall** have masonry on the side and rear elevations, equal to the front elevation from the table in subsection "D".
   a. These will be labeled as "Premium" elevations.
   b. Masonry (stone/cement stucco/brick) along sides and rear (per front elevation finish).





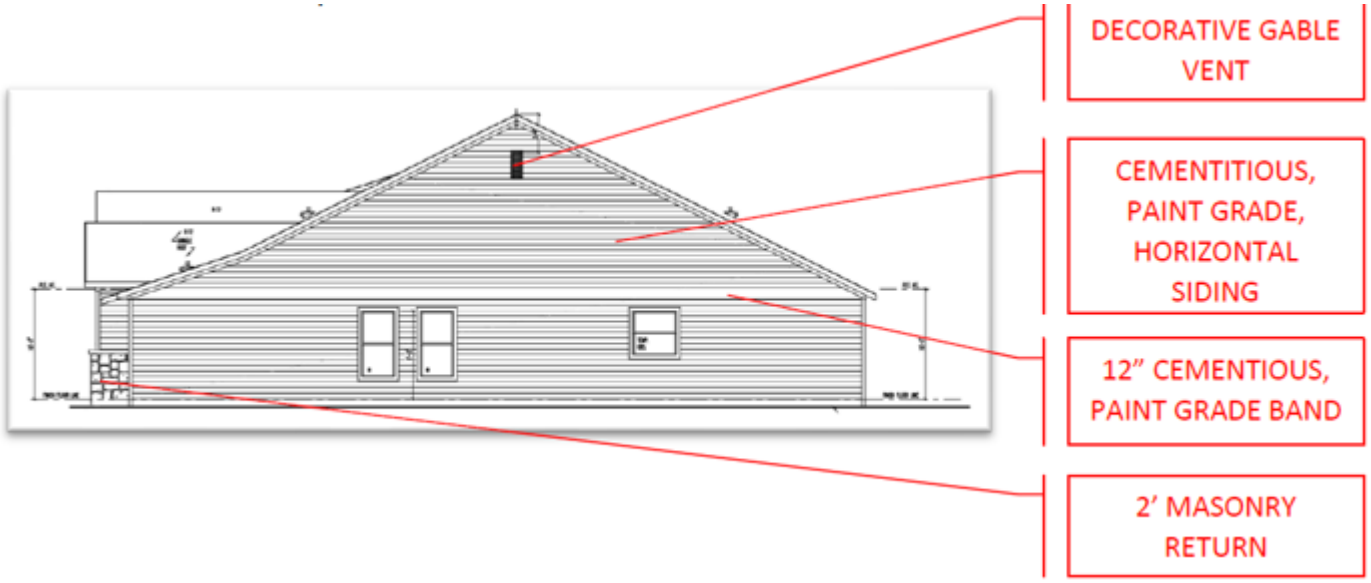

CEMENTITIOUS, PAINT GRADE, SIDING MATIERIAL
MASONRY
LEFT ELEVATION
CEMENTITIOUS, PAINT GRADE, SIDING MATIERIAL
MASONRY
REAR ELEVATION

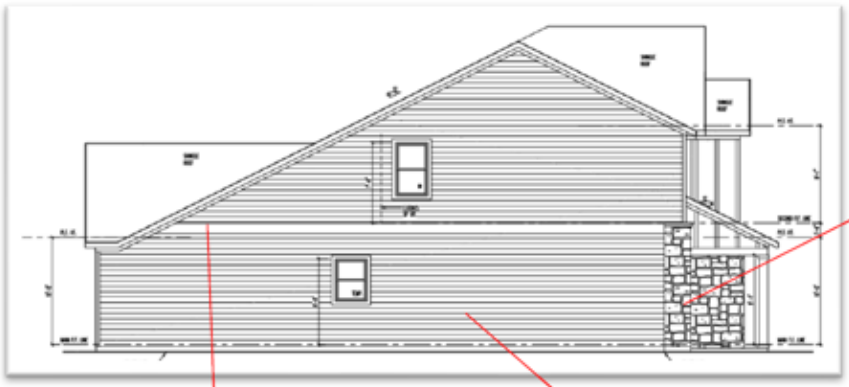
C. **Interior Lots shall** consist of cementitious fiber siding at the sides and rear elevations.

a. Horizontal or Board & Batten, cementitious fiber siding

i. Side elevations that consist of a gable, or that are 2-story will include a 10-12" band to break-up the siding material and add character.

b. 2' Masonry Return

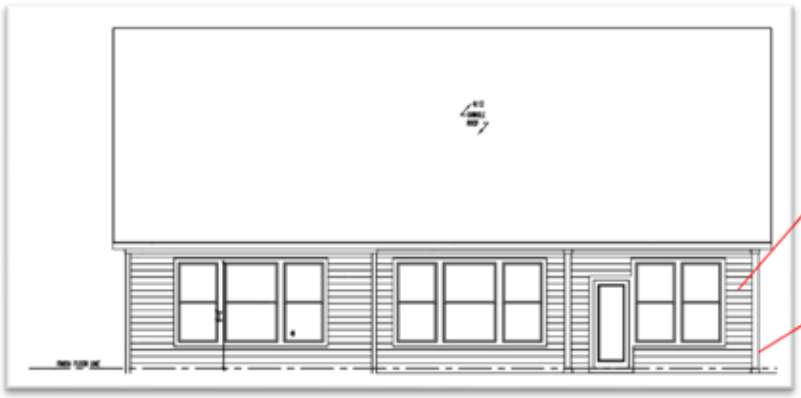




2' MASONRY RETURN

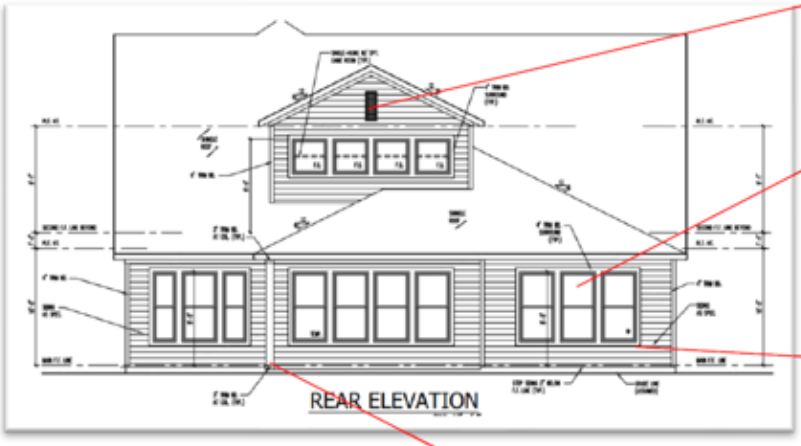
12" CEMENTIOUS, PAINT GRADE BAND

CEMENTITIOUS, PAINT GRADE, HORIZONTAL SIDING



CEMENTITIOUS, PAINT GRADE, HORIZONTAL SIDING

WRAPPED POST



DECORATIVE GABLE VENT

REAR ELEVATIONS WITH PLENTY OF WINDOWS

CEMENTITIOUS, PAINT GRADE, HORIZONTAL SIDING

WRAPPED POST

D. **Masonry and Dwelling Unit Size Table**

Dwelling Unit Size (conditioned space)	Minimum Front Façade* Masonry Percentage
1,300 – 1,400 sq. ft.	70%
1,401 – 1,500 sq. ft.	60%
1,501 – 1,600 sq. ft.	50%
1,600 – 1,700 sq. ft.	40%
1,701 + sq. ft.	30%

* Collector Road and Corner Lots shall have side and rear masonry percentages equal to the minimum front façade percentage.

6/26/2024

City of Manor Development Services

Notification for a Planned Use Development (PUD) Amendment

Project Name: Monarch Ranch PUD Amendment
Case Number: 2024-P-1644-ZO
Case Manager: Michael Burrell
Contact: mburrell@manortx.gov – 512-215-8158

The City of Manor Planning and Zoning Commission and City Council will be conducting a Regularly Scheduled meeting for the purpose of considering and acting upon a Planned Use Development (PUD) Amendment for the Monarch Ranch Subdivision located at the southwest corner of the intersection at Gregg Lane and FM 973, Manor, TX. The request will be posted on the agenda as follows:

Public Hearing: Conduct a public hearing on a Rezoning Application for the Monarch Ranch Subdivision, being 134.53 acres, more or less, and located at the southwest corner of the intersection at Gregg Lane and FM 973, Manor, TX from Planned Unit Development (PUD) to Planned Unit Development (PUD).
Applicant: SEC Planning
Owner: Blackburn Group LLC

Purpose: The proposed amendment will decrease the minimum dwelling unit size from 1,700 square feet to 1,300 square feet.

The Planning and Zoning Commission will meet at 6:30PM on July 10, 2024 at 105 East Eggleston Street in the City Hall Council Chambers.

The City Council will meet at 7:00PM on July 17, 2024 at 105 East Eggleston Street in the City Hall Council Chambers.

You are being notified because you own property within 300 feet of the property for which this Rezoning Application has been filed. Comments may be addressed to the email address or phone number above. Any communications received will be made available to the Commissioners and Council Members during the discussion of this item.

CITY OF PFLUGERVILLE
PO BOX 589
PFLUGERVILLE, TX 78691-0589

GREGG LANE DEV LLC
101 PARKLANE BLVD STE 102
SUGAR LAND, TX 77478-5521v

BOARD OF TRUSTEES OF TH
ISD
DENNIS ANDERSON ETAL
533 HIWASEE ROAD
WAXAHACHIE, TX 75165-6448

UNITED STATES OF AMERICA
ANDERSON DENNIS ETAL
UNITED STATES ATTORNEYS OFFICE
533 HIWASEE RD
WAXAHACHIE, TX 75165-6448

BURATTI, ROBERT JOE 6903
GENEVA DR
AUSTIN, TX 78723-1506

STRABO HOLDINGS LLC
13510 BR0ADMEADE AVE
AUSTIN, TX 78729

FOXTROT HOLDING LLC
14605 FM 973 N
MANOR, TX 78653-3539

HOLLEY, EBONY L & TERRY G JR
14526 PERNELLA RD
MANOR, TX 78653-2062

BLAKELY, ARTURO S V & JENNIFER A
14522 PERNELLA RD
MANOR, TX 78653-2062

SHEPPERD, RICHARD & ROSE MARY
14518 PERNELLA RD
MANOR, TX 78653-2062

AGUILERA, JAVIER R & LAURA GUDINO
PENA & RAUL PENA & LUZ ROSAS DE
GUDINO
14514 PERNELLA RD
MANOR, TX 78653-2062

RODARTE, GAMALIEL & ALEXANDRIA
SERPAS
14510 PERNELLA RD
MANOR, TX 78653-2062

MORALES, GERARDO M 14506
PERNELLA RD
MANOR, TX 78653-2062

SW HOMEOWNERS ASSOCIATION INC
9601 AMBERGLEN BLVD STE 150
AUSTIN, TX 78729-1190

CHHETRI SHANKAR & ANJANA KARKI
14428 PERNELLA RD
MANOR, TX 78653-2061

JORDAN ANDY ZEWDE & TSEHAY MUHE
14424 PERNELLA RD
MANOR, TX 78653-2061

CHAPARRO, JUAN P & SULEIVA
CHAPARRO-RODRIGUEZ
14408 PERNELLA RD
MANOR, TX 78653-2061

CLARK, MARY M
14404 PERNELLA RD
MANOR, TX 78653-2061

ESCOBEDO, KRISTINE A & MATTHEW J
14400 PERNELLA RD
MANOR, TX 78653-2061

ESTRADA, GILBERTO A & MARIA D
14411 FM 973 N
MANOR, TX 78653

LEKCAM COMMUNICATION LLC
16404 MARCELLO DR
PFLUGERVILLE, TX 78660-2570

14420 PERNELLA RD INTERVIVOS
REVOCABLE TRUST
14420 PERNELLA RD
MANOR, TX 78653-2061

RUST CREEK LLC
9606 OLD MANOR RD #1
AUSTIN, TX 78724-1114

TAYLOR ARTHUR RAY & ODETTE VANESSA
14416 PERNELLA RD
MANOR, TX 78653-2061

REZA MASRUR & MUSTAFA ALI REZA
CHOWDHURY & FAUZIA ZAMAN
14412 PERNELLA RD
MANOR, TX 78653-2061

ESTRADA, MARIA D
14411 FM 973
MANOR, TX 78653-3933

OKRA LAND INCORPORATED
9505 JOHNNY MORRIS RD
AUSTIN , TX 78724-1527

AGENDA ITEM NO. _____

AGENDA ITEM SUMMARY FORM

PROPOSED MEETING DATE: August 7, 2024
PREPARED BY: Scott Dunlop, Director
DEPARTMENT: Development Services

AGENDA ITEM DESCRIPTION:

Consideration, discussion, and possible action on the Third Amendment to the Development Agreement Establishing Development Standards for Monarch Ranch.

BACKGROUND/SUMMARY:

The Monarch Ranch development agreement was originally approved on May 4, 2022. The agreement includes certain provision related to the single-family architectural standards including a minimum 30% masonry requirement for the public facing frontages of the homes. The agreement was first amended in December 2022 and a second time in February 2024. These amendments did not affect the architectural standards of the original agreement.

This third amendment is paired with the second amendment of the Monarch Ranch PUD zoning. The amended PUD reduced the minimum dwelling unit sized from 1,700 square feet to a range of sizes, with the new minimum being 1,300 square feet. In exchange for the smaller dwelling unit sizes, it was negotiated that the as the square footage of the homes was reduced, the masonry percentage on the dwelling units would be increased. This is a similar provision that is already within our Zoning Code that allows, through a development agreement, the dwelling unit size to be reduced 100 square feet for each 10% of façade masonry that is included.

With this development agreement, since the 1,700 square foot homes were already approved to have 30% masonry, for every 100 square feet the homes are reduced the masonry goes up 10%, as provided in the table below:

A. **Masonry and Dwelling Unit Size Table**

Dwelling Unit Size (conditioned space)	Minimum Front Façade* Masonry Percentage
1,300 – 1,400 sq. ft.	70%
1,401 – 1,500 sq. ft.	60%
1,501 – 1,600 sq. ft.	50%
1,600 – 1,700 sq. ft.	40%
1,701 + sq. ft.	30%

* Collector Road and Corner Lots shall have side and rear masonry percentages equal to the minimum front façade percentage.

This table has been added to the existing Exhibit F of the development agreement which regulates the Residential Exterior Standards.

No other changes were made to the architectural standards and no other provisions of the development are amended with this Third Amendment to the Development Agreement.

LEGAL REVIEW:	Yes, Veronica Riveria
FISCAL IMPACT:	No
PRESENTATION:	No
ATTACHMENTS:	No

- 3rd DA Amendment

STAFF RECOMMENDATION:

The City Staff recommends that the City Council approve the Third Amendment to the Development Agreement Establishing Development Standards for Monarch Ranch.

PLANNING & ZONING COMMISSION: **Recommend Approval** **Disapproval** **None**

THIRD AMENDMENT TO DEVELOPMENT AGREEMENT ESTABLISHING DEVELOPMENT STANDARDS FOR MONARCH RANCH

This Third Amendment to the Development Agreement Establishing Development Standards for Monarch Ranch (this "**Third Amendment**") is dated effective August ____, 2024 (the "**Third Amendment Effective Date**") and is entered into between the **City of Manor**, a Texas home-rule municipal corporation (the "**City**"), **Monarch Ranch at Manor, LLC**, a Texas limited liability company ("**Monarch Developer**"), **Enfield Partners LLC**, a Texas limited liability company, as to a 40% undivided ownership interest, **Birdview LLC**, a Texas limited liability company, as to a 10% undivided ownership interest, **MP 973, LLC**, a Texas limited liability company, as to a 25% undivided ownership interest, and **Payne Travis LLC**, a Texas limited liability company, as to a 25% undivided ownership interest (collectively "**Enfield Developer**") (collectively referred to as the "**Developers")**, and **Gregg Lane Dev LLC**, a Texas limited liability company ("**Gregg Lane Dev LLC**") hereby joins and consents to this Third Amendment for the limited purposes described herein. Enfield Developer and Monarch Developer are sometimes referred to, collectively, herein as the "**Developers**." The City and the Developer are sometimes referred to as a "**Party**" and collectively herein as the "**Parties**."

RECITALS:

A. City and Developers previously entered into that certain Development Agreement Establishing Development Standards for Monarch Ranch dated effective May 4, 2022, that certain First Amendment to Development Agreement Establishing Development Standards for Monarch Ranch dated effective December 21, 2022 and that certain Second Amendment to Development Agreement Establishing Development Standards for Monarch Ranch dated effective February 21, 2024 (collectively the "**Agreement**"), for that certain residential and commercial project located in the City of Manor, Travis County, Texas, as more particularly described in the Agreement.

B. The Agreement provides, among other things, provisions related to residential development requirements.

C. The City and Developers desire to modify and amend the Agreement in certain respects, as more particularly set forth in this Third Amendment to address the residential development requirements as applied to the number of square feet in the structure.

AGREEMENT:

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, City and Developers hereby agree as follows:

1. Incorporation of Recitals. The recitals set forth above are incorporated herein and made a part of this Third Amendment to the same extent as if set forth herein in full.

2. Capitalized Terms. All capitalized terms in this Third Amendment shall have the same meanings as in the Agreement unless expressly provided otherwise herein.

3. Development Standards. Section 3(a) Residential Development Requirement of the Agreement is hereby deleted in its entirety and replaced with the following:

" **Section 3. Development Standards**

(a) **Residential Development Requirement.** The exterior wall standards set forth in this section shall apply to the structures located on the Monarch Property, including any amenity building structures:

1. Front Elevations. The exterior façade of the front elevations shall be constructed to the following minimum standards:

i. All street facing, exterior walls of primary buildings / structures shall include at least three (3) variations of architectural accents that break the wall plane, as outlined in **Exhibit F**, Section A. Architectural features may include:

1. Cantilevered overhangs;
2. Cedar brackets / details;
3. Awnings (with option metal roofs);
4. Shutters;
5. Gable vents; or
6. Dormers.

2. Collector Road and Corner Lots. The exterior façade of the side and rear elevations, when adjacent to a collector road or on a corner lot, shall be constructed to the following minimum standards:

i. All exterior walls of primary buildings / structures that face public R.O.W shall include at least one (1) variation of an architectural accent that breaks the wall plane, as outlined in **Exhibit F**, Section B. Architectural features may include:

1. Cantilevered overhangs;
2. Cedar brackets / details;
3. Awnings (with option metal roofs);
4. Shutters;
5. Gable vents; or
6. Dormers.

3. Interior Lots. The exterior façade of the side and rear elevations on interior lots will consist of cementitious fiber siding with at least a 2' masonry return, as outlined in **Exhibit F**, Section C.

4. Amenity Building. Architectural split-faced, integrally colored limestone CMU block shall be an acceptable masonry material for the residential amenity building(s) and picnic pavilion structures.

5. Masonry Requirement and Dwelling Unit Size. The Monarch Developer agrees to provide a minimum percentage of the total exterior facade area constructed of Masonry as provided for in **Exhibit F**, Section D. "Masonry" is considered clay brick, natural stone, cultured stone, cast stone, stucco or natural stone panels or similar material approved by the Development Services Director, exclusive of roofs, eaves, soffits, windows, balconies, gables, doors and trim work. Masonry excludes cementitious planking."

4. Ratification of Agreement/Conflict. Except as expressly amended hereby, the Agreement and all rights and obligations created thereby or thereunder are in all respects ratified and confirmed and remain in full force and effect. Where any section, subsection or clause of the Agreement is modified or deleted by this Third Amendment, any unaltered provision of such section, subsection or clause of the Agreement shall remain in full force and effect. However, where any provision of this Third Amendment conflicts or is inconsistent with the Agreement, the provisions of this Third Amendment shall control.

5. No Waiver. Neither City's nor Developer's execution of this Third Amendment shall (a) constitute a waiver of any of its rights and remedies under the Agreement or at law with respect to the other party's obligations under the Agreement or (b) be construed as a bar to any subsequent enforcement of any of its rights or remedies against the other party.

6. Governing Law. This Third Amendment shall be governed by and construed in accordance with the laws of the State of Texas and shall be performable in Travis County, Texas. Venue shall lie exclusively in Travis County, Texas.

7. Entire Agreement. This Third Amendment, together with any exhibits attached hereto, and the Agreement, as amended by this Third Amendment, constitute the entire agreement between the Parties with respect to the subject matter stated therein, supersedes all prior agreements relating to such subject matter and may not be amended except by a writing signed by the Parties and dated subsequent to the date hereof. The Parties hereto agree and understand that this Third Amendment shall be binding upon and inure to the benefit of the parties hereto and their respective representatives, heirs, successors and assigns.

8. Covenant Running with the Land. The Agreement, as amended by this Third Amendment, shall continue to constitute a binding covenant on the Property (as defined and detailed in the Agreement) and shall run with the land. A copy of this Third Amendment shall be recorded in the Official Public Records of Travis County, Texas. The Owner and the City acknowledge and agree that this Third Amendment is binding upon the City and the Owner and their respective successors, executors, heirs, and assigns, as applicable, for the term of this Third Amendment.

9. Captions. The captions preceding the text of each section and paragraph hereof, if any, are included only for convenience of reference and shall be disregarded in the construction and interpretation of this Third Amendment.

10. Interpretation. This Third Amendment has been jointly negotiated by the Parties and shall not be construed against a party because that Party may have primarily assumed responsibility for the drafting of this Third Amendment.

11. Authority. Each party hereto warrants that each has the full legal authority to execute and deliver this Third Amendment. In addition, the individual who executes this Third Amendment on behalf of each party hereto is authorized to act for and on behalf of such party and to bind such party to the terms and provisions hereof.

12. Severability. If any provision of this Third Amendment shall be held to be invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable, unless enforcement of this Third Amendment as so invalidated would be unreasonable or grossly inequitable under the circumstances or would frustrate the purpose of this Third Amendment.

13. Anti-Boycott Verification. To the extent this Third Amendment constitutes a contract for goods or services within the meaning of Section 2271.002 of the Texas Government Code, as amended, solely for purposes of compliance with Chapter 2271 of the Texas Government Code, and subject to applicable Federal law, Developers and Gregg Lane Dev LLC represent that neither Developers, Gregg Lane Dev LLC nor any wholly owned subsidiary, majority-owned subsidiary, parent company or affiliate of Developers or Gregg Lane Dev LLC (i) boycotts Israel or (ii) will boycott Israel through the term of this Third Amendment. The terms "boycotts Israel" and "boycott Israel" as used in this paragraph have the meanings assigned to the term "boycott Israel" in Section 808.001 of the Texas Government Code, as amended.

14. Iran, Sudan and Foreign Terrorist Organizations. To the extent this Third Amendment constitutes a governmental contract within the meaning of Section 2252.151 of the Texas Government Code, as amended, solely for purposes of compliance with Chapter 2252 of the Texas Government Code, and except to the extent otherwise required by applicable federal law, Developers and Gregg Lane Dev LLC represent that Developers and Gregg Lane Dev LLC nor any wholly owned subsidiary, majority-owned subsidiary, parent company or affiliate of Developers or Gregg Lane Dev LLC is a company listed by the Texas Comptroller of Public Accounts under Sections 2270.0201, or 2252.153 of the Texas Government Code.

15. Anti-Boycott Verification – Energy Companies. The Developers and Gregg Lane Dev LLC hereby verify that they and their parent company, wholly- or majority-owned subsidiaries, and other affiliates, if any, do not boycott energy companies and will not boycott energy companies during the term of this Third Amendment. The foregoing verification is made solely to comply with Section 2274.002, Texas Government Code, and to the extent such Section is not inconsistent with a governmental entity's constitutional or statutory duties related to the issuance, incurrence, or management of debt obligations or the deposit, custody, management, borrowing, or investment of funds. As used in the foregoing verification, "boycott energy company" means, without an ordinary business purpose, refusing to deal with, terminating business activities with, or otherwise taking any action that is intended to penalize, inflict economic harm on, or limit commercial relations with a company because the company: (A) engages in the exploration, production, utilization, transportation, sale, or manufacturing of fossil fuel-based energy and does not commit or pledge to meet environmental standards beyond

applicable federal and state law; or (B) does business with a company described by the preceding statement in (A).

16. Anti-Discrimination Verification – Firearm Entities and Firearm Trade Associations. The Developers and Gregg Lane Dev LLC hereby verify that they and their parent company, wholly- or majority-owned subsidiaries, and other affiliates, if any, do not have a practice, policy, guidance, or directive that discriminates against a firearm entity or firearm trade association and will not have a practice, policy, guidance, or directive that discriminates against a firearm entity or firearm trade association during the term of this Third Amendment. The foregoing verification is made solely to comply with Section 2274.002, Texas Government Code. As used in the foregoing verification, "discriminate against a firearm entity or firearm trade association" means: (i) refuse to engage in the trade of any goods or services with the entity or association based solely on its status as a firearm entity or firearm trade association; (ii) refrain from continuing an existing business relationship with the entity or association based solely on its status as a firearm entity or firearm trade association; or (iii) terminate an existing business relationship with the entity or association based solely on its status as a firearm entity or firearm trade association; but does not include (a) the established policies of a merchant, retail seller, or platform that restrict or prohibit the listing or selling of ammunition, firearms, or firearm accessories; or (b) a company's refusal to engage in the trade of any goods or services, decision to refrain from continuing an existing business relationship, or decision to terminate an existing business relationship to comply with federal, state, or local law, policy, or regulations or a directive by a regulatory agency; or for any traditional business reason that is specific to the customer or potential customer and not based solely on an entity's or association's status as a firearm entity or firearm trade association.

17. Counterparts. This Third Amendment may be executed in multiple counterparts, each of which will be deemed original, and all of which will constitute one and the same agreement. Each such executed copy shall have the full force and effect of an original executed instrument.

[SIGNATURES ON FOLLOWING PAGES]

EXECUTED in multiple originals, and in full force and effect as of the Third Amendment Effective Date.

CITY:

CITY OF MANOR, TEXAS
A Texas Home Rule Municipal Corporation

By: _____
Dr. Christopher Harvey, Mayor

ATTEST:

_____
Lluvia T. Alvaraz, City Secretary

STATE OF TEXAS
COUNTY OF TRAVIS

This instrument was acknowledged before me on the _____ day of _____, 2024 by Dr. Christopher Harvey, Mayor of Manor, Texas, a Texas home rule municipality on behalf of the City.

_____
Notary Public for Texas

DEVELOPER:

MONARCH RANCH AT MANOR LLC

By: _____
David B. Blackburn, Manager

STATE OF MISSISSIPPI
COUNTY OF LAFAYETTE

This instrument was acknowledged before me on the ___ day of _____, 2024 by David B. Blackburn, Manager of Monarch Ranch at Manor LLC on behalf of the entity.

_____
Notary Public for Texas

ENFIELD DEVELOPER:

ENFIELD PARTNERS LLC

By: _____
Russell T. Thurman
Manager/Member

STATE OF TEXAS
COUNTY OF TRAVIS

This instrument was acknowledged before me on the ___ day of _____, 2024 by Russell T. Thurman, manager of Enfield Partners LLC on behalf of the entity.

_____
Notary Public for Texas

BIRDVIEW LLC

By: _____
Bryan White, Manager

STATE OF TEXAS
COUNTY OF TRAVIS

This instrument was acknowledged before me on the ___ day of _____, 2024 by Bryan White, manager of Birdview LLC on behalf of the entity.

_____
Notary Public for Texas

MP 973 LLC

By: _____
Martin B. Payne, Manager/Member

STATE OF TEXAS
COUNTY OF FAYETTE

This instrument was acknowledged before me on the ___ day of _____, 2024 by Martin B. Payne manager of MP 973 LLC on behalf of the entity.

_____
Notary Public for Texas

PAYNE TRAVIS LLC

By: _____
John Thurman Payne

STATE OF TEXAS
COUNTY OF LLANO

This instrument was acknowledged before me on the ___ day of _____, 2024 by John Thurman Payne, manager of Payne Travis LLC on behalf of the entity.

_____
Notary Public for Texas

CONSENTING PARTY

Gregg Lane Dev LLC, a Texas limited liability company, hereby joins and consents to the execution of this Third Amendment solely for the purpose of agreeing to the terms, obligations and provisions outlined in this Third Amendment expressly applicable to Gregg Lane Dev LLC.

GREGG LANE DEV LLC,
a Texas limited liability company

By: _____
Name: _____
Title: _____

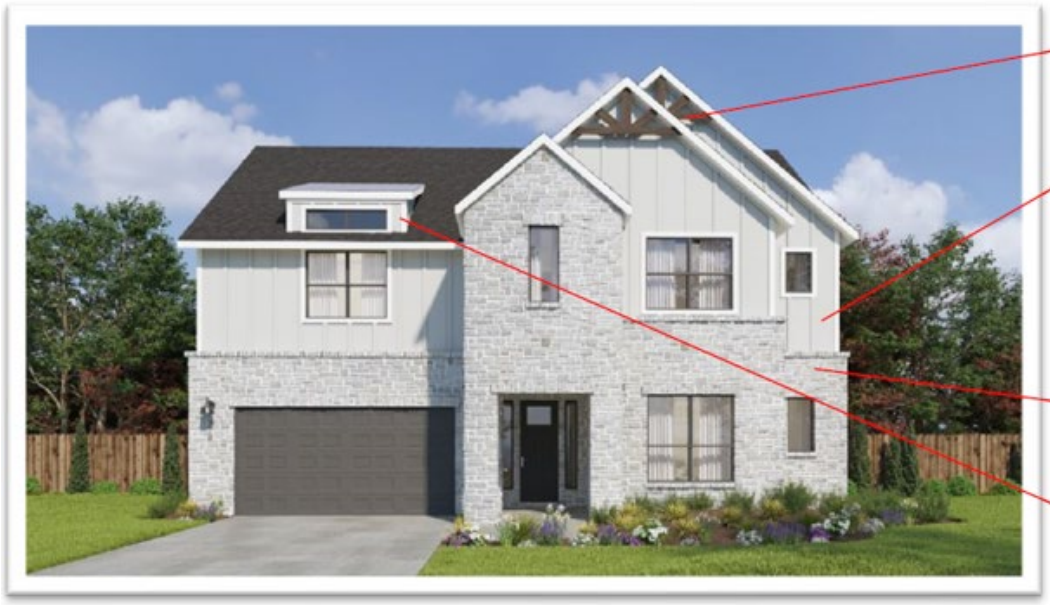
STATE OF TEXAS
COUNTY OF _____

This instrument was acknowledged before me on the _____ day of _____, 2024 by _____, _____ of Gregg Lane Dev LLC, a Texas limited liability company on behalf of the entity.

_____
Notary Public for Texas

EXHIBIT F
RESIDENTIAL EXTERIOR STANDARDS

A. All **Front elevations shall** consist of:
   a. Minimum masonry percentage (cement stucco, stone, or brick) from the table in subsection "D"
   b. At least three (3) variations of architectural accents.
      1. Cantilevered Overhangs
      2. Cedar Brackets / Details
      3. Awnings (with optional metal roofs)
      4. Shutters
      5. Gable Vents
      6. Dormers


DECORATIVE CEDAR TRUSS
CEMENTITIOUS, PAINT GRADE, BOARD & BATTEN
MASONRY
DORMER

CEMENTITIOUS, PAINT GRADE, BOARD & BATTEN
MASONRY WAINSCOT
WRAPPED POST
POP-UP DORMER

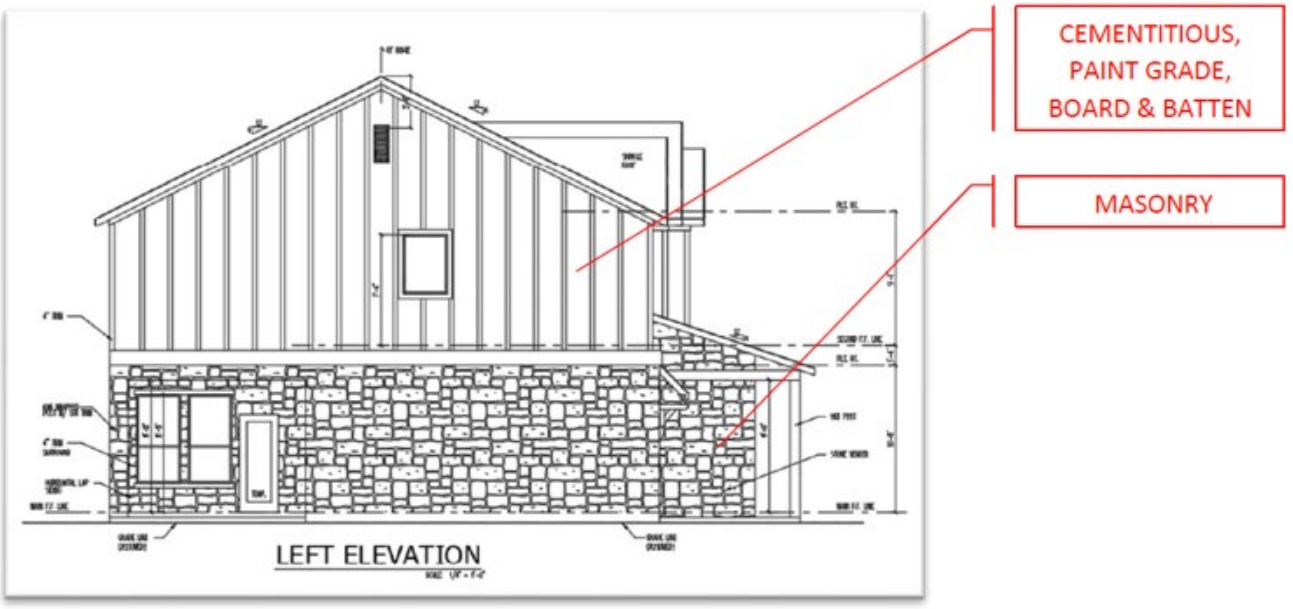
DECORATIVE CEDAR TRUSS
PAINTED STUCCO
MASONRY
CANTILVERED OVERHANG

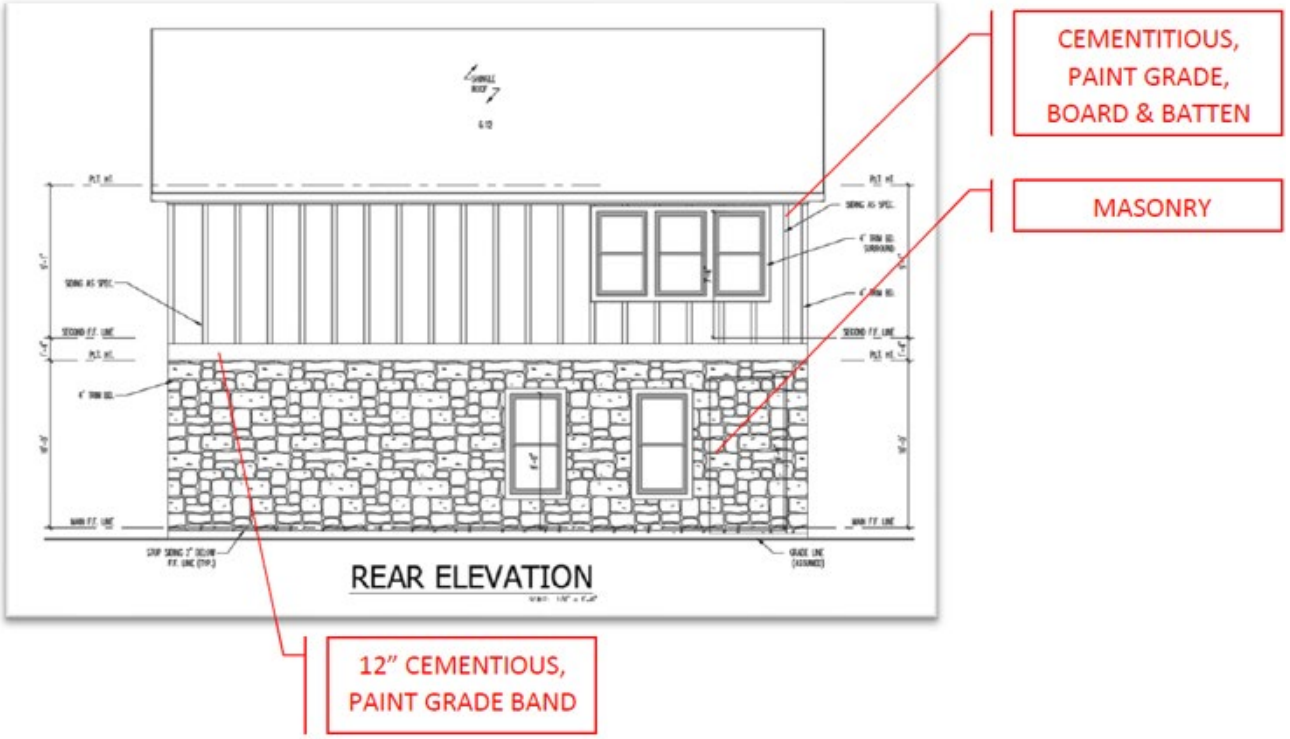
PAINTED STUCCO
MASONRY WAINSCOT
ANGLED COLUMN
POP-UP DORMER

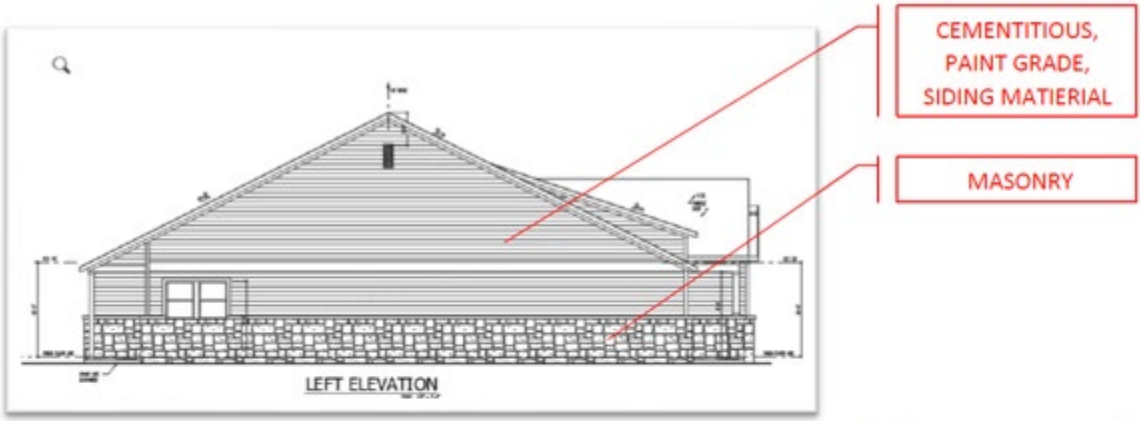
DECORATIVE CEDAR TRUSS
PAINTED STUCCO
MASONRY
SHUTTERS

DECORATIVE CEDAR TRUSS
CEMENTITIOUS, PAINT GRADE, BOARD & BATTEN
MASONRY
METAL ACCENT ROOF

B. **Collector Road & Corner Lots shall** have masonry on the side and rear elevations, equal to the front elevation from the table in subsection "D".
   a. These will be labeled as "Premium" elevations.
   b. Masonry (stone/cement stucco/brick) along sides and rear (per front elevation finish).

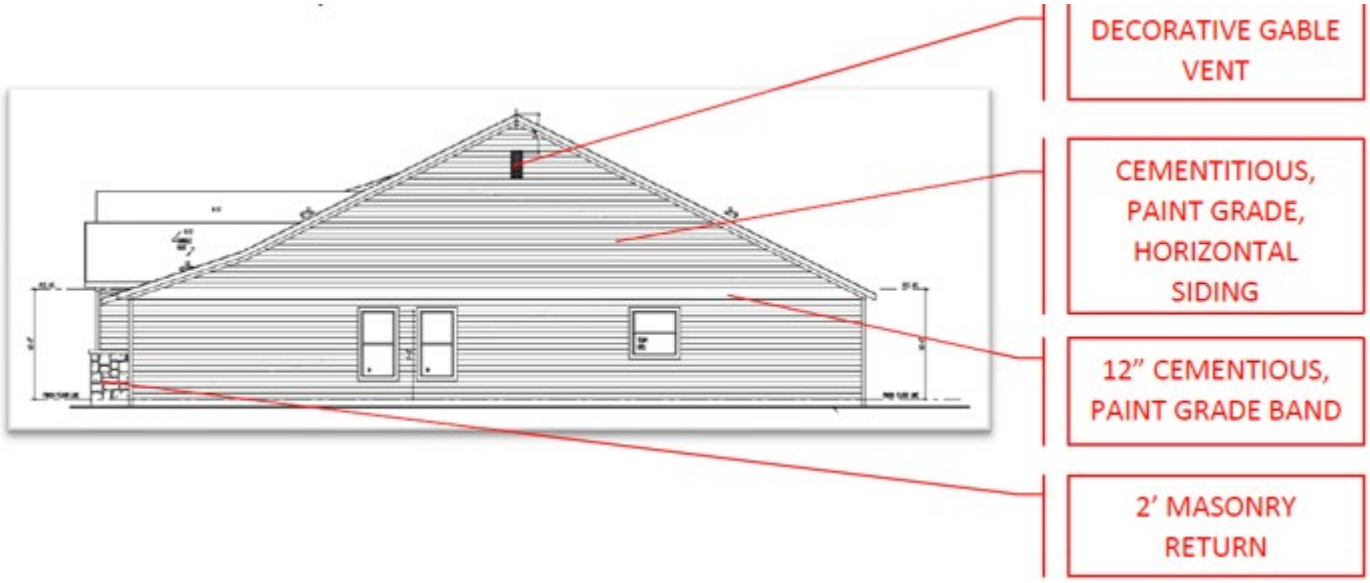


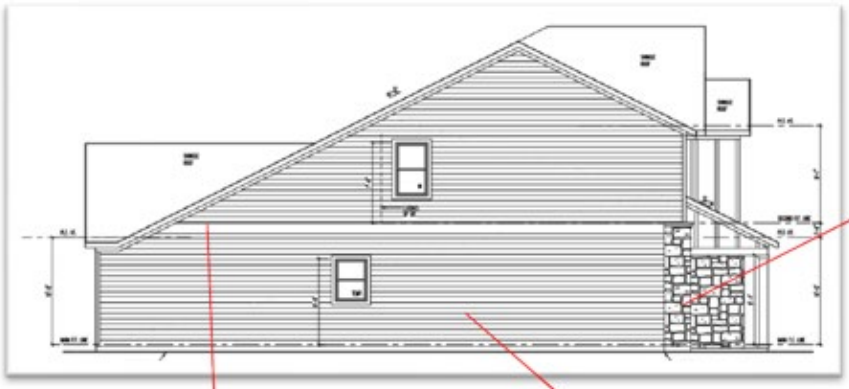



CEMENTITIOUS, PAINT GRADE, SIDING MATIERIAL
MASONRY
LEFT ELEVATION

CEMENTITIOUS, PAINT GRADE, SIDING MATIERIAL
MASONRY
REAR ELEVATION

C. **Interior Lots shall** consist of cementitious fiber siding at the sides and rear elevations.
   a. Horizontal or Board & Batten, cementitious fiber siding
      i. Side elevations that consist of a gable, or that are 2-story will include a 10-12" band to break-up the siding material and add character.
   b. 2' Masonry Return

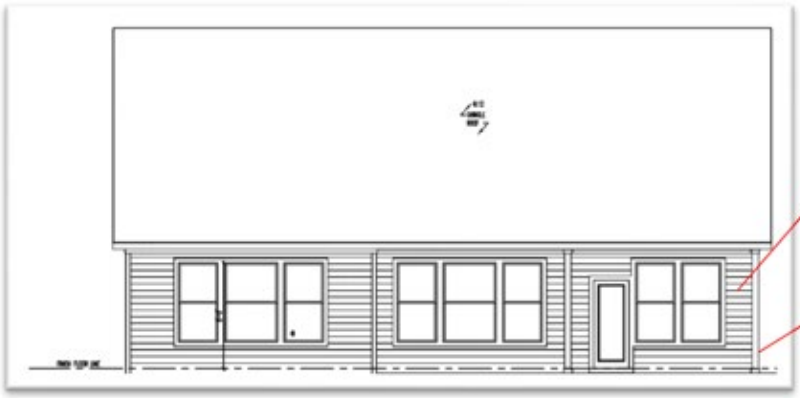




2' MASONRY RETURN

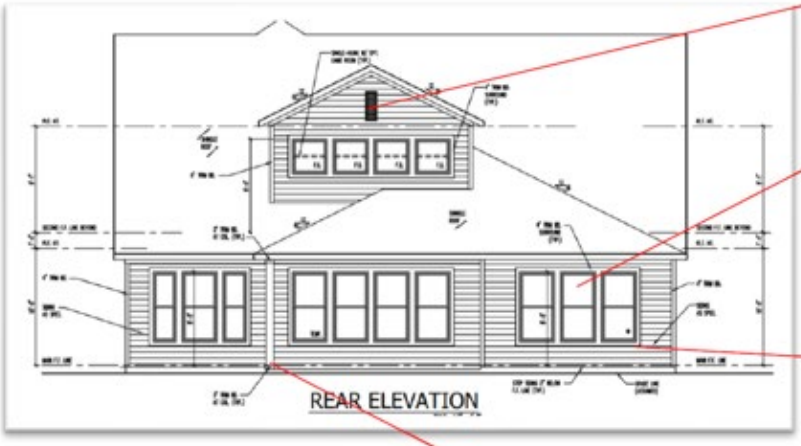
CEMENTITIOUS, PAINT GRADE, HORIZONTAL SIDING

12" CEMENTIOUS, PAINT GRADE BAND



CEMENTITIOUS, PAINT GRADE, HORIZONTAL SIDING

WRAPPED POST



DECORATIVE GABLE VENT

REAR ELEVATIONS WITH PLENTY OF WINDOWS

CEMENTITIOUS, PAINT GRADE, HORIZONTAL SIDING

WRAPPED POST

D. **Masonry and Dwelling Unit Size Table**

Dwelling Unit Size (conditioned space)	Minimum Front Façade* Masonry Percentage
1,300 – 1,400 sq. ft.	70%
1,401 – 1,500 sq. ft.	60%
1,501 – 1,600 sq. ft.	50%
1,600 – 1,700 sq. ft.	40%
1,701 + sq. ft.	30%

* Collector Road and Corner Lots shall have side and rear masonry percentages equal to the minimum front façade percentage.

AGENDA ITEM NO. _____

AGENDA ITEM SUMMARY FORM

PROPOSED MEETING DATE: August 7, 2024
PREPARED BY: Scott Dunlop, Director
DEPARTMENT: Development Services

AGENDA ITEM DESCRIPTION:

Second and Final Reading: Consideration, discussion, and possible action on an Ordinance rezoning one (1) lot on 0.31 acres, more or less, and being located near the intersection of Gregg Manor Road and West Eggleston Street, Manor, TX from (C-1) Light Commercial to Multi-Family 25 (MF-2).
Applicant: MWSW LLP
Owner: DD&B Construction Inc.

BACKGROUND/SUMMARY:

The C-1 Light Commercial area was approved by Ordinance 371 in August 2009 and Ordinance 477 in May 2017. 10.742 acres of that C-1 area was rezoned to Multi-Family 25 (MF-2) in June 2022 by Ordinance 655, which left a 2.482 acre C-1 tract. That tract was reduced to 1.67 acres, its current configuration, with the extension of West Eggleston Street.

In the First Amendment to the Entradaglen Development Agreement approved by the City Council on June 15, 2022, there was a shared parking agreement that allowed up to 40 parking spaces needed for the multi-family development to be constructed on the commercial tract. Upon submittal of the Site Development Plan for the multi-family, only 29 spaces needed to be located on the commercial lot.

A daycare business is planned to be located on the 1.67-acre commercial lot, but they do not need the full lot, and their site layout does not provide for shared parking. Due to this, the multi-family developer is acquiring the unused portion of the commercial lot, 0.31 acres, to incorporate into their development. Since it is being incorporated into the multi-family development, the 29 parking spaces that were planned to be shared on the commercial lot will now be solely on the multi-family lot, as required by our code. Adding the 0.31-acre tract to the multi-family lot requires it to be rezoned from C-1 Light Commercial to MF-2 Multi-Family 25. This additional acreage will not add more dwelling units to the project, which is planned to have 216 units.

An Amended Plat will be filed to move the lot lines between the commercial and multi-family properties to align the lots with the new zoning requested here. Amended Plats are approved administratively.

Planning and Zoning Commission voted 5-0 to recommend approval.

At the July 17th meeting, the City Council voted 6-0 to approve, with no questions asked.

LEGAL REVIEW: No
FISCAL IMPACT: No
PRESENTATION: No

ATTACHMENTS: Yes

- Ordinance No. 756
- Letter of Intent
- Rezoning Map
- Aerial Image
- MF Site Layout
- DA Shared Parking Section
- Letter of Authorization
- Metes and Bounds
- Notice and Mailing Labels

STAFF RECOMMENDATION:

The City Staff recommends that the City Council approve the second and final reading of Ordinance No. 756 rezoning one (1) lot on 0.31 acres, more or less, and being located near the intersection of Gregg Manor Road and West Eggleston Street, Manor, TX from (C-1) Light Commercial to Multi-Family 25 (MF-2).

PLANNING & ZONING COMMISSION:	Recommend Approval	Disapproval	None
	X		

ORDINANCE NO. 756

AN ORDINANCE OF THE CITY OF MANOR, TEXAS, AMENDING THE ZONING ORDINANCE BY REZONING A PARCEL OF LAND FROM LIGHT COMMERCIAL (C-1) TO MULTI-FAMILY 25 (MF-2); MAKING FINDINGS OF FACT; AND PROVIDING FOR RELATED MATTERS.

Whereas, the owner of the property described hereinafter (the "Property") has requested that the Property be rezoned;

Whereas, after giving ten days written notice to the owners of land within three hundred feet of the Property, the Planning & Zoning Commission held a public hearing on the proposed rezoning and forwarded its recommendation on the rezoning to the City Council;

Whereas, after publishing notice of the public hearing at least fifteen days prior to the date of such hearing, the City Council at a public hearing has reviewed the request and the circumstances of the Property and finds that a substantial change in circumstances of the Property, sufficient to warrant a change in the zoning of the Property, has transpired;

NOW, THEREFORE, BE IT ORDAINED BY THE CITY COUNCIL OF THE CITY OF MANOR, TEXAS, THAT:

Section 1. Findings. The foregoing recitals are hereby found to be true and correct and are hereby adopted by the City Council and made a part hereof for all purposes as findings of fact.

Section 2. Amendment of Ordinance. City of Manor Code of Ordinances Chapter 14 Zoning Ordinance ("Zoning Ordinance" or "Code"), is hereby modified and amended by rezoning the Property as set forth in Section 3.

Section 3. Rezoned Property. The Zoning Ordinance is hereby amended by changing the zoning district for the land and parcel of property described in Exhibit "A" (the "Property"), from the current zoning district Light Commercial (C-1) to zoning district Multi-Family 25 (MF-2). The Property is accordingly hereby rezoned to Multi-Family 25 (MF-2).

Section 4. Open Meetings. That it is hereby officially found and determined that the meeting at which this ordinance is passed was open to the public as required and that public notice of the time, place, and purpose of said meeting was given as required by the Open Meetings Act, Chapt. 551, Texas Gov't. Code.

PASSED AND APPROVED FIRST READING on this the 17th day of July 2024.

PASSED AND APPROVED SECOND AND FINAL READING on this the 7th day of August 2024.

THE CITY OF MANOR, TEXAS

_____
Dr. Christopher Harvey,
Mayor

ATTEST:

_____
Lluvia T. Almaraz, TRMC
City Secretary

EXHIBIT "A"

Property Legal Description:

Legal Description

BEING A DESCRIPTION OF A TRACT OF LAND CONTAINING 0.3067 ACRES (13,360 SQUARE FEET) OF LAND, MORE OR LESS, BEING OUT OF THE JAMES MANOR SURVEY NO. 40, ABSTRACT NO. 546 IN TRAVIS COUNTY, TEXAS, BEING A PORTION OF A CALLED 13.224 ACRE TRACT CONVEYED TO MANOR MF, LLC IN DOCUMENT NO. 2022156154 OF THE OFFICIAL PUBLIC RECORDS OF TRAVIS COUNTY, TEXAS (O.P.R.T.C.T.), SAID 1.4304 ACRES BEING MORE PARTICULARLY DESCRIBED BY METES AND BOUNDS AS FOLLOWS:

4WARD Land Surveying
PO Box 90876
Austin, TX 78709
(512) 537-2384
jward@4wardls.com
www.4wardls.com

COMMENCING, at a 1/2-inch iron rod with "4Ward Boundary" cap set in the east line of the remainder of a called 105.17 acres tract conveyed to Las Entradas Development Corporation in Document No. 2007002485 (O.P.R.T.C.T.), being in the west line of said 13.224 acre Manor MF tract, from which a 1/2-inch iron rod with "4Ward Boundary" cap set in the common line of said remainder of a called 105.17 acres tract and said 13.224 acre Manor MF tract bears, along the arc of a curve to the left, whose radius is 645.00 feet, whose arc length is 148.57 feet and whose chord bears N01°07'11"W, a distance of 148.24 feet;

THENCE, leaving the east line of said remainder of a called 105.17 acres tract, over and across said 13.224 acre Manor MF tract, S82°57'15"E, a distance of 314.49 feet to a calculated point for the southwest corner and **POINT OF BEGINNING** hereof;

THENCE, over and across said 13.224 acre Manor MF tract, the following five (5) courses and distances:

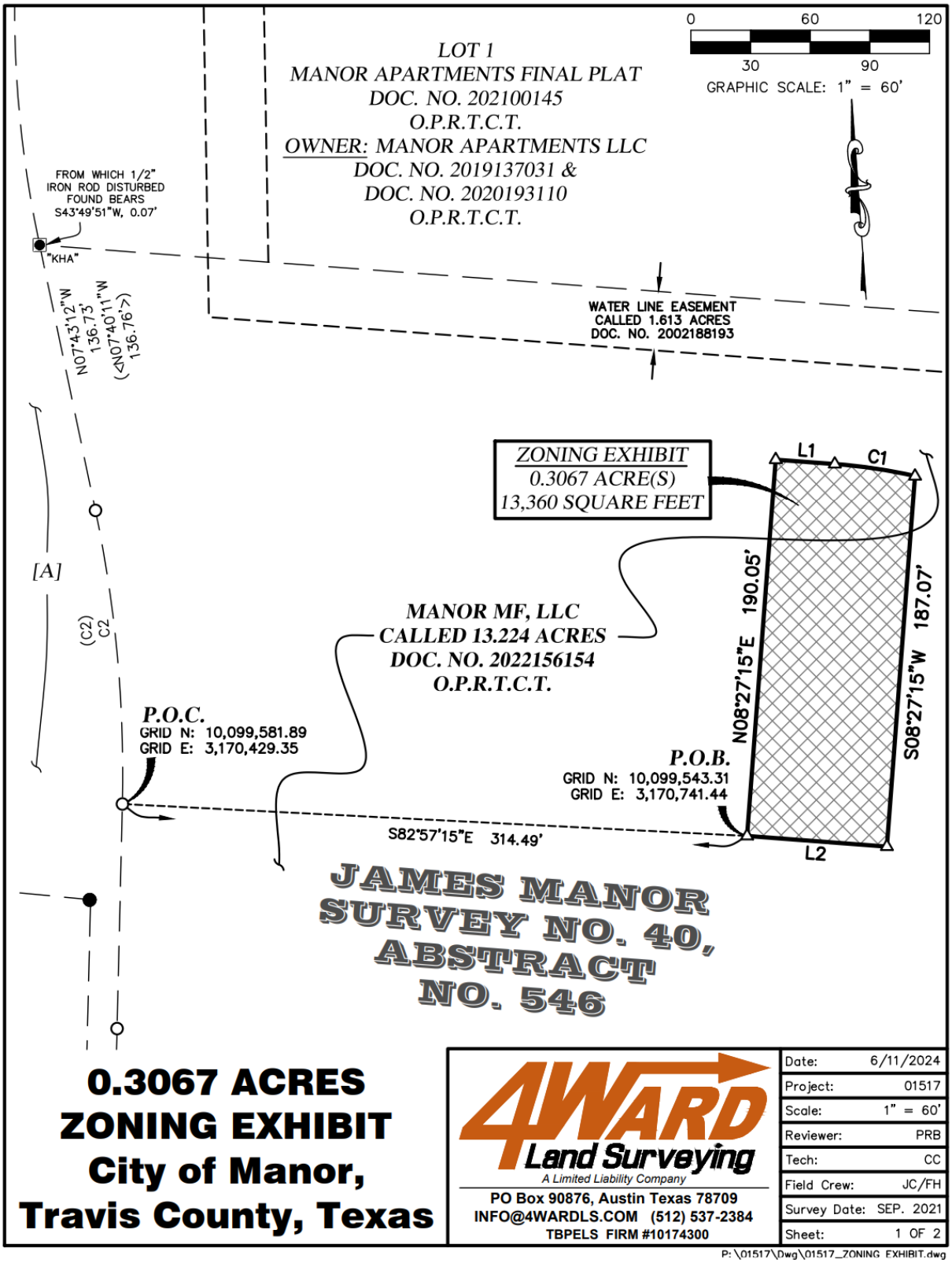
1) **N08°27'15"E**, a distance of **190.05** feet to a calculated point for the northwest corner hereof,
2) **S81°35'13"E**, a distance of **29.80** feet to a calculated point for an angle point hereof,
3) Along the arc of a curve to the right, whose radius is **274.98** feet, whose arc length is **40.85** feet and whose chord bears **S77°19'48"E**, a distance of **40.82** feet to a calculated point for the northeast corner hereof,
4) **S08°27'15"W**, a distance of **187.07** feet to a calculated point for the southeast corner hereof, and
5) **N81°32'45"W**, a distance of **70.50** feet to the **POINT OF BEGINNING** hereof containing 0.3067 Acres (13,360 Square Feet) of land, more or less.

NOTE:

All bearings are based on the Texas State Plane Coordinate System, Grid North, Central Zone (4203), all distances were adjusted to surface using a combined scale factor of 1.000077099614. See attached sketch (reference drawing: 01517_ZONING EXHIBIT.dwg).

6/11/2024
Jason Ward, RPLS #5811
4Ward Land Surveying, LLC

STATE OF TEXAS REGISTERED JASON WARD 5811 PROFESSIONAL LAND SURVEYOR


LOT 1
MANOR APARTMENTS FINAL PLAT
DOC. NO. 202100145
O.P.R.T.C.T.
OWNER: MANOR APARTMENTS LLC
DOC. NO. 2019137031 &
DOC. NO. 2020193110
O.P.R.T.C.T.
0 60 120
30 90
GRAPHIC SCALE: 1" = 60'
FROM WHICH 1/2" IRON ROD DISTURBED FOUND BEARS S43°49'51"W, 0.07'
"KHA"
N07°43'12"W 136.73'
(<N07°40'11"W 136.76'>)
WATER LINE EASEMENT
CALLED 1.613 ACRES
DOC. NO. 2002188193
ZONING EXHIBIT
0.3067 ACRE(S)
13,360 SQUARE FEET
L1
C1
[A]
(C2)
C2
MANOR MF, LLC
CALLED 13.224 ACRES
DOC. NO. 2022156154
O.P.R.T.C.T.
N08°27'15"E 190.05'
S08°27'15"W 187.07'
P.O.C.
GRID N: 10,099,581.89
GRID E: 3,170,429.35
P.O.B.
GRID N: 10,099,543.31
GRID E: 3,170,741.44
S82°57'15"E 314.49'
L2
JAMES MANOR
SURVEY NO. 40,
ABSTRACT
NO. 546
0.3067 ACRES
ZONING EXHIBIT
City of Manor,
Travis County, Texas
4WARD Land Surveying
A Limited Liability Company
PO Box 90876, Austin Texas 78709
INFO@4WARDLS.COM (512) 537-2384
TBPELS FIRM #10174300
Date: 6/11/2024
Project: 01517
Scale: 1" = 60'
Reviewer: PRB
Tech: CC
Field Crew: JC/FH
Survey Date: SEP. 2021
Sheet: 1 OF 2
P:\01517\Dwg\01517_ZONING EXHIBIT.dwg

CURVE TABLE					
CURVE #	RADIUS	LENGTH	DELTA	BEARING	DISTANCE
C1	274.98'	40.85'	8°30'45"	S77°19'48"E	40.82'
C2	645.00'	148.57'	13°11'52"	N01°07'11"W	148.24'

CURVE TABLE					
CURVE #	RADIUS	LENGTH	DELTA	BEARING	DISTANCE
(C2)	645.00'	148.61'	13°12'04"	N1°04'10"W	148.28'

LINE TABLE		
LINE #	DIRECTION	LENGTH
L1	S81°35'13"E	29.80'
L2	N81°32'45"W	70.50'

[A]
LAS ENTRADAS DEVELOPMENT CORPORATION
REMAINDER OF A CALLED 105.17 ACRES
DOC. NO. 2007002485
O.P.R.T.C.T.

LEGEND

———	PROPERTY LINE
— —— —	EXISTING PROPERTY LINES
- - - - -	EXISTING EASEMENTS
○	1/2" IRON ROD WITH "4WARD BOUNDARY" CAP SET
●	IRON ROD WITH "RPLS 6392" CAP FOUND (UNLESS NOTED)
VOL./PG.	VOLUME, PAGE
DOC. NO.	DOCUMENT NUMBER
R.O.W.	RIGHT-OF-WAY
P.O.B.	POINT OF BEGINNING
R.P.R.T.C.T.	REAL PROPERTY RECORDS, TRAVIS COUNTY, TEXAS
O.P.R.T.C.T.	OFFICIAL PUBLIC RECORDS, TRAVIS COUNTY, TEXAS
D.R.T.C.T.	DEED RECORDS, TRAVIS COUNTY, TEXAS
(.....)	RECORD INFORMATION PER DOC. NO. 2007002485
(<.....>)	RECORD INFORMATION PER DOC. NO. 2022156154

STATE OF TEXAS
REGISTERED
JASON WARD
5811
PROFESSIONAL
LAND SURVEYOR

6/10/2024

BEARING BASIS:

1) ALL BEARINGS ARE BASED ON THE TEXAS STATE PLANE COORDINATE SYSTEM, GRID NORTH, CENTRAL ZONE, (4203), NAD83, ALL DISTANCES WERE ADJUSTED TO SURFACE USING A COMBINED SCALE FACTOR OF 1.000077099614.
2) SEE ATTACHED METES AND BOUNDS DESCRIPTION.

0.3067 ACRES
ZONING EXHIBIT
City of Manor,
Travis County, Texas

4WARD Land Surveying
A Limited Liability Company
PO Box 90876, Austin Texas 78709
INFO@4WARDLS.COM (512) 537-2384
TBPELS FIRM #10174300

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Survey Date:	SEP. 2021
Sheet:	2 OF 2

P:\01517\Dwg\01517_ZONING EXHIBIT.dwg

METCALFE WOLFF
STUART & WILLIAMS, LLP

TALLEY WILLIAMS
Partner

twilliams@mwswtexas.com
512-404-2234

June 14, 2024

Mr. Scott Dunlop
Development Services Director
105 E Eggleston St.,
Manor, Texas 78653

Via Online Submittal

Re: Application for Rezoning; Approximately 0.3067 acres within the Las Entradas South Project located along the future Gregg Manor Extension and North of Highway 290 in Manor, Texas (the "Property").

Dear Mr. Dunlop:

As representatives of the owner of the above stated Property we respectfully submit the attached Zoning Application to request a change from Light Commercial (C-1) to Multi-family 25 (MF-2). The Property is located along the future Gregg Manor Extension and North of Highway 290 in Manor, Texas (see attached Location Map).

The Property is part of the Las Entradas South Project which is a mixed-use development that also includes commercial and residential uses as well as publicly accessible open space. With this rezoning the shared parking between the multifamily and commercial sites, will not be required. The Property will provide the parking requirements for the unique multifamily development in this high quality, pedestrian oriented development of horizontal mixed use, which is desired by the City of Manor.

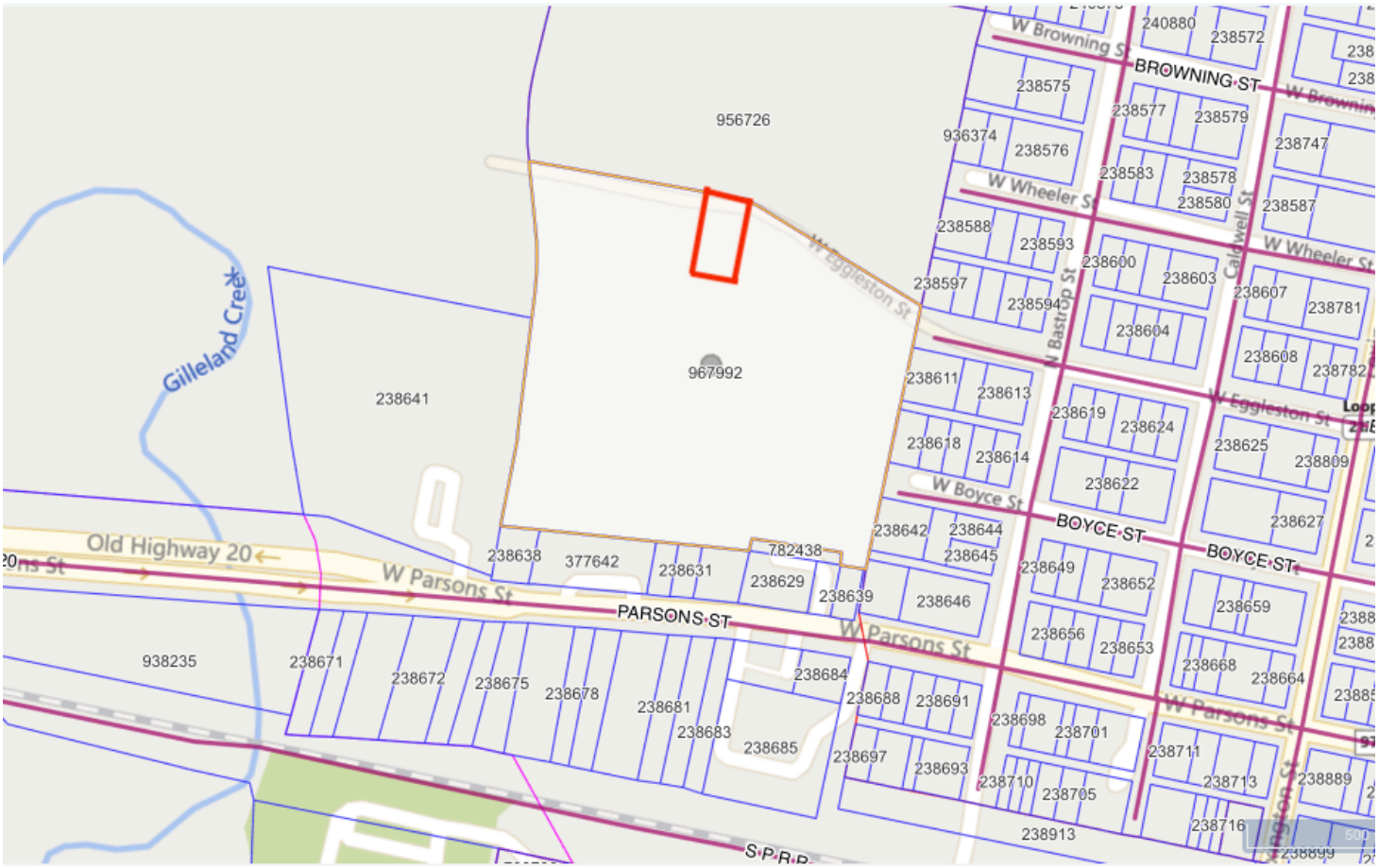
Attached to this application is a Microsoft Word document with the names and addresses of property owners within 300 feet of the Property, tax certificates and metes and bounds for the Property.

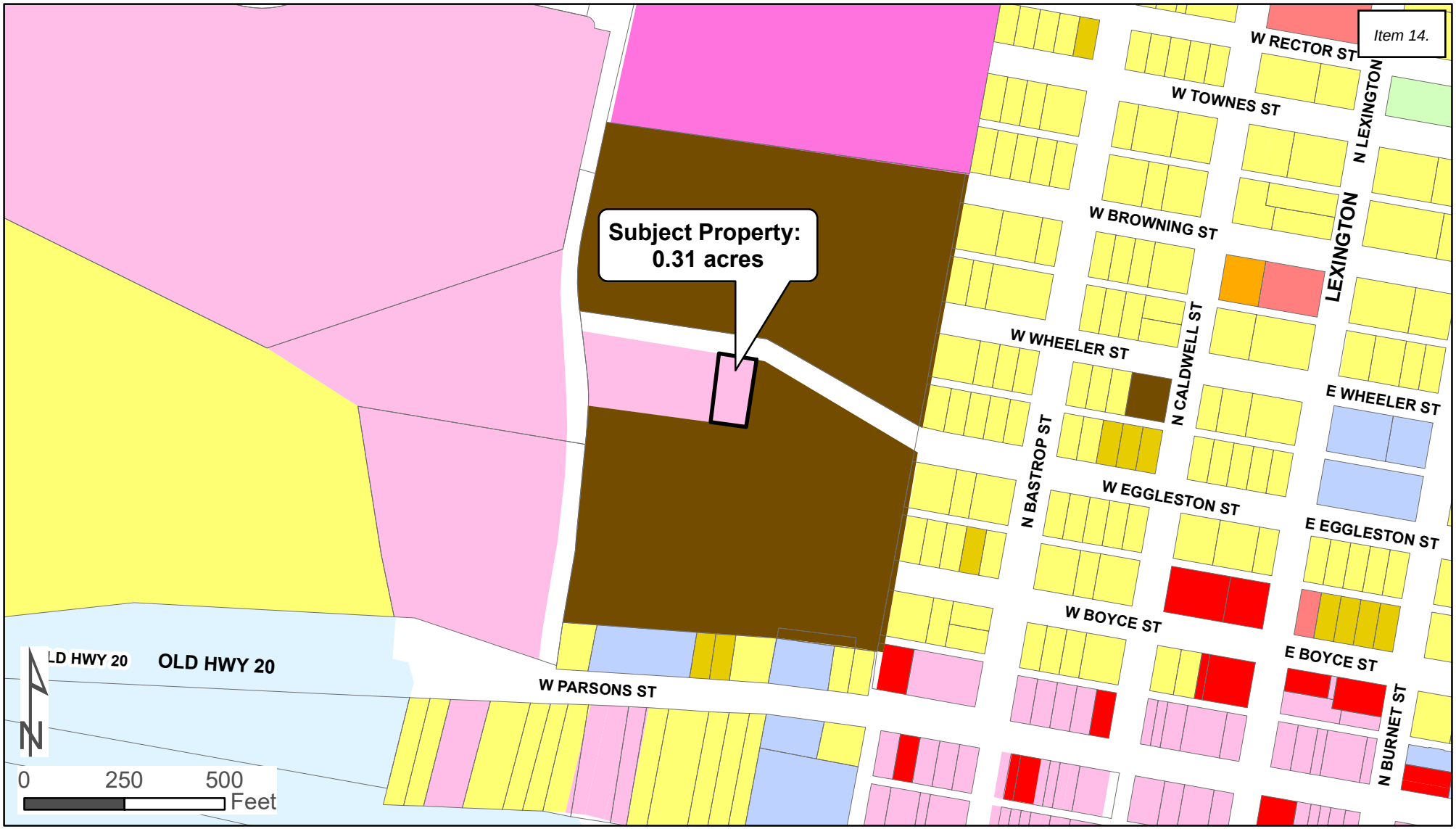
If you have any questions about the proposed Zoning Application or need additional information, please do not hesitate to contact me at your convenience. Thank you for your time and attention to this project.

Very truly yours,

Talley Williams

ZONING EXHIBIT



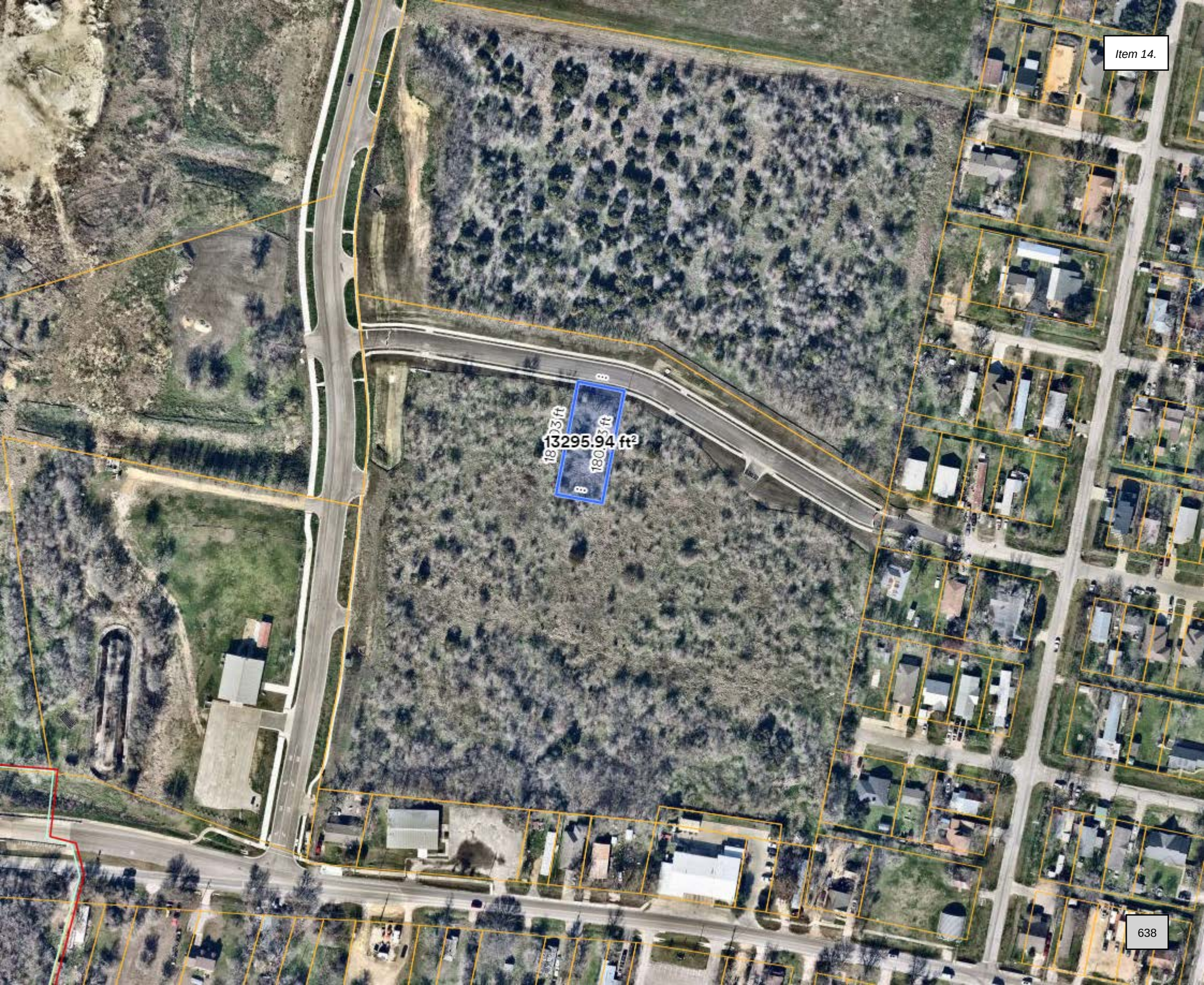


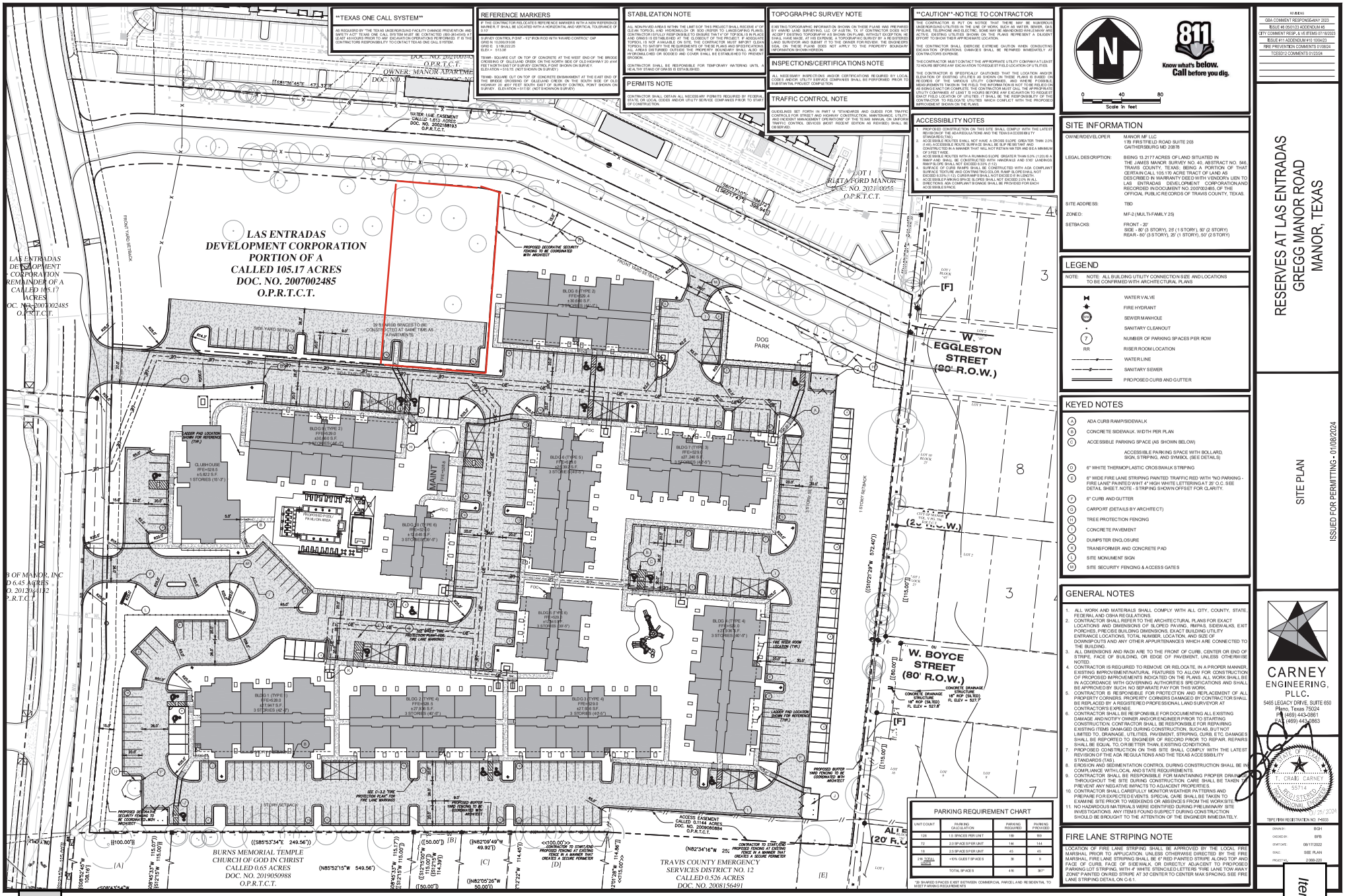
MANOR
EST. TEXAS 1872

Current:
(C-1) Light Commercial

Proposed:
(MF-2) Multi-Family 25

Zone	
A - Agricultural	GO - General Office
SF-1 - Single Family Suburban	C-1 - Light Commercial
SF-2 - Single Family Standard	C-2 - Medium Commercial
TF - Two Family	C-3 - Heavy Commercial
TH - Townhome	NB - Neighborhood Business
MF-1 - Multi-Family 15	DB - Downtown Business
MF-2 - Multi-Family 25	IN-1 - Light Industrial
MH-1 - Manufactured Home	IN-2 - Heavy Industrial
I-1 - Institutional Small	PUD - Planned Unit Development
I-2 - Institutional Large	ETJ


13295.94 ft²
180.03 ft



N

811 Know what's below. Call before you dig.

0 40 80
Scale 'n feet

SITE INFORMATION

OWNER/DEVELOPER:	MANOR MF LLC 178 FIRSTFIELD ROAD SUITE 203 GAITHERSBURG MD 20878
LEGAL DESCRIPTION:	BEING 13.2177 ACRES OF LAND SITUATED IN THE JAMES MANOR SURVEY NO. 40, ABSTRACT NO. 546, TRAVIS COUNTY, TEXAS; BEING A PORTION OF THAT CERTAIN CALL 105.170 ACRE TRACT OF LAND AS DESCRIBED IN WARRANTY DEED WITH VENDOR'S LIEN TO LAS ENTRADAS DEVELOPMENT CORPORATION AND RECORDED IN DOCUMENT NO. 2007002485, OF THE OFFICIAL PUBLIC RECORDS OF TRAVIS COUNTY, TEXAS.
SITE ADDRESS:	TBD
ZONED:	MF-2 (MULTI-FAMILY 25)
SETBACKS:	FRONT - 20' SIDE - 80' (3 STORY), 25' (1 STORY), 50' (2 STORY) REAR - 80' (3 STORY), 25' (1 STORY), 50' (2 STORY)

LEGEND

NOTE: NOTE: ALL BUILDING UTILITY CONNECTION SIZE AND LOCATIONS TO BE CONFIRMED WITH ARCHITECTURAL PLANS

- WATER VALVE
- FIRE HYDRANT
- SEWER MANHOLE
- SANITARY CLEANOUT
- NUMBER OF PARKING SPACES PER ROW
- RR RISER ROOM LOCATION
- WATER LINE
- SANITARY SEWER
- PROPOSED CURB AND GUTTER

KEYED NOTES

- A ADA CURB RAMP/SIDEWALK
- B CONCRETE SIDEWALK. WIDTH PER PLAN
- C ACCESSIBLE PARKING SPACE (AS SHOWN BELOW)
  ACCESSIBLE PARKING SPACE WITH BOLLARD, SIGN, STRIPING, AND SYMBOL (SEE DETAILS)
- D 6" WHITE THERMOPLASTIC CROSSWALK STRIPING
- E 6" WIDE FIRE LANE STRIPING PAINTED TRAFFIC RED WITH "NO PARKING - FIRE LANE" PAINTED WHT 4" HIGH WHITE LETTERING AT 25' O.C. SEE DETAIL SHEET NOTE - STRIPING SHOWN OFFSET FOR CLARITY.
- F 6" CURB AND GUTTER
- G CARPORT (DETAILS BY ARCHITECT)
- H TREE PROTECTION FENCING
- I CONCRETE PAVEMENT
- J DUMPSTER ENCLOSURE
- K TRANSFORMER AND CONCRETE PAD
- L SITE MONUMENT SIGN
- M SITE SECURITY FENCING & ACCESS GATES

GENERAL NOTES

1. ALL WORK AND MATERIALS SHALL COMPLY WITH ALL CITY, COUNTY, STATE, FEDERAL AND OSHA REGULATIONS.
2. CONTRACTOR SHALL REFER TO THE ARCHITECTURAL PLANS FOR EXACT LOCATIONS AND DIMENSIONS OF SLOPED PAVING, RMPAS, SIDEWALKS, EXIT PORCHES, PRECISE BUILDING DIMENSIONS, EXACT BUILDING UTILITY ENTRANCE LOCATIONS, TOTAL NUMBER, LOCATION, AND SIZE OF DOWNSPOUTS AND ANY OTHER APPURTENANCES WHICH ARE CONNECTED TO THE BUILDING.
3. ALL DIMENSIONS AND RADII ARE TO THE FRONT OF CURB, CENTER OR END OF STRIPE, FACE OF BUILDING, OR EDGE OF PAVEMENT, UNLESS OTHERWISE NOTED.
4. CONTRACTOR IS REQUIRED TO REMOVE OR RELOCATE, IN A PROPER MANNER, EXISTING IMPROVEMENT/NATURAL FEATURES TO ALLOW FOR CONSTRUCTION OF PROPOSED IMPROVEMENTS INDICATED ON THE PLANS. ALL WORK SHALL BE IN ACCORDANCE WITH GOVERNING AUTHORITIES SPECIFICATIONS AND SHALL BE APPROVED BY SUCH. NO SEPARATE PAY FOR THIS WORK.
5. CONTRACTOR IS RESPONSIBLE FOR PROTECTION AND REPLACEMENT OF ALL PROPERTY CORNERS. PROPERTY CORNERS DAMAGED BY CONTRACTOR SHALL BE REPLACED BY A REGISTERED PROFESSIONAL LAND SURVEYOR AT CONTRACTOR'S EXPENSE.
6. CONTRACTOR SHALL BE RESPONSIBLE FOR DOCUMENTING ALL EXISTING DAMAGE AND NOTIFY OWNER AND/OR ENGINEER PRIOR TO STARTING CONSTRUCTION. CONTRACTOR SHALL BE RESPONSIBLE FOR REPAIRING EXISTING ITEMS DAMAGED DURING CONSTRUCTION, SUCH AS, BUT NOT LIMITED TO, DRAINAGE, UTILITIES, PAVEMENT, STRIPING, CURB, ETC. DAMAGES SHALL BE REPORTED TO ENGINEER OF RECORD PRIOR TO REPAIR. REPAIRS SHALL BE EQUAL TO, OR BETTER THAN, EXISTING CONDITIONS.
7. PROPOSED CONSTRUCTION ON THIS SITE SHALL COMPLY WITH THE LATEST REVISION OF THE ADA REGULATIONS AND THE TEXAS ACCESSIBILITY STANDARDS (TAS).
8. EROSION AND SEDIMENTATION CONTROL DURING CONSTRUCTION SHALL BE IN COMPLIANCE WITH LOCAL AND STATE REQUIREMENTS.
9. CONTRACTOR SHALL BE RESPONSIBLE FOR MAINTAINING PROPER DRAINAGE THROUGHOUT THE SITE DURING CONSTRUCTION. CARE SHALL BE TAKEN TO PREVENT ANY NEGATIVE IMPACTS TO ADJACENT PROPERTIES.
10. CONTRACTOR SHALL CAREFULLY MONITOR WEATHER PATTERNS AND PREPARE FOR EXPECTED EVENTS. SPECIAL CARE SHALL BE TAKEN TO EXAMINE SITE PRIOR TO WEEKENDS OR ABSENCES FROM THE WORK SITE.
11. NO HAZARDOUS MATERIALS WERE IDENTIFIED DURING PRELIMINARY SITE INVESTIGATIONS. ANY ITEMS FOUND SUSPECT DURING CONSTRUCTION SHOULD BE BROUGHT TO THE ATTENTION OF THE ENGINEER IMMEDIATELY.

FIRE LANE STRIPING NOTE

LOCATION OF FIRE LANE STRIPING SHALL BE APPROVED BY THE LOCAL FIRE MARSHAL PRIOR TO APPLICATION. UNLESS OTHERWISE DIRECTED BY THE FIRE MARSHAL, FIRE LANE STRIPING SHALL BE 6" RED PAINTED STRIPE ALONG TOP AND FACE OF CURB, FACE OF SIDEWALK, OR DIRECTLY ADJACENT TO PROPOSED PARKING LOT STRIPING, WITH 4" WHITE STENCILED LETTERS "FIRE LANE TOW AWAY ZONE" PAINTED ON RED STRIPE AT 30' CENTER TO CENTER MAX SPACING. SEE FIRE LANE STRIPING DETAIL ON C-6.1.

ISSUEING
GBA COMMENT RESPONSE-MAY 2023
ISSUE #6 (05/12/23 ADDENDUM #6
CITY COMMENT RESP.,& VE ITEMS-07/18/2023
ISSUE #11 ADDENDUM #10 (10/04/23)
FIRE PREVENTION COMMENTS 01/08/24
TCEQ#12 COMMENTS 01/23/24

RESERVES AT LAS ENTRADAS
GREGG MANOR ROAD
MANOR, TEXAS

SITE PLAN

ISSUED FOR PERMITTING - 01/08/2024

CARNEY ENGINEERING, PLLC.
5465 LEGACY DRIVE, SUITE 650
Plano, Texas 75024
PH (469) 443-0861
FAX (469) 443-0863

H. CRAIG CARNEY 55714 LICENSED PROFESSIONAL ENGINEER 01/25/2024

TBPE FIRM REGISTRATION NO. F-6033

DRAWN BY: BGH
CHECKED BY: BPB
START DATE: 09/17/2022
SCALE: SEE PLAN
PROJECT NO. 0069-020

AGREEMENT:

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, City and Developer hereby agree as follows:

1) Incorporation of Recitals. The recitals set forth above are incorporated herein and made a part of this First Amendment to the same extent as if set forth herein in full.

2) Capitalized Terms. All capitalized terms in this First Amendment shall have the same meanings as in the Agreement unless expressly provided otherwise herein.

3) Zoning/Land Use. (a) Pursuant to Section 4.3 of the Agreement, zoning of the LE Property shall be subject to the process, notices, hearings and procedures applicable to all other properties within the City and any re-zoning that is subsequently approved for the LE Property shall allow the LE Property to be developed in accordance with terms and conditions of the Agreement.

(b) To reflect the rezoning of the LESC-2 Parcel, the portion of the Land Use Summary Table attached to the Agreement as Exhibit E-1 solely applicable to the LESC-2 Parcel is hereby deleted and replaced with the following:

Entrada Glen Land Use Sumary

Tract	Block	Area (AC)	Use	Units	SF Parking Required*
LESC 2	2A	1.754	Right of Way	n/a	n/a
	2B	1.67	Commercial	tbd at site plan	tbd at site plan
	2C	9.8	Multifamily	Tbd at stie plan	tbd at site plan
Subtotal		13.224			

*Up to 40 parking spaces on Block 2B (Commercial) may be jointly used by Block 2C (Multifamily) in order to meet required parking numbers. The shared parking spaces on Block 2B (Commercial) will be constructed concurrently with the development of the multifamily project on Block 2C.

(c) The map/drawing contained on the Land Use Summary Table attached to the Agreement as Exhibit E-1 is hereby amended to add "Exhibit E-1.1" attached hereto and made a part hereof which is solely applicable to the LESC-2 Parcel.

4) Open Space/Parkland. Open Space and Parkland dedication for all of the Property covered by the Agreement has (or will be) satisfied pursuant to Section 4.11 of the Agreement, therefore, the Parties acknowledge and agree that DD&B shall not be required to dedicate any onsite parkland with respect to the LESC-2 Parcel, but will require a fee-in-lieu per section 15.01.001 (C)(8).

June 14, 2024

Scott Dunlop
CITY OF MANOR
105 E. Eggleston Street
Manor, Texas 78653

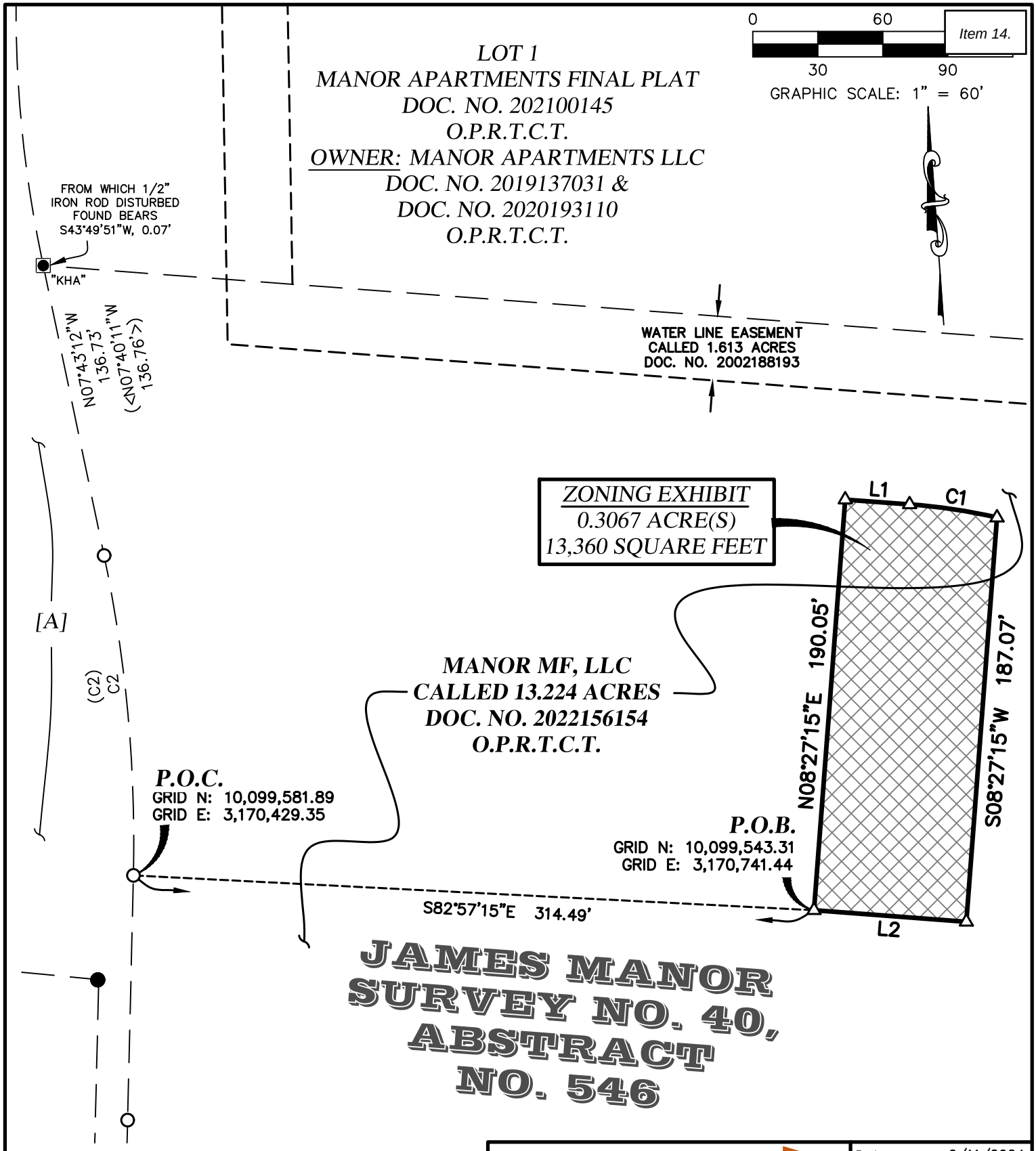
Re: Authorized Signatory for the Zoning Application – Approximately 0.3067 acres of land, more or less, being out of the James Manor Survey No. 40, Abstract No. 546 in Travis County, Texas, being a portion of a called 13.224 acre tract conveyed to Manor MF, LLC

Dear Mr. Dunlop:

The following letter serves to herby authorize Talley Williams and Katherine Nicely, both with Metcalfe Wolff Stuart & Williams, LLP (The Agent) listed on this application to act on Owner's behalf during the processing of this zoning request. Mrs. Williams and Mrs. Nicely will be the principal contact with the City in processing this application.

DD&B Construction Inc.,

By: _____
Sushil Mehta, President



0.3067 ACRES
ZONING EXHIBIT
City of Manor,
Travis County, Texas

4WARD Land Surveying
A Limited Liability Company
PO Box 90876, Austin Texas 78709
INFO@4WARDLS.COM (512) 537-2384
TBPELS FIRM #10174300

Date:	6/11/2024
Project:	01517
Scale:	1" = 60'
Reviewer:	PRB
Tech:	CC
Field Crew:	JC/FH
Survey Date:	SE
Sheet:	642

P:\01517\Dwg\01517_ZONING EXHIBIT.dwg

6/26/2024

City of Manor Development Services

Notification for a Rezoning Application

Project Name: Reserves at Las Entradas Additional Area
Case Number: 2024-P-1663-ZO
Case Manager: Michael Burrell
Contact: mburrell@manortx.gov – 512-215-8158

The City of Manor Planning and Zoning Commission and City Council will be conducting a Regularly Scheduled meeting for the purpose of considering and acting upon a Rezoning Application for the corner of Gregg Manor Road and West Eggleston Street, Manor, TX from (C-1) Light Commercial to Multi-Family 25 (MF-2). The request will be posted on the agenda as follows:

Public Hearing: Conduct a public hearing on a Rezoning Application for one (1) lot on 0.31 acres, more or less, and being located near the intersection of Gregg Manor Road and West Eggleston Street, Manor, TX from (C-1) Light Commercial to Multi-Family 25 (MF-2).

Applicant: MWSW LLP
Owner: DD&B Construction Inc.

The Planning and Zoning Commission will meet at 6:30PM on July 10, 2024 at 105 East Eggleston Street in the City Hall Council Chambers.

The City Council will meet at 7:00PM on July 17, 2024 at 105 East Eggleston Street in the City Hall Council Chambers.

You are being notified because you own property within 300 feet of the property for which this Rezoning Application has been filed. Comments may be addressed to the email address or phone number above. Any communications received will be made available to the Commissioners and Council Members during the discussion of this item.

Manor MF LLC (1956048)
17B Firstfield Rd. Ste. 203
Gaithersburg MD 20878-1779

MANOR HOUSING PUBLIC FACILITY
(2002094)
105 E EGGLESTON ST
MANOR TX 78653-3463

AGENDA ITEM SUMMARY FORM

PROPOSED MEETING DATE: August 7, 2024

PREPARED BY: Scott Moore, City Manager

DEPARTMENT: Administration

AGENDA ITEM DESCRIPTION:

Consideration, discussion, and possible action on authorizing a letter of support to the Central Texas Regional Mobility Authority for U.S. 290 Highway Improvements.

BACKGROUND/SUMMARY:

On February 1, 2024, city officials met with Commissioner Travillion, TXDOT and CTRMA representatives to discuss the current growth projections and traffic impacting the community and public safety response times. The US290 corridor was discussed and has become a priority to be considered for future consideration. Another option for the city to explore is to request CTRMA to consider adding this project to their capital project list to initiate the preliminary environmental study. The preliminary study is a high-level assessment that is required to evaluate best approach to expanding the highway within the existing right-of-way limits and identify any environmental constraints while understanding the community and economic goals during the planning phase of the study. The study will assist the state and federal agencies to properly evaluate the project development, design, and construction, including capital and operating costs. The preliminary study is required to gather community feedback and inform us of those significant findings during the entire review process.

The City Council is being requested to support the Central Texas Regional Mobility Authority (CTRMA) to initiate the process of conducting a feasibility study for the expansion of U.S. 290 from SH130 Toll to the City of Elgin. The 290 corridor through the City of Manor generates over 62,000 vehicles per day. With an estimated 14,400 new homes planned for the community, this will increase the city's population by an estimated 43,200 new residents over the next 7 to 10 years.

LEGAL REVIEW: Not Applicable

FISCAL IMPACT: Not Applicable

PRESENTATION: No

ATTACHMENTS: Yes

- Letter of Support CTRMA

STAFF RECOMMENDATION:

It is the city staff's recommendation that the City Council approve and authorizing a letter of support to the Central Texas Regional Mobility Authority for U.S. 290 Highway Improvements.

PLANNING & ZONING COMMISSION: **Recommend Approval** **Disapproval** **None**

August 7, 2024

Bobbie Jenkins, Chairman
3300 N IH-35, Suite 300
Austin, TX 78705

Re: Letter of Support for U.S. 290 Highway Feasibility Study

Dear Mr. Jenkins,

On behalf of the citizens and businesses of the City of Manor, I am seeking Central Texas Regional Mobility Authority's support in initiating a feasibility study of the US290 corridor from Parmer Lane to the Travis/Bastrop County line. Since the 2010 census, the City of Manor has emerged from a small town of 5,087 population with limited transportation assets to be strategically located in the path of growth at the intersection of U.S. 290 and FM 973, to a community of 30,000+ citizens that include ShadowGlen and Presidential Meadow municipal utility districts.

The estimated daily traffic count through the City of Manor has reached as high as 62,000 vehicle per day along US 290 East, which increased from 45,000 vehicles per day. With the increased traffic traveling through our community, our Public Safety officials have dealt with multiple facilities on the state highways within our corporate limits since 2020. Improving our regional transportation in this portion of Travis County is critical for our community's growth and economic development endeavors. CTRMA supporting this request will illustrate to our citizens and business stakeholders of this unique opportunity to transcend jurisdictional boundaries and accelerate public infrastructure improvements for viable short- and long-term solutions for our local and regional mobility needs.

With City of Manor projected to add 14,400 units (an estimated 43,200 population increase) residing in our community over the next 7 to 10 years, managing the region's rapid growth and transportation infrastructure has become a top priority for TML Region 10 cities to stand united with us.

We look forward to collaborating with and supporting CTRMA's priorities for the eastern crescent of Travis County, as well as engaging CAMPO, TXDOT, and other agencies committed to regional partnerships and business development.

Always working to make the world a better place,

Dr. Chris Harvey, Mayor