CITY OF OAKLAND **AGENDA REPORT**

TO: DEANNA J. SANTANA
CITY ADMINISTRATOR

FROM: LaTonda Simmons
CITY CLERK

SUBJECT: Offsite Storage Vendor Contract Extension **DATE:** June 4, 2012

City Administrator Approval Deanna J. Santana Date 6/10/12

COUNCIL DISTRICT: City-Wide

RECOMMENDATION

Staff recommends that the City Council adopt a Resolution to waive the request for proposal/qualifications process for a contract extension with CRM Information Management Services ("GRM") (formerly SIMMBA Systems) in an amount not to exceed one hundred thousand dollars ($100,000) for the continued retention and offsite storage of city records for the period October 15, 2011 through February 15, 2013.

EXECUTIVE SUMMARY

Preservation of records is an essential function of municipal operations. The Office of the City Clerk administers the Citywide Records Management Program which includes the contract for off-site storage of archived records. States, counties and cities have the option to establish the location and methodology for management of Records Management programs as an essential function of municipal operations. Prior to 1999, the Office of the City Clerk utilized internal resources for the management of the City's archived records located within a City facility on Poplar Street in the City of Oakland. Subsequent to the extensive damage to City facilities due to the Leoma Prieta earthquake and a reduction in staff resources, management of the City's inventory was contracted out to provide for the protection and effective management of City's records and to conform to records management best practices for preservation of municipal records. The limited extension of the offsite records storage contract will ensure the City's ability to retrieve records to comply with public records and discovery requests. The offsite storage is elemental in a Comprehensive Records Management Program. A Comprehensive Records Management program will be presented to Council in early fall of 2012. In the interim, the City must maintain access and controls to the offsite inventory to comply with public records and discover requests. The limited extension of the GRM contract ensures City access to our inventory and provides sufficient time to pursue a competitive bid of the service.

OUTCOME

The waiver of the request for proposal/qualifications (RFP/Q) process for a limited contract extension with GRM will provide for continued access to City records for public records and discovery requests, sufficient time to develop and conduct a "RFP/Q" process, and addhional opportunity to obtain feedback from the City Council regarding the Comprehensive Records Management Program.

BACKGROUND/LEGISLATIVE HISTORY

In 1999 Council authorized execution of a contract with SIMMBA Systems for the retention and offsite storage of city records. In October 2002, the City Council authorized execution of a contract extension with SIMMBA Systems. This resolution, No. 77481 C.M.S provided for an extension of contract services through the end of 2005 and authorized the City Administrator to approve subsequent amendments and/or extensions for up to three years.

During the contracted period in 2003, SIMMBA Systems was sold to GRM. The acquisition provided for the immediate transfer of access controls and management of the inventory of City records to GRM. A review of the inventory revealed several inaccuracies in the management and categorization of City records, which occurred in the change of control to GRM. Extensive work has been performed with the current vendor to correct the migration errors, reconcile the inventory, clarify controls, and provide for effective and efficient retrieval of City records going forward.

Pursuant to the authorization of Resolution No. 77481 C.M.S., the City Administrator entered into another agreement with GRM for the period of October 15, 2005 to October 15, 2008. Since 2008 services have been continued on a month-to-month basis to complete the work to resolve issues with the records inventory and ensure access to City records for public access and discovery requests. The existing agreement allows extensions on a month-to-month basis for a total of three years; therefore the agreement expired on October 15, 2011. In accordance with City rules, as of October 2011 payments to the vendor were withheld. The Office of the City Clerk Records Management Division requests a waiver of the RFP/Q process for a limited contract extension to pay expenses for Records Management services incurred from the period of October 2011 to the present, and to provide for continued managed services through February 15, 2013, to ensure access to public records, and provide sufficient time to complete an RFP/Q for the assignment of a new contract for this service.

ANALYSIS

Access to and proper organization of City Records is essential to the City's ability to comply with federal, state, and local laws in the response to public records and discovery requests. This includes storage of thousands of cartons of records. Resources required to facihtate and manage

in-house records storage are unavailable to the City of Oakland. Use of a professional records and information management company to provide secured storage of records is the most cost effective option.

Oakland Municipal Code section 2.04.051.B authorizes the City Council to waive the RFP/Q process upon a finding that it is in the City's best interest to do so.

Staff recommends waiving the RFP/Q process for the contract with GRM in an amount not to exceed $100,000 for the continued retention and offsite storage of city records. This will allow the city to comply with state and federal law while staff prepares and conducts a RFP/Q process and will allow staff to seek council input on the records management system

PUBLIC OUTREACH/INTEREST

Utilization of offsite storage contracts is one of many components to a Comprehensive Records Management Program. Records management is near the core of the City's complaints. Status and progress of records management is of high interest to the League of Women Voters, the Public Ethics Commission, and the public.

COORDINATION

The Office of the City Clerk has reviewed the issue of access to public records with the Office of the City Attorney and the Public Ethics Commission to discuss the importance of access to the offsite City records. These key departments and departments Citywide acknowledge that continued access to the off-site inventory ensures the City's ability to comply with statutory requirements for information request, and further the City's ability to function. The limited extension of the contract specifically ensures the City's access to records is in compliance with the Public Records Act and discovery requests in accordance with federal and state law.

COST SUMMARY/IMPLICATIONS

AMOUNT OF RECOMMENDATION/COST OF PROJECT:

	FY 2011-2012 October 2011 to June 30, 2012	FY 2012-2013 July 1, 2012 to February 15, 2013
Total Service Costs:	***$52,500***	***$43,800***

1. SOURCE OF FUNDING: FY 2011 – 12 and Fiscal Year 2012-13 Adopted budget

2. FISCAL IMPACT: Assumes use of the adopted budgeted funds for Fiscal Years 2011-12 and 2012-13 for the Office of the City Clerk IP 63 - Records Management Program

SUSTAINABLE OPPORTUNITIES

Economic: None

Environmental: None

Social Equity: Approval of the Resolution ensure access to public information for all members of the public

CEQA

This report is not a project under CEQA.

For questions regarding this report, please contact DEIDRE SCOTT, RECORDS MANAGER at 510-238-3624.

Respectfully submitted,

LaTonda Simmons
City Clerk, Office of the City Clerk

Prepared by:
Deidre Scott, Records Manager
Records Division

Attachment: A
2006 Contract Extension

Item:
Finance & Management Committee
June 26, 2012

Attachment A

02-1429

FILED
OFFICE OF THE CITY CLERK
OAKLAND

2006 SEP 27 AM 10: 35

PROFESSIONAL OR SPECIALIZED SERVICE AGREEMENT BETWEEN THE CITY OF OAKLAND AND GRM INFORMATION MANAGEMENT SERVICES

Whereas, the City Council has authorized the City Manager to enter into contracts for professional or specialized services if the mandates of Oakland City Charter Section 902(e) have been met.

Now therefore the parties to this Agreement covenant as follows:

1. Parties and Effective Date

This Agreement is made and entered into as of October 15, 2005, between the City of Oakland, a municipal corporation, ("City" or 'DEPOSITOR"), One Frank H. Ogawa Plaza, Oakland, California 94612, and GRM Information Management Services, ("Contractor" or "GRM").

2. Scope of Services

GRM hereby agrees to store DEPOSITOR's records, property and/or other materials (hereinafter collectively referred to as the "Materials") and to provide additional services as described more specifically in the Exhibit "A" attached hereto and incorporated herein by this reference.

3. DEPOSITOR Addendum. In addition to the terms set forth herein, Exhibits hereto and attachments to exhibits, all tenns and conditions set forth in the "City of Oakland Addendum No. 1" attached, are incorporated herein and made part of this Agreement.

4. Compensation.

(a) Contract Price. Payments made by DEPOSITOR under this agreement shall not in any event exceed SEVENTY THOUSAND DOLLARS AND NO CENTS ($70,000.00) annually for the initial three (3) year term. Any increase in the contract price shah not be valid unless approved by a two-thirds (2/3) vote of the Oakland City Council.

(b) Storage rates. Charges for storage and related services shall be at the rates shown on the GRM price schedule attached hereto as Exhibit "B" and incoiporated herein by this reference. Rates for storage and related services shall be fixed at the rates set forth in Exhibit B for the term of this Agreement.

5. Not an insurer. DEPOSITOR hereby understands and agrees that GRM is NOT AN INSURER of the Materials provided by DEPOSITOR and DEPOSITOR agrees that, notwithstanding the actual or known value of the Materials or any portion thereof, GRM shall in no event be liable for any loss or damage to the Materials in excess of the following valuations:

(a) Business records: $2.10 per box
(b) Film or video tape: $2.10 per unit
(c) X-Rays: $2.10 per box
(d) Other: _____ (use addendum if necessary).

DEPOSITOR UNDERSTANDS AND AGREES THAT ANY VALUATION INSURANCE OR OTHER PROTECTION BEYOND THE VALUATIONS SET FORTH HEREIN ARE THE SOLE RESPONSIBILITY OF DEPOSITOR AND THAT SUCH INSURANCE OR OTHER PROTECTION SHALL BE OBTAINED PRIOR TO THE DELIVERY TO GRM OF THE MATERIALS SUBJECT TO THE TERMS AND PROVISIONS OF THIS AGREEMENT.

6. Term. The term of this Agreement shall be for a period of three (3) year(s), commencing on October **15, 2005** and ending on October **15, 2008**. This Agreement shall automatically expire at the end of the three (3) year term unless the parties mutually agree, 90 days before the termination date, to extend the Agreement on a month-to-month basis up to three (3) additional years. Rates during the term(s) of such extension shall be at seventy five percent (75%) of the then prevailing document storage rates charged by GRM and at then prevailing rates charged by GRM for all other services.

7. Return of stored materials. Upon termination of this Agreement for any reason, GRM shall return to DEPOSITOR at DEPOSITOR's reasonable request for return of the Materials stored by GRM on DEPOSITOR's behalf in the form originally supplied by DEPOSITOR to GRM, unless such data shall have been destroyed at DEPOSITOR's instructions pursuant to the Retention Policy set forth below in Paragraph 6 hereof DEPOSITOR shall pay those rates then in effect for the return to DEPOSITOR of the Materials contemplated by this Agreement, at which time of delivery all of CRM's liabilities therefore shall forever terminate and all risk of loss of any kind or nature shall automatically revert to DEPOSITOR. In the event DEPOSITOR shall request that the Materials subject to the terms and provisions of this Agreement be returned to DEPOSITOR in a format or media different than originally provided by DEPOSITOR, DEPOSITOR understands and agrees that GRM may impose an additional charge for such format or media subject to DEPOSITOR's approval at the time of such request.

8. Retention policies and procedures. It is CRM's policy that no portion of the Materials shall be destroyed or deleted without the prior written consent of an authorized representative of DEPOSITOR. Where DEPOSITOR establishes a schedule of destruction or deletion of any of the Materials in CRM's possession, such schedule shall be the sole responsibility of DEPOSITOR and GRM shall have no liability therefor.

DEPOSITOR shall provide to GRM a written schedule setting forth the date(s) of destruction or deletion of the Materials as well as identification of the specific Materials to be destroyed or deleted. Arrangements for archive, backup, or other supplemental record(s) of the Materials shall be die sole responsibility of DEPOSITOR and GRM shall have no liability for DEPOSITOR's failure to arrange for such archive, backup or other copies prior to or following any destruction or deletion of the Materials as ordered by DEPOSITOR.

9. Materials controls and work orders. Only those authorized representatives of DEPOSITOR shall be enthled to instruct GRM as to the handling, management and/or disposition of the Materials of DEPOSITOR subject to this Agreement. Withm seven (7) days of the Effective Date hereof, DEPOSITOR shall provide to GRM in wrhing the name(s) of the individual(s) having authority to instruct GRM with respect to the handling, management and/or disposition of the Materials (the "Authorized Persons"), such list remaining in effect until and umless modified in a writing signed by DEPOSITOR's authorized representative and received by GRM.

GRM expressly reserves the right to authenticate or confirm any instruction received by GRM from DEPOSITOR which GRM reasonably believes is or may be invalid or issued by someone other than an Authorized Person of DEPOSITOR.

10. Payment terms. All charges for storage under this Agreement shall be billed and are due on the first day of each month on a monthly basis. All charges for services shall be billed and are due on the first day of the following month on a monthly basis. All charges for storage shall be on a flat fee basis by month. DEPOSITOR(s) shall be responsible for all storage and service charges for the term of this Agreement. GRM shall be deemed to have earned its regularly scheduled storage charges for all Materials in connection with DEPOSITOR's account herein, notwithstanding the fact that all or a portion of the Materials in GRM's possession may be temporarily in the custody and possession of DEPOSITOR, its agents or representatives. A finance charge in an amount equal to one and one-half percent (1.5%) of the amount past due shall be applied to any past due amounts thirty (30) days from the date payment is due.

11. Disclosure of Materials. GRM shall hold the Materials in confidence and safekeeping and only GRM's staff and the Authorized Person(s) of DEPOSITOR shall have access to those Materials stored by GRM on DEPOSITOR's behalf. Unless requested by DEPOSITOR, or as provided under the terms and provisions of this Agreement, GRM shall not examine the Materials submitted by DEPOSITOR for storage. GRM is not DEPOSITOR's custodian of records for litigation purposes. If GRM is served a subpoena or other legal document that requires it to produce any portion or all of the Materials to a third party,. GRM shall have no liability to DEPOSITOR for compliance; provided that GRM shall notify DEPOSITOR thereof promptly and shall send DEPOSITOR by facsimile a copy of any such document within one (1) business day of the time it is received by GRM at city of Oakland; provided further that GRM shall not produce such document(s) earlier than twenty-four (24) hours prior to the deadline for such document production without the prior written consent of

the DEPOSITOR, to allow DEPOSITOR sufficient time to legally challenge the production of such record(s) and/or to determine whether such records production request is legally correct. GRM agrees to comply with any valid judicial order, judgment or decree compelling or preventing GRM's disclosure of the Materials specified in such order, judgment or decree, in which case DEPOSITOR shall be deemed to have authorized the disclosure of the Materials. DEPOSITOR agrees to reimburse GRM for GRM's reasonable production charges in responding to subpoenas or other legal orders requiring production of Materials and to defend, indemnify and hold harmless GRM from any claims, actions, causes of action or damages arising from GRM's release and/or disclosure of the Materials as hereinbefore set forth.

12. Warranfies of DEPOSITOR. DEPOSITOR warrants as follows:

(a) it is either the lawful owner or authorized custodian of the Materials and that it has the lawful right of possession of the Materials;

(b) it has the authority to negotiate and enter into this Agreement and to authorize GRM to store, manage and retrieve the Materials subject to this Agreement;

(c) none of the Materials provided by DEPOSITOR violate any civil or property rights, nor the privacy rights, of any third person(s), organization(s) or entity(ies), including trademark, copyright, trade secret or other form of intellectual property;

(d) DEPOSITOR will not deliver to GRM any nitrate or flammable items or dangerous or hazardous materials of any kind or nature the storage of which could result in a public hazard or nuisance; and

(e) that none of the Materials stored pursuant to this Agreement are contraband, illicit or controlled substances or otherwise illegal to possess under any state or federal statute, regulafion or ordinance.

13. Warranties of GRM. GRM warrants as follows:

(a) that it will take all reasonable steps necessary to safeguard the Materials from the elements and unauthorized access; and

(b) to maintain its systems in proper working order to ensure access and availability of the Materials to DEPOSITOR in accordance with the terms and provisions of this Agreement.

14. Limitation of liability. EXCEPT AS SET FORTH IN THIS AGREEMENT, UNDER NO CIRCUMSTANCES, SHALL GRM SYSTEMS, L.L.C., ITS DIRECTORS, OFFICERS, EMPLOYEES OR AGENTS BE LIABLE FOR ANY INCIDENTAL, SPECIAL OR CONSEQUENTIAL DAMAGES (INCLUDING LOST

PROFITS, BUSINESS INTERRUPTION, LOSS OF BUSINESS INFORMATION AND THE LIKE) ARISING OUT OF THE STORAGE, MAINTENANCE, POSSESSION OR HANDLING OF THE MATERIALS EVEN IF GRM HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. SOME JURISDICTIONS MAY OR MAY NOT ALLOW THIS LIMITATION OR EXCLUSION OF LIABILITY FOR INCIDENTAL OR CONSEQUENTIAL DAMAGES, SO THE ABOVE LIMITATION MAY OR MAY NOT APPLY TO YOU.

15. Containers. GRM reserves the right to approve of containers prior to GRM'S acceptance. DEPOSITOR agrees to pay the prices for such containers and/or transfer services then in effect and agrees that GRM shall have no liability for the rejected containers or the Materials contained therein. Further, GRM shall have the right, subject to the prior written approval of DEPOSITOR, to remove all or part of the materials to an altemative location within seventy-five (75) miles of the initial archive location and shall notify DEPOSITOR of such new location at least seven (7) business days prior to such transfer.

16. Termination. GRM and DEPOSITOR shall have the right to terminate this Agreement upon at least sixty (60) days prior written notice to the other upon the following causes:

(a) violation or breach by DEPOSITOR or GRM, its officers or employees of any provision of this Agreement, including, but not limited to, non-payment of charges;

(b) the termination of the business of DEPOSITOR or GRM or the voluntary or involuntary filing of a bankruptcy petition or similar proceeding under state law with respect to DEPOSITOR; or

(c) DEPOSITOR's or GRM's becoming insolvent or making any assignment for the benefit of creditors.

The termination of this Agreement shall automatically, and without any further action by DEPOSITOR, terminate and extinguish the Agreement. In the event of the termination hereof, GRM shall have the right to (1) retiun the Materials to the last known address of DEPOSITOR, charging DEPOSITOR the maximum fee allowed by its rates then in effect; and/or (2) seek recovery imder any theory allowed at law or in equity; provided that GRM shall not, in any way, dispose of the public records of DEPOSITOR in violation of law, whether Califomia law or otherwise.

17. Defauh. DEPOSITOR may terminate this agreement, without further obligafion, for the following reasons:

(a) GRM fails to meet the time requirements specified in the scope of services for delivery for less than 95% of the requests for any two (2) successive months (the rate of compliance will be determined by review of

Depositor's and GRM's facsimile records of written orders sent and received, and actual delivery times logged); or

(b) GRM fails to provide any and/or all of the services covered by sections 6-15 of the RFQ response, when requested by the City, in a complete and accurate form, for a period of two (2) successive months; or

(c) GRM fails to produce any or all of the inventory reports covered by Exhibit B, Items AB-AG of the Response for a period of two (2) successive months; or

(d) GRM provides access to any unauthorized individual, except as provided under Section 11 above.

DEPOSITOR must show cause and will provide written notice to GRM of any default and a thirty- (30) day period to cure. In the event that GRM fails to cure all defaults within thirty (30) days, DEPOSITOR may terminate this agreement without further notice. In the event of default, GRM will remove DEPOSITOR's boxes from its storage facility to GRM's loading dock at no cost to DEPOSITOR.

18. Force Majeure. GRM shall not be liable to DEPOSITOR for any delay or failure to perform due to causes beyond its reasonable control, including, but not limited to, wars, hostilities, revolutions, riots, civil commotion, national emergency, strikes, lockouts, unavailability of supplies, epidemics, fire, flood, earthquake, force of nature, explosion, embargo, or any Act of God, or any law, proclamation, regulation, ordinance, or other act or order of any court, government or governmental agency. Other than Force Majeure, as set forth in this Paragraph 18, GRM is not relieved of any contractual obligations pursuant to this Agreement.

19. Compliance with Laws. The parties hereto agree that they will comply with any and all applicable laws and regulations of any country, state, or political sub-division thereof in the performance of the terms and conditions of this Agreement.

20. Form of Agreement. The subject headings of the paragraphs and subparagraphs of this Agreement are included for convenience only and shall not affect the constmction or interpretation of any of its provisions.

21. Merger. Except where specified and except for the representafions in GRM's response to the RFQ, this Agreement consütutes the entire agreement between the parties pertaining to the subject matter contained in it and supersedes all prior and contemporaneous agreements, representations, and understandings of the parties. No supplement, modification, or amendment of this Agreement shall be binding unless executed in writing by the parties. No waiver of any of the provisions of this Agreement shall be deemed, or shall constitute, a waiver of any other provisions, whether or not similar, nor shall any waiver constitute a continuing waiver. No waiver shall be binding unless executed in wrifing by the party making the waiver.

22. Counterparts. This Agreement may be executed simultaneously in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

23. Parties in Interest. Nothing in this Agreement, whether express or implied, is intended to confer any rights or remedies under or by reason of this Agreement on any persons other than the parties to it and their respective heirs and assigns, nor is anything in this Agreement intended to relieve or discharge the obligation or liability of any third persons to any party to this Agreement, nor shall any provision give any third persons any right of subrogation or action over or against any party to this Agreement.

24. Assignment. This Agreement shall be binding upon DEPOSITOR and GRM, their representatives, successors, and assigns; provided, however, that neither DEPOSITOR nor GRM may assign any of its rights under this Agreement without the prior written consent of the other; which shall not be unreasonably withheld, provided further that GRM may terminate this Agreement upon ninety days 90 days advance notice if DEPOSITOR will not provide its prior written consent within fourteen(14) business days of the date it has received written notice of the proposed assignment of its rights and obligations hereunder, including specifically the correct names, addresses, telephone numbers, and reasonable evidence of the financial responsibility of any proposed transferees.

25. Notices. All notices, requests, demands, and other communicafions under this Agreement shall be in writing and shall be deemed to have been duly given on the date of service if served personally on the party to whom notice is to be given, or on the fifth day after mailing if mailed to the party to whom notice is to be given, by first class mail, registered or certified, postage prepaid, and properly addressed as follows:

GRM: 1150 Ballena Boulevard, Suite 250
Alameda CA 94501
Attn: ~~Patriek-McKillop~~ → Pablo Bettran

DEPOSITOR: Office of the City Clerk
City of Oakland
1 Frank Ogawa Plaza, 2nd Floor
Oakland CA 94612
Attn: LaTonda Simmons

Any party may change its address for purposes of this paragraph by giving the other parties written notice of the new address in the manner set forth above.

26. Goveming Law. This Agreement shall be construed in accordance with, and govemed by the laws of the State of Califomia, without regard to conflict of laws, as applied to contracts that are executed and performed emirely in Califomia.

27. Warranty of Authority. DEPOSITOR warrants that it has the right and authority to execute this Agreement and that all necessary corporate actions have been duly taken in the execution and adoption of this Agreement.

28. Independent Contractor

a. Rights and Responsibilifies

It is expressly agreed that in the performance of the services necessary to carry out this Agreement, Contractor shall be, and is, an independent contractor, and is not an employee of the City. Contractor has and shall retain the right to exercise full control and supervision of the services, and full control over the employment, direction, compensation and discharge of all persons assisting Contractor in the performance of Contractor's services hereumder. Contractor shall be solely responsible for all matters relafing to the payment of his/her employees, including compliance with social security, withholding and all other regulafions governing such matters, and shall be solely responsible for Contractor's own acts and those of Contractor's subordinates and employees. Contractor will determine the method, details and means of performing the services described in **Exhibit A.**

b. Contractor's Qualifications

Contractor represents that Contractor has the qualifications and skills necessary to perform the services umder this Agreement in a competent and professional maumer without the advice or direction of The City. This means Contractor is able to fulfill the requirements of this Agreement. Failure to perform all of the services required under this Agreement will constitute a material breach of the Agreement and may be cause for termination of the Agreement. Contractor has complete and sole discretion for the manner in which the work umder this Agreement is performed.

c. Payment of Income Taxes

Contractor is responsible for paying, when due, all income taxes, including esfimated taxes, incurred as a result of the compensation paid by the City to Contractor for services under this Agreement. On request, Contractor will provide the City with proof of timely payment. Contractor agrees to indemnify the City for any claims, costs, losses, fees, penalties, interest or damages suffered by the City resulting from Contractor's failure to comply with this provision.

d. Non-Exclusive Relationship

Contractor may perform services for, and contract with, as many additional clients, persons or companies as Contractor, in his or her sole discretion, sees fit.

e. Tools, Materials and Equipment

Contractor will supply all tools, materials and equipment required to perform the services under this Agreement.

f Cooperation of the City

The City agrees to comply with all reasonable requests of Contractor necessary to the performance of Contractor's duties under this Agreement.

g. Extra Work

Contractor will do no extra work under this Agreement without first receiving prior written authorization from the City.

29. Proprietary or Confidential Information of the City

Contractor understands and agrees that, in the performance of the work or services under this Agreement or in contemplation thereof, Contractor may have access to private or confidential information which may be owned or controlled by the City and that such information may contain proprietary or confidential details, the disclosure of which to third parties may be damaging to the City. Contractor agrees that all information disclosed by the City to Contractor shall be held in confidence and used only in performance of the Agreement. Contractor shall exercise the same standard of care to protect such information as a reasonably prudent contractor would use to protect its own proprietary data.

30. Ownership of Results

Any interest of Contractor or its Subcontractors, in specifications, studies, reports, memoranda, computation documents prepared by Contractor or its Subcontractors in drawings, plans, sheets or other connection with services to be performed under this Agreement shall be assigned and transmitted to the City. However, Contractor may retain and use copies for reference and as documentation of its experience and capabilities.

31. Audit

Contractor shall maintain (a) a full set of accounting records in accordance with generally accepted accounting principles and procedures for all funds received under this Agreement; and (b) full and complete documentation of performance related matters such as benchmarks and deliverables associated with this Agreement.

Contractor shall (a) permit the City to have access to those records for the purpose of making an audit, examination or review of financial and performance data pertaining to this Agreement; and (b) maintain such records for a period of four years following the

last fiscal year during which the City paid an invoice to Contractor under this Agreement.

32. Agents/Brokers

Contractor warrants that Contractor has not employed or retained any subcontractor, agent, company or person other than bona fide, full-time employees of Contractor working solely for Contractor, to solicit or secure this Agreement, and that Contractor has not paid or agreed to pay any subcontractor, agent, company or persons other than bona fide employees any fee, commission, percentage, gifts or any other consideration, contingent upon or resulting from the award of this Agreement. For breach or violation of this warranty, the City shall have the right to rescind this Agreement without liability or, in its discretion, to deduct from the Agreement price or consideration, or otherwise recover, the full amount of such fee, commission, percentage or gift.

33. Conflict of Interest

a. Contractor

The following protections against conflict of interest will be upheld:

i. Contractor certifies that no member of, or delegate to the Congress of the United States shall be permitted to share or take part in this Agreement or in any benefit arising therefrom.

ii. Contractor certifies that no member, officer, or employee of the City or its designees or agents, and no other public official of the City who exercises any functions or responsibilities with respect to the programs or projects covered by this Agreement, shall have any interest, direct or indirect in this Agreement, or in its proceeds during his/her tenure or for one year thereafter.

iii. Contractor shall immediately notify the City of any real or possible conflict of interest between work performed for the City and for other clients served by Contractor.

iv. Contractor warrants and represents, to the best of its present knowledge, that no public official or employee of City who has been involved in the making of this Agreement, or who is a member of a City board or commission which has been involved in the making of this Agreement whether in an advisory or decision-making capacity, has or will receive a direct or indirect financial interest in this Agreement in violation of the rules contained in California Government Code Section 1090 et seq., pertaining to conflicts of interest in public contracting. Contractor shall exercise due diligence to ensure that no such official will receive such an interest.

v. Contractor further warrants and represents, to the best of its present knowledge and excepting any written disclosures as to these matter already made by Contractor to City, that (1) no public official of City who has participated in decision-making concerning this Agreement or has used his or her official position to influence decisions regarding this Agreement, has an economic interest in Contractor or this Agreement, and (2) this Agreement will not have a direct or indirect financial effect on said official, the official's spouse or dependent children, or any of the official's economic interests. For purposes of this paragraph, an official is deemed to have an "economic interest" in any (a) for-profit business entity in which the official has a direct or indirect investment worth $2,000 or more, (b) any real property in which the official has a direct or indirect interest worth $2,000 or more, (c) any for-profit business entity in which the official is a director, officer, partner, trustee, employee or manager, or (d) any source of income or donors of gifts to the official (including nonprofit enthies) if the income or value of the gift totaled more than $320 the previous year. Contractor agrees to promptly disclose to City in wrhing any information it may receive concerning any such potential conflict of interest. Contractor's attention is directed to the conflict of interest rules applicable to governmental decision-making contained in the Political Reform Act (Califomia Government Code Section 87100 et seq.) and its implementing regulations (Califomia Code of Regulations, Title 2, Section 18700 et seq.).

vi. Contractor understands that in some cases Contractor or persons associated with Contractor may be deemed a "city officer" or "public official" for purposes of the conflict of interest provisions of Government Code Section 1090 and/or the Political Reform Act. Contractor further understands that, as a public officer or official, Contractor or persons associated with Contractor may be disqualified from future City contracts to the extent that Contractor is involved in any aspect of the making of that future contract (including preparing plans and specifications or performing design work or feasibility studies for that contract) through its work under this Agreement.

vii. Contractor shall incorporate or cause to be incorporated into all subcontracts for work to be performed under this Agreement a provision goveming conflict of interest in substantially the same form set forth herein.

b. No Waiver

Nothing herein is intended to waive any applicable federal, state or local conflict of interest law or regulation

c. Remedies and Sanctions

In addition to the rights and remedies otherwise available to the City under this Agreement and under federal, state and local law, Contractor understands and agrees that, if the City reasonably determines that Contractor has failed to make a good faith effort to avoid an improper conflict of interest situation or is responsible for the conflict situation, the City may (1) suspend payments under this Agreement, (2) terminate this Agreement, (3) require reimbursement by Contractor to the City of any amounts disbursed under this Agreement. In addition, the City may suspend payments or terminate this Agreement whether or not Contractor is responsible for the conflict of interest situation.

34. Non-Discrimination/Equal Employment Practices

Contractor shall not discriminate or permit discrimination against any person or group of persons in any manner prohibited by federal, state or local laws. During the performance of this Agreement, Contractor agrees as follows:

a. Contractor and Contractor's subcontractors, if any, shall not discriminate against any employee or applicant for employment because of age, marital status, religion, gender, sexual preference, race, creed, color, national origin, Acquired-Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or disability. This nondiscrimination policy shall include, but not be limited to, the following: employment, upgrading, failure to promote, demotion or transfer, recruitment advertising, layoffs, termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.

b. Contractor and Contractor's Subcontractors shall state in all solicitations or advertisements for employees placed by or on behalf of Contractor that all qualified applicants will receive consideration for employment without regard to age, marital status, religion, gender, sexual preference, race, creed, color, national origin, Acquired-Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or disability.

c. Contractor shall make its goods, services, and facilities accessible to people with disabilities and shall verify compliance with the Americans with Disabilities Act by executing Schedule C-1 "Declaration of Compliance with the Americans with Disabilities Act," attached hereto and incorporated herein.

d. If applicable, Contractor will send to each labor union or representative of workers with whom Contractor has a collective bargaining agreement or contract or understanding, a notice advising the labor union or workers' representative of Contractor's commitments under this nondiscrimination clause and shall post copies of the notice in conspicuous places available

to employees and applicants for employment.

35. Local/Small Business Enterprise Program (L/SLBE)

a. For contracts exceeding $15,000, Contractors utilizing subcontractors shall comply with the LBE/SLBE goals or demonstrate compliance with all good faith effort requirements of the City's Professional Services Contract Program. Additionally, opportunities for training and employment shall be given to residents of the City of Oakland.

b. All affirmative action efforts of Contractor are subject to tracking by the City. This information or data shall be used for statistical purposes only. All contractors are required to provide data regarding the make-up of their subcontractors and agents who will perform City contracts, including the race and gender of each employee and/or contractor and his or her job title or function and the methodology used by Contractor to hire and/or contract with the individual or entity in question.

c. In the recruitment of subcontractors, the City of Oakland requires all contractors to undertake nondiscriminatory and equal outreach efforts, which include outreach to minorities and women-owned businesses as well as other segments of Oakland's business community. The City Manager will track the City's MBE/WBE utilization to ensure the absence of unlawful discrimination on the basis of age, marital status, religion, gender, sexual preference, race, creed, color, national origin, Acquired-Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or disability.

d. In the use of such recruitment, hiring and retention of employees or subcontractors, the City of Oakland requires all contractors to undertake nondiscriminatory and equal outreach efforts which include outreach to minorities and women as well as other segments of Oakland's business community.

36. Living Wage Ordinance

This Agreement is subject to the Oakland Living Wage Ordinance. The Living Wage Ordinance requires that nothing less than a prescribed minimum level of compensation (a living wage) be paid to employees of service contractors (consultants) of the City and employees of CFARs (Ord. 12050 § 1, 1998). The Ordinance also requires submission of the Declaration of Compliance attached and incorporated herein as Schedule **N** and made part of this Agreement, and, unless specific exemptions apply or a waiver is granted, the consultant must provide the following to its employees who perform services under or related to this Agreement:

a. Minimum compensation – Said employees shall be paid an initial hourly wage rate of $9.90 with health benefits or $11.39 without health benefits. These initial rates shall be upwardly adjusted each year no later than April 1 in proportion to the increase at the immediately preceding December 31 over the year earlier level of the Bay Region Consumer Price Index as published by the Bureau of Labor Statistics, U.S. Department of Labor.

b. Health benefits – Said full-time and part-time employees paid at the lower living wage rate shall be provided health benefits of at least $1.25 per hour. Contractor shall provide proof that health benefits are in effect for those employees no later than 30 days after execution of die contract or receipt of City financial assistance.

c. Compensated days off – Said employees shall be entitied to twelve compensated days off per year for sick leave, vacation or personal necessity at the employee's request, and ten uncompensated days off per year for sick leave. Employees shall accme one compensated day off per month of full time employment. Part-time employees shall accme compensated days off in increments proportional to that accmed by full-time employees. The employees shall be eligible to use accmed days off after the first six months of employment or consistent with company policy, whichever is sooner. Paid holidays, consistent with established employer policy, may be counted toward provision of the required 12 compensated days off Ten uncompensated days off shall be made available, as needed, for personal or immediate family illness after the employee has exhausted his or her accmed compensated days off for that year.

d. Federal Eamed Income Credit (EIC) – Contractor shall inform said employees who earn less than $12.00 per hour that he or she may be eligible for EIC and shall provide forms to apply for advance EIC payments to eligible employees.

e. Contractor shall provide to all employees and to the Office of Contract Compliance, written notice of its obligation to eligible employees imder the City's Living Wage requirements. Said notice shall be posted prominently in communal areas of the work site(s) and shall inciude the above-referenced information.

f Contractor shall provide all written notices and forms required above in English, Spanish or other languages spoken by a significant number of employees within 30 days of employment under tiiis Agreement.

g. Reporting – Contractor shall maintain a listing of the name, address, hire date, occupation classification, rate of pay and benefits for each of its employees. Contractor shall provide a copy of said list to the Office of

Contract Compliance, on a quarterly basis, by March 31, June 30, September 30 and December 31 for the applicable compliance period. Failure to provide said list within five days of the due date will result in liquidated damages of five hundred dollars ($500.00) for each day that the list remains outstanding. Contractor shall maintain employee payroll and related records for a period of four (4) years after expiration of the compliance period.

h. Contractor shall require subcontractors that provide services under or related to this Agreement to comply with the above Living Wage provisions. Contractor shall include the above-referenced sections in its subcontracts. Copies of said subcontracts shall be submitted to the Office of the City Administrator, Contract Compliance & Employment Services Division.

37. Equal Benefits Ordinance

This Agreement is subject to the Equal Benefits Ordinance of Chapter 2.232.010 of the Oakland Municipal Code and its implementing regulations. The purpose of this Ordinance is to protect and further the public, health, safety, convenience, comfort, property and general welfare by requiring that public funds be expended in a manner so as to prohibit discrimination in the provision of employee benefits by City contractors (consultants) between employees with spouses and employees with domestic partners, and/or between domestic partners and spouses of such employees. (Ord. 12394 (part), 2001)

Entities which enter into a "contract" with the City for an amount of twenty-five thousand dollars ($25,000.00) or more for public works or improvements to be performed, or for goods or services to be purchased or grants to be provided at the expense of the City or to be paid out of moneys deposited in the treasury or out of tmst moneys under the control of or collected by the city; and Entities which enter into a "property contract" pursuant to Section 2.32.020(D) with the City in an amount of twenty-five thousand dollars ($25,000.00) or more for the exclusive use of or occupancy (1) of real property owned or controlled by the city or (2) of real property owned by others for the city's use or occupancy, for a term exceeding twenty-nine (29) days in any calendar year.

The Ordinance shall only apply to those portions of a contractor's operations that occur (1) within the city; (2) on real property outside the city if the property is owned by the city or if the city has a right to occupy the property, and if the contract's presence at that location is comected to a contract with the city; and (3) elsewhere in the United States where work related to a city contract is being performed. The requirements of this chapter shall not apply to subcontracts or subcontractors of any contract or contractor

The Equal Benefits Ordinance requires among other things, submission of the attached and incorporated herein as Schedule **N-1** – Equal Benefits-Declaration of Nondiscrimination.

38. Insurance

Unless a written waiver is obtained from the City's Risk Manager, Contractor must provide the insurance listed in Schedule **Q**. Schedule **Q** is attached hereto and incorporated herein by reference.

39. Indemnification

Contractor shall protect, defend (with counsel acceptable to City), indemnify and hold harmless City, its councilmembers, officers, employees and agents from any and all actions, causes of actions, claims, losses, expenses (including reasonable attorneys' fees and costs) or liability (collectively called "Actions") on account of damage of property or injury to or death of persons arising out of or resuhing in any way from work performed in connection with this Agreement by Contractor, its officers, employees, subconsultants or agents.

Contractor acknowledges and agrees that it has an immediate and independent obligation to defend City, its councilmembers, officers, employees and agents from any claim or Action which potentially falls within this indemnification provision, which obligation shall arise at the time such claim is tendered to Contractor by City and continues at all times thereafter.

All of Contractor's obligations under this section are intended to apply to the fullest extent permitted by law and shall survive the expiration or sooner termination of this Agreement.

40. Political Prohibition

Subject to applicable State and Federal laws, moneys paid pursuant to this Agreement shall not be used for political purposes, sponsoring or conducting candidate's meetings, engaging in voter registration activity, nor for publicity or propaganda purposes designed to support or defeat legislation pending before federal, state or local government.

41. Religious Prohibition

There shall be no religious worship, instmction, or proselytization as part of, or in connection with the performance of the Agreement.

42. Business Tax Certificate

Contractor shall obtain and provide proof of a valid City business tax certificate.

43. Termination on Notice

The City may terminate this Agreement immediately for cause or without cause upon giving (30) calendar days' written notice to Contractor. Unless otherwise terminated as provided in this Agreement, this Agreement will terminate on October 15, 2005.

44. Validity of Contracts

The Oakland City Council must approve all agreements greater than $15,000. This Agreement shall not be binding or of any force or effect until signed by the City Manager or his or her designee and approved as to form and legality by the City Attorney or his or her designee.

45. Modification

Any modification of this Agreement will be effective only if it is in a writing signed by all parties to this Agreement.

46. Severability/Partial Invalidity

If any term or provision of this Agreement, or the application of any term or provision of this Agreement to a particular situation, shall be finally found to be void, invalid, illegal or unenforceable by a court of competent jurisdiction, then notwithstanding such determinafion, such term or provision shall remain in force and effect to the extent allowed by such ruling and all other terms and provisions of this Agreement or the application of this Agreement to other situation shall remain in full force and effect.

Notwithstanding the foregoing, if any material term or provision of this Agreement or the application of such material term or condition to a particular situation is finally found to be void, invalid, illegal or unenforceable by a court of competent jurisdiction, then the Parties hereto agree to work in good faith and fully cooperate with each other to amend this Agreement to carry out its intent.

47. Time of the Essence

Time is of the essence in the performance of this Agreement.

48. Approval

If the terms of this Agreement are acceptable to Contractor and the City, sign and date below.

49. Inconsistency

If there is any inconsistency between the main agreement and the attachments/exhibits, the text of the main agreement shall prevail.

City of Oakland,
a municipal corporation

(City Administrator's Office) (Date)

(Department Head Signature) (Date)

Approved as to form and legality:

(City Attorney's Office Signature) (Date)

Contractor

(Signature) 9-21-06 (Date)

1906186
Business Tax Certificate No.

77481
Resolution Number

	Description of Services	Estmiated Quantity	Unit	Umt Price
MONTHLY STORAGE CHARGES				
A	Standard 10x12x15	20,000	Box	.15
B	Letter Transfer Cases	100	Box	.15/cf
C	Legal Transfer Cases	400	Box	.15/cf
D	Check Boxes	100	Box	.15
E	Copier Paper Boxes	100	Box	.15/cf
F	10x12x15 Moving Boxes	200	Box	.15
G	Misc. Odd Size Boxes	500	Box	.15/cf
STANDARD SERVICES				
H	Box Retrieval	20/month	Box	2.10
I	File Retrieval	20/month	File	2.10
J	Document Retrieval	1/month	Box	2.10
K	Box Refile	20/month	Box	1.75
L	File Refile	20/month	File	2.10
M	Interfile	1/month	Box	2.10
N	Receiving New Boxes	50/month	Box	1.00
O	Receiving Refile Boxes	20/month	Box	0.00
P	Data Entry New Boxes	50/month	Box	0.00
Q	Data Entry Refile Boxes	20/month	Box	0.00
R	Date Entry New Files	1000/month	File	0.00
S	Labeling New Boxes	50/month	Box	0.00
T	Labeling Files	1000/month	File	0.00
U	Destruction	20/month	Box	3.10
TRANSPORTATION				
V	24 Hour Delivery	15/month	Box	9.50
W	4 Hour Delivery	2/month	Box	25.00
X	2 Hour Delivery	3/month	Box	45.00
Y	Pick-up New Boxes	50/month	Box	1.75
Z	Pick-up Refile Boxes	20/month	Box	1.75
AA	Pick-up Refile Files	20/month	Files	1.75
REPORTS				
AB	Quarterly Inventory (Dept/Box#)	1/month	Report	0.00
AC	Inventory by Description Field	1/year	Report	0.00
AD	Destruction	1/month	Report	0.00
AE	New Boxes Received	1/month	Report	0.00
AF	Monthly Activity	1/month	Report	0.00
AG	Boxes Out Report	1/month	Report	0.00
AH	Permanent Removal Fee		Box	No additional charge
AI	Contract Termination Fee		Box	No additional Charge

Any service regarding the movement of boxes is charged at a Standard Box rate. A Standard Box is any box up to and including 10x12x15 boxes (or up to 1.0 cubic feet of storage area). Any box larger than this will be charged according to a multiple of the Standard Box size. For example a 10x12x24 box is charged at two times the Standard Box rate. Regarding the storage of City of Oakland Maps – same storage cost applies as in current contract; $0.23 per cubic foot. Service rates are subject to cost of living CPI increase not to exceed 5% annually.

Equal Benefits - Declaration of Nondiscrimination

Equal Access

Section A. Vendor/Contractor/Consultant/*CFAR Information

1 Name of Company GRM INFORMATION MANAGEMENT SYSTEMS

2 Name of Company Contact PABLO BELTRAN

3 Phone Number 800·932·3006 Fax Number 510·623·9517

4 Vendor Number (If Known) 09100487 Federal ID or Social Security #

5 Approximate Number of Employees in the U.S. 320

6 Are any of your employees covered by a collective bargaining agreement or union trust fund ? Yes ☐ No ☒

7 Union Name(s) N/A

Section B Compliance Questions

1 Does your company provide or offer access to any benefits to employees with spouses or to spouses of employees.

Yes ☒ or No ☐ (please check one)

2 Does your company provide or offer access to any benefits to employees with **domestic partners ?

Yes ☒ or No ☐ (please check one)

Section C Compliance Questions

3 Please check each benefit that applies to answers 1 & 2 above and list as "other" any additional benefits not listed below. Some benefits (i.e. bereavement leave) are provided to employees because they have a spouse or domestic partner. Other benefits (i.e. medical insurance) are provided directly to the spouse or domestic partner.

	Benefit	Yes, this benefit is offered to Employees only	Yes, this benefit is offered to Employees and their Spouses	Yes, this benefit is offered to Employees and their Domestic Partners	No this benefit is not offered at all	Yes, documents were submitted for this benefit
a	Health	☐	☐	☒	☐	☐
b	Dental	☐	☐	☒	☐	☐
c	Vision	☐	☐	☒	☐	☐
d	Retirement (Pension, 401(k), etc)	☐	☐	☒	☐	☐
e	Bereavement	☐	☐	☒	☐	☐
f	Family Leave	☐	☐	☒	☐	☐
g	Parental Leave	☐	☐	☒	☐	☐
h	Employee Assistance Program	☐	☐	☒	☐	☐
I	Relocation & Travel	☐	☐	☐	☒	☐
j	Company Discount, Facilities & Events	☐	☐	☐	☒	☐
k	Credit Union	☐	☐	☐	☒	☐
l	Child Care	☐	☐	☐	☒	☐
m.	Other	☐	☐	☐	☒	☐

* CFAR is a City Financial Assistance Recipient

** The term "Domestic Partner" is defined as same-or opposite-sex couples registered with a state or local government domestic partnership registry.

DECLARATION OF COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT

The Americans with Disabilities Act (ADA) requires that private organizations serving the public make their goods, services and facilities accessible to people with disabilities. Furthermore, the City of Oakland requires that all of its Contractors comply with their ADA obligations and verify such compliance by signing this Declaration of Compliance.

The Contractor certifies that it will comply with the Americans with Disabilities Act by:

A. Adopting policies, practices and procedures that ensure non-discrimination and equal access to Contractor's goods, services and facilities for people with disabilities;

B. Providing goods, services and facilities to individuals with disabilities in an integrated setting, except when separate programs are required to ensure equal access;

C. Making reasonable modifications in programs, activities and services when necessary to ensure equal access to individuals with disabilities, unless fundamental alteration in the nature of the Contractor's program would result;

D. Removing architectural barriers in existing facilities or providing altemative means of dehvering goods and services when removal of barriers is cost-prohibitive;

E. Furnishing auxiliary aids to ensure equally effective communication with persons with disabilities; and

F. If contractor provides transportation to the public, by providing equivalent accessible transportation to people with disabilities.

The undersigned authorized representative hereby obligates the applicant to the above stated conditions under penalty of perjury.

GRM	[signature]
Company Name	Signature of Authorized Representative
41099 BOYCE ROAD	PABLO BELTRAN
Address	Type or Print Name
800-932-3006	GENERAL MANAGER
Phone	Type or Print Title
3-17-06	
Date	

FOR CITY USE ONLY
Based upon a review of this questionnaire and any other factors I have cited below, I have determined that this person (is) (is not) an independent contractor.

_____

_____

_____

Date_____ _____

City Attorney/Assistant City Attorney/
Deputy City Attorney

PART A: INDEPENDENT CONTRACTOR QUESTIONNAIRE TO BE COMPLETED BY PROPOSED CONTRACTOR

Name of Contractor GRM Information Management Services
SSN or Corporate Taxpayer ID No. of Contractor 02-0635887

Please answer questions "yes" or "no" whenever possible. When a more extensive explanation is required and there is no space on this form, please attach a separate sheet.

The word contract refers to the agreement the City is contemplating entering into with you.

NOTE: IF YOU ARE A CORPORATION, YOU NEED NOT COMPLETE THE REMAINDER OF THIS QUESTIONNNAIRE IF YOU RETURN IT SHOWING, ABOVE, YOUR CORPORATE FEDERAL TAXPAYER NUMBER AND ATTACHING A COPY OF YOUR CERTIFICATE OF CORPORATE GOOD STANDING ISSUED BY THE STATE OF CALIFORNIA.

	Yes	No
1. Have you performed services for the City in any year(s) prior to 199__? If yes, please indicate which years.		
2. Have you received any training, guidance, or direction from the City as to how the City expects the job (for which your services are contemplated) to be done. If yes, please describe what you are expecting (or have received) in the way of training or direction. _____		
3. Will your services under the contract be performed on City property? If no, please describe where the services are to be performed. _____ _____		
4. Do you expect to devote any full days (6 or more hours) or full weeks (30 or more hours) towards performing the services under the contract? If yes, please indicate approximately how many full days and/or full weeks you expect to devote during the life of the contract _____		
5. Are there any set or fixed hours or days of the week during which the City is expecting you to perform services under the contract? If yes, please indicate the days and hours during which you will be performing services. _____		

	Yes	No
6. Please provide the date on which you expect to complete your services under the contract.		
7. In order to perform services under the contract, do you Intend to provide your own supplies or equipment? If yes, briefly describe the equipment/supplies. _____		
8. If your response to No. 7 is yes, has the City promised to or will you be expecting the City to reimburse you in any way for the cost of the supplies or equipment?		
9. Other than the above-referenced supplies and equipment, do you anticipate incurring any unreimbursable out-of-pocket expenses in the performance of the contract with the City? If yes. please describe. _____		
10. Do you have federal and state employer identification numbers? If so, please provide these numbers. _____		
11. Within the past two years have you performed the same type services (as called for in the contract) for any client or customer other than the City? If yes, please identify the client or customer and briefly describe the services performed. _____		
12. Do you currently have clients or customers other than the City for whom you are or will perform services during the duration of the contract? If yes, please identify client or customer by name and briefly describe the nature of services performed. _____		
13. In the past two years have you notified any insurance company in conjunction with obtaining a business-related insurance policy that you are self-employed? If yes, please indicate the insurance company and the nature of the business-related policy. _____ _____		
14. Do you have your own employees to help you perform the services called for by your contract? (Do not refer to independent contractors you may use to assist you.) _____		
15. Within the past two years have you been the employee of any employer (received a W-2)? If yes, state the employer(s), the date(s) of employment, and the nature of the services performed. _____ _____		
16. Do you have an office or business address other than your own home address, a City of Oakland office or your employer's business address? If yes, please state the address. _____ _____		

	Yes	No
17. With regard to the following, please indicate whether you have:		
a. an existing business letterhead? (please attach)		
b. an existing business phone number other than your home number? (please indicate #)		
c. filed for a fictitious business name? If yes, please attach a certified copy of the County issued certificate and an affidavit of publication.		
d. done public advertising for your business? If yes, please attach the ad copy or briefly describe your advertising efforts.		
18. If you have answered parts or all of No. 17 with "Yes," are the services represented in your answers the same type of services you will be performing for the City?		
19. Do you have a license from any governmental agency to perform the services under the contract? If yes, please state the type of license and name of the licensing agency. _____		
20. Please describe the extent of any personal financial investment you have made in order to be self-employed. You may either choose to indicate the actual dollar amount of investment or, without disclosing any dollar amount, briefly describe any purchases, leases or other types of financial commitments made by you for self employment purposes. _____ _____ _____ _____		

I VERIFY THAT THE RESPONSES ABOVE ARE TRUE AND CORRECT.

3/28/06
Date

Contractor Account Manager

PLEASE INDICATE WHETHER YOU OBJECT IF THE CITY DECIDES TO TREAT YOU AS A SHORT-TIME CONTRACT EMPLOYEE RATHER THAN AN INDEPENDENT CONTRACTOR AND THE REASON FOR YOUR OBJECTION. _____

Schedule N

Office of The City Manager - Contract Compliance and Employment Services

DECLARATION OF COMPLIANCE - LIVING WAGE ORDINANCE

The Oakland Living Wage Ordinance (the "Ordinance"). Codified as Oakland Municipal Code provides that certain employers under contracts for the fiimishing of services to or for the City that involve an expenditure equal to or greater than S25,000 and certain recipients of City financial assistance that involve receipt of fmancial assistance equal to or greater than $100,000 shall pay a prescribed minimum level of compensation to their employees for the time their employees work on City of Oakland contracts. The Redevelopment Agency of the City of Oakland adopted the City's Living Wage policy as its own policy Agency Resolution No. 98-13 C.M.S.

The contractor or city financial assistance recipient (CFAR) further agrees:

(a) To pay employees a wage no less than the minimum initial compensation of $9.90 per hour with health benefits, as described in Section 3-C "Health Benefits" of the Ordinance, or otherwise SI 1.39 per hour, and to provide for the annual increase pursuant to Section 3-A 'Wages" of the Ordinance. Effective July 1st of each year, contractor shall pay adjusted wage rates.

(b) To provide at least twelve compensated days off per year for sick leave, vacation or personal necessity at the employees request, and at least ten additional days per year of uncompensated time off pursuant to Section 3- B "Compensated Days Off" of the Ordinance.

(c) To inform employees that he or she may be eligible for EIC and shall provide forms to apply for advance EIC payments to eligible employees. There are several websites and other sources available to assist you. Web sites include but are not limited to: (1) http://www.irs.govfor current guidelines as prescribed by the Internal Revenue Service and (2) the 2005 Eamed Income Tax Outreach Kit www.cbpp.or/eic/2005.

(d) To permit access to work sites for authorized City representatives to review the operation, payroll and related documents, and to provide certified copies of the relevant records upon request by the City; and

(e) Not to retaliate against any employee claiming non-compliance with the provisions of this Ordinance and to comply with federal law prohibiting retaliation for union organizing.

The undersigned authorized representative hereby obligates the proposer to the above stated conditions under penalty of perjury.

GRM	Pablo Beltran
Company Name	Signature of Authorized Representative
41099 Boyce Road	PABLO BELTRAN
Address	Type or Print Name
510 / 438 · 8923 / 3·17·06	GENERAL MANAGER
Area Code / Phone / Date	Type or Print Title

CITY OF OAKLAND

NUCLEAR FREE ZONE DISCLOSURE FORM – S

I, PABLO BELTRAN, the undersigned, a
(Name)

GENERAL MANAGER of GRM
(Title) (Business Entity)
(hereinafter referred to as Business Entity am duly authorized to attest on behalf of the business Entity)

I. Neither this Business Entity nor any of its subsidiaries, affiliates or agents engages in nuclear weapons work or anticipates entering into such work for the duration of its contract(s) with the City of Oakland.

II. The appropriate individuals of authority are cognizant of their responsibility to notify the Office of Finance of the City of Oakland if the Business Entity or any of its subsidiaries, affiliates or agents subsequently engages in nuclear weapons work.

I declare that the foregoing is true and correct to the best of my knowledge.

3·17·06
(Date)

Pablo Beltran PABLO BELTRAN
(Signature and Name)

GRM
(Name of Business Entity)

41099 BOYCE ROAD
(Street Address)

FREMONT, CA 94538
(City, State and Zip Code)

M. MANAGEMENT
(Name of Parent Company)

Original form should be retained in the project file and a copy to be included with the contract documents submitted to the City Clerks office.

Schedule **Q**

INSURANCE REQUIREMENTS

a. General Liability, Automobile, Worker's Compensation and Professional Liability

Contractor shall procure, prior to commencement of service, and keep in force for the term of this contract, at Contractor's own cost and expense, the following policies of insurance or certificates or binders as necessary to represent that coverage as specified below is in place with companies doing business in California and acceptable to the City. If requested, Contractor shall provide the City with copies of all insurance policies. The insurance shall at a minimum include:

i. Commercial General Liability insurance, shall cover liability arising from premises, operations, independent contractors, products-completed operations, personal and advertising injury, Bodily Injury, Broad Form Property Damage, and liability assumed under an insured contract [(including the tort liability of another assumed in a business contract)]. If such CGL insurance contains a general aggregate limit, it shall apply separately to this agreement.

A. Coverage afforded on behalf of the City shall be primary insurance and any other insurance available to the City under any other policies shall be excess insurance (over the insurance required by this Agreement).

B. Limits of liability: Contractor shall maintain commercial general liability (CGL) and, if necessary, commercial umbrella insurance with a limit of not less than $2,000,000 each occurrence. If such CGL insurance contains a general aggregate limit, it shall apply separately to this location [project].

C. If the policy is a "claim made" type policy, the following should be included as endorsements:

1) The retroactive date shall be the effective date of this Agreement or a prior date.
2) The extended reporting or discovery period shall not be less than thirty-six (36) months.

ii. Automobile Liability Insurance. Contractor shall maintain automobile liability insurance with a limit of not less than $1,000,000 each accident. Such insurance shall cover liability arising out of any auto (including owned, hired, and non-owned autos). Coverage shall be written on ISO form CA 00 01, CA 00 05, CA 00 12, CA 00 20, or a substitute form providing equivalent liability coverage. If necessary, the policy shall be

endorsed to provide contractual liability coverage equivalent to that provided in the 1990 and later editions of CA 00 01. In the event the Contractor does not own vehicles, but utilized non-owned and hired vehicles, evidence of such coverage is acceptable with a signed statement from Contractor stating that only non-owned and hired vehicles are used in the course of the contract.

iii. Worker's Compensation insurance as required by the laws of the State of California. Statutory coverage may include Employers Liability coverage with limits not less than $1,000,000. The Contractor certifies that he/she is aware of the provisions of section 3700 of the California Labor Code, which requires every employer to provide Workers' Compensation coverage, or to undertake self-insurance in accordance with the provisions of that Code. The Contractor shall comply with the provisions of section 3700 of the California Labor Code before commencing performance of the work under this Agreement and thereafter as required by that code.

iv. Professional Liability/errors and omissions insurance in the amount of _____.

b. Terms Conditions and Endorsements

The aforementioned insurance shall be endorsed and have all the following conditions:

i. Insured Status (Additional Insured): Contractor shall provide insured status using ISO endorsement CG 20 10 or its equivalent naming the City of Oakland, its Councilmembers, directors, officers, agents and employees as insureds in its Comprehensive Commercial General Liability policy. If Contractor submits the ACORD Insurance Certificate, the insured status endorsement must be set forth on a CG 20 10 (or equivalent). A STATEMENT OF ADDITIONAL INSURED STATUS ON THE ACORD INSURANCE CERTIFICATE FORM IS INSUFFICIENT AND WILL BE REJECTED AS PROOF OF MEETING THIS REQUIREMENT; and

ii. Cancellation Notice: 30-day prior written notice of termination or material change in coverage and 10-day prior written notice of cancellation for non-payment;

iii. Cross-liability coverage as provided under standard ISO forms' separation of insureds clause; and

iv. Certificate holder is to be the same person and address as indicated in the "Notices" section of this Agreement; and

v. Insurer shall carry a insurance from an admitted company with a Best Rating of A VII or better.

c. Replacement of Coverage

In the case of the breach of any of the insurance provisions of this Agreement, the City may, at the City's option, take out and maintain at the expense of Contractor, such insurance in the name of Contractor as is required pursuant to this Agreement, and may deduct the cost of taking out and maintaining such insurance from any sums which may be found or become due to Contractor under this Agreement.

d. Insurance Interpretation

All endorsements, certificates, forms, coverage and limits of liability referred to herein shall have the meaning given such terms by the Insurance Services Office as of the date of this Agreement.

e. Proof of Insurance

Contractor will be required to provide proof of all insurance required for the work prior to execution of the contract, including copies of Contractor's insurance policies if and when requested. Failure to provide the insurance proof requested or failure to do so in a timely manner shall constitute ground for rescission of the contract award.

f Subcontractors

Should the Contractor subcontract out the work required under this agreement, they shall include all subcontractors as insureds under its policies or shall maintain separate certificates and endorsements for each subcontractor. As an alternative, the Contractor may require all subcontractors to provide at their own expense evidence of all the required coverages listed in this Schedule. If this option is exercised, both the City of Oakland and the Contractor shall be named as addhional insured under the subcontractor's General Liability policy. All coverages for subcontractors shall be subject to all the requirements stated herein. The City reserves the right to perform an insurance audit during the course of the project to verily compliance with requirements.

g. Deductibles and Self-Insured Retentions

Any deductible or self-insured retentions must be declared to and approved by the City. At the option of the City, either: the insurer shall reduce or eliminate such deductible or self-insured retentions as respects the City, its Councilmembers, directors, officers, agents, employees and volunteers; or the Contractor shall provide a financial guarantee satisfactory to the City guaranteeing payment of losses and related investigations, claim administration and defense expenses.

h. Waiver of Subrogation

Contractor waives all rights against the City of Oakland and its Councilmembers, officers, directors and employees for recovery of damages to the extent these damages are covered by the forms of insurance coverage required above.

i. Evaluation of Adequacy of Coverage

The City of Oakland maintains the right to modify, delete, alter or change these requirements, with reasonable notice, upon not less than ninety (90) days prior written notice.

ACORD CERTIFICATE OF LIABILITY INSURANCE

REVISED | DATE (MM/DD/YY) 03/22/2006

PRODUCER — Serial # 101604

WILLIAM J. REDMOND AND ASSOCIATES
7 SOUTH MAIN STREET, SUITE B
MARLBORO, NJ 07746
732-A25-2100

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED

GRM INFORMATION MANAGEMENT SERVICES OF CALIFORNIA, LLC
41099 BOYCE ROAD
FREEMONT, CA 94538

INSURERS AFFORDING COVERAGE	NAIC#
INSURER A: ADMIRAL INSURANCE COMPANY	
INSURER B: COMMERCE AND INDUSTRY / AIG	
INSURER C: ILUNOIS NATIONAL INSAJRANCE/AIG	
INSURER D: UNITED STATES FIRE INSURANCE CO	
INSURER E:	

COVERAGES

THE POLICIES OF INSUAANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH TMIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADDL INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A		GENERAL LIABILITY [X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS MADE [X] OCCUR CEN'L AGGREGATE LIMIT APPLIES PER [ ] POLICY [ ] PRO-JECT [ ] LOC	CA0000005749-02	9/30/05	9/30/06	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 50,000 $ 0 $ 1,000,000 $ 2,000,000 $ 1,000,000
0		AUTOMOBILE LIABILITY [X] ANY AUTO [ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS [X] HIRED AUTOS [X] NON OWNED AUTOS [X] COMP/COLL SCHED VEHS [X] DEDUCTIBLE $1,000	1337207643	9/30/05	9/30/06	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
		GARAGE LIABILITY [ ] ANY AUTO				AUTO ONLY - EA ACCIDENT OTHER THAN AUTO ONLY: EA ACC AGG	$ $ $
C		EXCESS/UMBRELLA LIABILITY [X] OCCUR [ ] CLAIMS MADE [ ] DEDUCTIBLE [X] RETENTION $	BE4766904	9/30/05	9/30/06	EACH OCCURRENCE AGGREGATE 	$ 10,000,000 $ 10,000,000 $ $ $
B		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	WCS-131-497769-036	2/15/06	2/15/07	[X] WC STATUTORY LIMITS [ ] OTHER EL EACH ACCIDENT EL DISEASE - EA EMPLOYEE EL DISEASE - POLICY LIMIT	 $ 1,000,000 $ 1,000,000 $ 1,000,000
		OTHER					

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS

CITY OF OAKLAND, ITS COUNCIL MEMBERS, DIRECTORS, OFFICERS, AGENTS AND EMPLOYEES AS INSURED IN ITS COMPREHENSIVE COMMERCIAL GENERAL LIABILITY POLICY AS REQUIRED BY CONTRACT ATIMA WITH RESPECT TO GENERAL LIABILITY AND THE INSURED'S OPERATION.

CERTIFICATE HOLDER

CITY OF OAKLAND
OFFICE OF THE CITY CLERK
1 FRANK OGAWA PLAZA
OAKLAND, CA 94612

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRISED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WHITTEM NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE WILLIAM J. REDMOND AND ASSOCIATES, INC.

WILLIAM J. REDMOND

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL INSURED – OWNERS, LESSEES OR CONTRACTORS – SCHEDULED PERSON OR ORGANIZATION

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

SCHEDULE

Name Of Additional Insured Person(s) Or Organization(s):	Location(s) Of Covered Operations
Any person or organization that is an owner of real property or personal property on which you are performing ongoing operations, or a contractor on whose behalf you are performing ongoing operations, but only if coverage as an additional insured is required by a written contract or written agreement that is an "insured contract", and provided that the "bodily injury", "property damage" or "personal & advertising injury" first occurs subsequent to the execution of the contract or agreement.	All locations at which the Named Insured is performing ongoing operations except locations covered under a Consolidated (Wrap Up) Insurance Program.

Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

A. Section II – Who Is An Insured is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by:

1. Your acts or omissions; or
2. The acts or omissions of those acting on your behalf;

in the performance of your ongoing operations for the additional insured(s) at the location(s) designated above.

B. With respect to the insurance afforded to these additional insureds, the following additional exclusions apply:

This insurance does not apply to "bodily injury" or "property damage" occurring after:

1. All work, including materials, parts or equipment furnished in connection with such work, on the project (other than service, maintenance or repairs) to be performed by or on behalf of the additional insured(s) at the location of the covered operations has been completed; or
2. That portion of "your work" out of which the injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as a part of the same project

State of California
Secretary of State

CERTIFICATE OF GOOD STANDING
FOREIGN LIMITED LIABILITY COMPANY

I, **BRUCE McPHERSON**, Secretary of State of the State of California, hereby certify:

That on the **26**th day of **December, 2002, GRM INFORMATION MANAGEMENT SERVICES OF SAN FRANCISCO, LLC,** complied with the requirements of California law in effect on that date for the purpose of registering to transact intrastate business in the State of California; and further purports to be a limited liability company organized and existing under the laws of **Delaware** as **GRM INFORMATION MANAGEMENT SERVICES OF SAN FRANCISCO, LLC,** and;

That the above limited liability company is entitled to transact intrastate business in the State of California as of the date of this certificate subject, however, to any licensing requirements otherwise imposed by the laws of this state; and

That no information is available in this office on the financial condition, business activity or practices of this limited liability company.

IN WITNESS WHEREOF, I execute this certificate and affix the **Great Seal** of the State of California this day of **May 31, 2006.**

BRUCE McPHERSON
Secretary of State

kb

GRM-California
SIMMBA/GRM Information Management Services

Where To Find The Answers To Your Questions

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SUMMARY OF BENEFITS

This Summary of Benefits describes the benefits available to employees electing the PPO CA plan.

The Summary of Benefits provides a general description of your benefits. It does not list all benefits included under the Plan. The Plan contains limitations and restrictions which are described in the Booklet and could reduce the benefits payable under the Plan. See the detailed description to determine what expenses are covered and what benefits will be payable.

Alta PPO MEDICAL BENEFITS

Copay Amount for Network Services

Outpatient Mental Health Conditions and Chemical Dependency Treatment	$25.00
Other Office Visits	$10.00

Emergency Room Visit Copay

If admitted to a Hospital as an inpatient	None
If not admitted to a Hospital as an inpatient	$50.00

Deductible

The calendar year deductible applies to all covered expenses except:

- expenses subject to a copay
- facility expenses that are subject to the per confinement deductible

Individual Calendar Year Deductible

Network	None
Non-network and outside the PPO Network Area	$2,000.00

Family Deductible

Network	None
Non-network and outside the PPO Network Area	$6,000.00

Per Confinement Deductible

The Per Confinement Deductible applies to facility charges for each inpatient confinement in a Hospital, Hospice facility or Mental Heahh and Chemical Dependency Treatment facility and to outpatient surgery in a Hospital or an Ambulatory Surgical Center.

Network Facility	$100.00
Non-network Facility	$500.00

Medical Management Program

Non-compliance Penalty	50% reduction per claim

Percentage Payable after any applicable Deductible, Copay or Contracted Rate Reduction

Outpatient Surgery, including surgery performed in a Doctor's Office	
- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	50%
Hospital	
- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	50%
Physician charges for Hospital care and Surgery	

- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	50%
X-rays and lab tests, including emergency services	
- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	50%
Office Visits	
- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	50%
Outpatient Mental Health Conditions and Chemical Dependency Treatment	
- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	50%
Emergency Room Care	
- Network	100%
- Non-Network	100%
Ambulance Expenses	
- Network	100%
- Non-network	100%
Other Covered Expenses	
- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	50%
Individual Breakpoint	$25,000.00
Family Breakpoint	$75,000.00
Calendar Year Benefit Maximum	
Home Health Care	1 visit per day up to 100 visits
Skilled Nursing Facility	100 days
Inpatient Treatment of Mental Health Conditions and Chemical Dependency	30 days
Outpatient Treatment of Mental Health Conditions and Chemical Dependency	20 visits
Outpatient Occupational, Speech and Hearing Therapy	$2,000.00
Outpatient Physical Therapy	$2,000.00
TMJ Treatment	$1,000.00
Spinal Adjustment Treatment	$500.00

Lifetime Benefit Maximum

Inpatient Treatment of Mental Health Conditions and Chemical Dependency	60 days
Durable Medical Equipmem	$10,000.00
Infertility Treatment	$10,000.00

Maximum Benefit for all Covered Expenses

Lifetime benefit per Member	$1,000,000.00

PRESCRIPTION DRUG BENEFITS

Network Pharmacy

Tier 1 - Generic Drug copay	100% after $5.00 copay
Tier 2 - Lowest Brand Name Drug copay	100% after $10.00 copay
Tier 3 - Highest Brand Name Drug copay	100% after $20.00 copay

Non-network Pharmacy

Member must pay 100% of drug cost at time of purchase and submit a claim for reimbursement. Reimbursement will be 50% of the network pharmacy cost after the copay.

Mail Order Drug Program

Tier 1 - Generic Drug copay	100% after $10.00 copay
Tier 2 - Lowest Brand Name Drug copay	100% after $20.00 copay
Tier 3 - Highest Brand Name Drug copay	100% after $40.00 copay

DENTAL BENEFITS

Deductible

The Calendar Year deductible applies to all covered expenses except for Preventive Care.

Individual	$50.00
Family	$150.00

Percentage Payable after any Deductible

Preventive Care	100%
Basic Care	80%
Major Care	50%

Calendar Year Benefit Maximums

Preventive, Basic and Major Care	$1,500.00
Adjusted Annual Maximum (This maximum is applied to the first calendar year of coverage for Members who become covered on or after July 1 of any year.)	$750.00

VISION BENEFITS

Calendar Year Deductible	None

Percentage Payable

Eye examinations	100%
Eyeglass lenses and frames or contact lenses	100%

Benefit Maximum (per 24-month period)	
Eye examinations	$45.00
Eyeglass lenses and frames or contact lenses	$120.00

LIFE INSURANCE BENEFITS

The amount will be based on the following schedule:

Employees	$50,000.00
Employees	$50,000.00

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

The amount of AD&D Benefit that an Employee may receive is based on a Principal Sum. The amount of the Principal Sum is equal to the amount of Standard Life Insurance.

AD&D Benefit for the Loss of	Amount Payable
Life	Principal Sum
Both hands or both feet or sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand or one foot and sight of one eye	Principal Sum
One hand or one foot	1/2 of Principal Sum
Sight of one eye	1/2 of Principal Sum

Loss of hands and feet means permanent dismemberment by severance through or above the wrist or ankle joints. Loss of sight means total and permanent loss of sight beyond remedy by surgical or other means.

REDUCTIONS IN LIFE INSURANCE AND AD&D BENEFIT

The amount of an Employee's Life Insurance and AD&D Benefit in effect at the time the Employee reaches age 65 will reduce by 35% at age 65, 55% at age 70, 70% at age 75, 80% at age 80 and 85% at age 85.

NOTICES

■ Women's Health and Cancer Rights Act

This Notice is required by the Women's Health and Cancer Rights Act of 1998 (WHCRA) to inform you, as a member of the Plan, of your rights relating to coverage provided through the Plan in connection with a mastectomy. As a Plan Member, you have rights to coverage provided in a manner determined in consultation with your attending Physician for:

- 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; and
- prostheses and treatment of physical complications to produce a symmetrical appearance, including lymphedema.

This coverage may be subject to deductible and copayment provisions, if your Plan includes such provisions. Additional details regarding this coverage are provided in the Plan. Keep this notice for your records and call your Plan Administrator for more information.

INTRODUCTION

■ About This Plan

This summary plan description describes the benefits available to employees electing the PPO CA plan. Benefits for other Employees are described in separate summary plan descriptions.

Guarantee Records Managment Inc. (the Employer) has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). As of May 1, 2003, the benefits described in this booklet constitute the benefits available under the plan and are referred to collectively in this booklet as the Plan. The Plan will be maintained pursuant lo the terms of this booklet. The Plan may be amended from time to time.

If a booklet was issued to you under the Employer's prior plan, this is your new booklet. This new booklet replaces your old booklet in its entirety. If you were covered under the replaced booklet on the day before the effective date of the Plan, you will be covered under this booklet as of the date shown above.

If on the date shown above you are not Actively at Work, refer to Will My Coverage Change? within the section WHEN COVERAGE BEGINS & ENDS for details as to when a change in coverage will become effective.

Some of the benefits that form a part of the Plan and are described in this booklet are hilly insured by Alta Health & Life Insurance Company (Alta), 8505 E. Orchard Road, Greenwood Village, CO 80111. Others are self-funded by the Employer.

Defined terms are capitalized throughout this booklet. These terms have a special meaning with respect to the coverage outlined in the booklet and are defined in the Glossary.

Insured Benefits

The following benefits are insured and are subject to the Laws of the State of New Jersey.

Life and AD&D Insurance

For insured benefits, this booklet becomes your certificate of insurance only if you complete the appropriate application forms and are approved for coverage by Alta.

Alta has full discretion and authority to determine the benefits and amounts payable and to construe and interpret all terms and provisions of this booklet. This provision applies only where the interpretation of this Policy is governed by the Employee Retirement Income Security Act (ERISA).

Self-Funded Benefits

Medical, Prescription Drug, Dental and Vision Benefits

The Plan Administrator has complete authority to control and manage the Plan. For initial claim determination, the Plan Administrator has full discretion to determine eligibility and to interpret the Plan. For claim appeals, the Plan Administrator has designated Alta as the appeals fiduciary. Alta will have full discretion and authority to interpret the Plan and to determine whether a claim should be paid or denied on appeal and according to the provisions of the Plan as set forth in this booklet

The Employer is hully responsible for the self-funded benefits. Alta processes claims and provides other services to the Employer related to the self-funded benefits. Alta does not insure or guarantee the self-funded benefits.

Plan Modification/Termination

The Employer may:

- change the conuibutions a Member must pay for benefits; or
- amend or terminate the benefits provided to you in the Plan.

If the Plan is amended or terminated it will not affect coverage for services provided prior to the effective date of the change.

Choice of Plans

For certain benefits, the Employer may offer you a choice of plans. Contact the Plan Administrator for information on selecting or changing plans.

WHEN COVERAGE BEGINS & ENDS

■ When Will Coverage Begin?

The definition of Employee or Dependent will determine who is eligible for coverage under the Plan.

Coverage will begin after you have satisfied any eligibility waiting periods required by the Employer.

Before coverage can start, you must.

- Submit an application within 31 days after becoming eligible;
- Pay any required contribution; and
- For Life and AD&D Insurance, be Actively at Work on the eligibility date.

Coverage for a newly acquired Dependent will begin on the date you acquire the Dependent if you are covered and if you apply for coverage within 31 days after acquiring the new Dependent. If you have already elected Dependent coverage, any new Dependents will be covered automatically.

If the Dependent is an adoptive child, coverage will start:

- For an adoptive newborn, from the moment of birth if the child's date of placement is within 31 days after the birth; and
- For any other adoptive child, from the date of placement.

If your Employer receives a request to add your Dependent pursuant to a medical child support order, the Employer will determine whether the order is qualified. If the order is detennined to be a Qualified Medical Child Support Order (QMCSO) and if you are eligible to receive benefits under this Plan, then your Dependent child will be covered, subject to any applicable contribution requirements. Your Employer will provide your Dependent child with necessary information which includes, but is not limited to, a description of coverages and ID cards, if any. Upon request, your Employer will provide at no charge, a description of procedures governing QMCSO.

■ What If I Don't Apply On Time?

You are a late applicant under the Plan if you don't apply for coverage within 31 days of the date you become eligible for coverage. Your Dependent is a late applicant if you elect not to cover a Dependent and then later want coverage for that Dependent.

AD&D, Medical, Prescription Drug, Dental and Vision Benefits

A late applicant may apply for coverage only during an Open Enrollment Period. The Plan Administrator can tell you when the Open Enrollment Period begins and ends. Coverage for a late applicant who applies during the Open Enrollment Period will begin on the first day of the month following the close of the Open Enrollment period.

For Medical, Prescription Drug, Dental and Vision benefits, a Member is *not* a late applicant if:

- You did not apply for coverage within 31 days of the eligible date because the Member was covered under another health insurance plan or arrangement and coverage under the other plan was lost as a result of:
  - Exhausting the maximum period of COBRA coverage; or
  - Loss of eligibility for the other plan's coverage due to legal separation, divorce, death of a spouse, termination of employment or reduction in the number of hours of employment; or
  - Termination of the employer's contribution for the other plan's coverage.

You must have stated in writing that the other health coverage was the reason you declined coverage under this Plan, but only if the Employer required such a statement and notified you of the consequences of the requirement when you declined coverage.

- You did not apply to cover your spouse or a Dependent child within 31 days of the date you became eligible to do so and later are required by a qualified court order to provide coverage under this Plan for that person.
- You did not apply to cover yourself or an eligible Dependent within 31 days of the date you became eligible to do so and later experience a change in family status because you acquire a Dependent through marriage, birth or adoption. In this case, you may apply for coverage.

If you apply within 31 days of the date:

- Coverage is lost under the other plan, as described above, coverage will start on the day after coverage is lost under the other plan.
- A court order was issued, coverage will start on the court ordered date.
- You acquire a new Dependent, coverage will start:
  - In the case of marriage, on the date of marriage.
  - In the case of birth or adoption, on the date of birth, adoption or placement for adoption.

Life Insurance

Late applicants must provide Alta with Proof of Good Health at their own expense. Coverage for a late applicant will begin on the date Alta approves Proof of Good Health.

■ What If I Was Covered for Health Benefits Under the Employer's Prior Plan?

A Member who had similar coverage under the Employer's prior plan on the date of its termination will be covered under this Plan on the Plan effective date. Any waiting period under this Plan will be reduced by the part of the waiting period that had been satisfied under the prior plan. "Health benefits" mean medical, prescription drug, dental and vision benefits.

If a Member was on COBRA or any other continuation coverage or extension of benefits under the prior plan and that plan terminated, coverage will be provided for that Member until the earlier of:

- The date on which coverage would end under the terms of the Plan; or
- The last day of the period for which coverage would have been provided had the prior plan not terminated.

If a Member was covered under any extension of benefits under the prior plan, the benefits provided under this Plan will be the same as those provided by the prior plan, less any amount paid under the prior plan.

If you were on Family and Medical Care Leave on the effective date of this Plan and you were covered under the Employer's prior plan on the date of its termination, then you will become covered for the benefits provided under this Plan as of its effective date.

Deductible and Breakpoint Credits

Any amount a Member has already paid toward the calendar year medical deductible under the prior medical plan will be applied to this Plan's calendar year deductible for Network services.

Any benefit maximums under this Plan will be reduced by the amount paid under the prior plan in the calendar year in which your Employer transfers claims processing to Alta.

Any amount of covered expenses a Member has already used to satisfy any calendar year breakpoint under the prior medical plan will be applied to this Plan's calendar year breakpoint

Special Benefits for Pre-Existing Conditions

These benefits apply if a Member would not be eligible for coverage under the Plan because of the pre-existing conditions limitation and is not eligible for benefits under the prior plan because expenses were incurred after termination of that plan.

The amount of benefits will be the lesser of the amount that would have been paid under the prior plan if it had stayed in force and the amount that would have been paid under this medical Plan if it did not have a pre-existing conditions limitation.

Any length of time a Member has already satisfied toward the pre-existing conditions limitation waiting period of the prior plan will be carried over to this medical Plan.

■ How Is Life Insurance Affected by the Transfer to Alta?

If this Plan replaces a similar group life policy issued by another carrier, then a Member

- Who was validly covered under the replaced policy when it terminated; and
- Whose insurance is not being continued under any disability benefit extension in the replaced policy; and
- Who would not be eligible under this Plan on its effective date due to his or her absence from work on that date;

Will still be eligible for benefits under this Plan on its effective date. Benefits will be the same as those provided under the replaced policy. Life Insurance will terminate on the earliest of:

- The date insurance would terminate under the terms of this Plan;
- The date the Member is eligible for full benefits under the terms of this Plan; and
- The date insurance would have terminated under any disability benefit extension in the replaced policy.

■ Will My Coverage Change?

If the Employer amends the benefits or amounts provided under the Plan, a Member's coverage will change on the effective date of the amendment. If a Member changes classes, coverage will begin under the new class the first day of the month coinciding with or next following the date the Member's class status changes.

For Life and AD&D Insurance, if you are an active Employee and you are not Actively at Work when either of these changes occurs, the change in your coverage will not take place until you return to work with the Employer for one full day. This does not apply to Medical, Prescription Drug, Dental and Vision Benefits.

All claims will be based on the benefits in effect on the date the claim was incurred.

■ When Will My Coverage End?

Your coverage will end on the earliest of the following dates:

- The date the Employer terminates the benefits described in this booklet
- The date you are no longer eligible or the last day of the month coinciding with or next following the date your Service ends.
- The due date of the first contribution toward your coverage that you or the Employer fails to make.

Your Dependent coverage will end on the earliest of the following dates:

- The date your coverage ends; or
- The date your Dependent is no longer eligible for benefits; or
- The due date of the first contribution toward Dependent coverage that you or the Employer fails to make.

■ Can I Continue or Convert My Coverage If I Become Ineligible?

If you become ineligible for coverage under the Plan, you may be able to continue coverage for certain benefits.

Continuation of Life Insurance during an Illness, Approved Leave of Absence or Temporary Layoff

If your Service ends due to Illness, Life Insurance will continue for 12 months after your Service ends.

If your Service ends due to approved leave of absence or temporary layoff, Life Insurance will continue for 31 days after the date your Service terminates.

Your coverage will end sooner than stated above if you and/or your Employer fails to pay for this continuation coverage.

There is no continuation for AD&D benefits.

Continuation of Coverage during Family and Medical Care Leave

If the Employer approves your Family and Medical Care Leave, coverage under the Plan will continue during your leave. Contributions must be paid by you and/or the Employer. If contributions are not paid, your coverage will cease. However, a COBRA qualifying event does not occur unless you do not return to work on the date you are scheduled to return from your FMLA leave. If you return to work on your scheduled date, coverage will be on the same basis as that provided for any active Member on that date. If you have questions about Family and Medical Care Leave, see the Plan Administrator.

Continuation of Coverage During a Qualified Military Leave of Absence

If your Service ends because you take a qualified military leave of absence, pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) you may elect to continue your Medical, Prescription Drug, Dental and Vision subject to payment of applicable premium.

Continuation under COBRA for Medical, Prescription Drug, Dental and Vision Coverage

A Member may be eligible to continue coverage under COBRA. Qualifying events determine eligibility for COBRA coverage and the length of continuation.

If you lose your coverage due to a reduction in your hours of employment, or termination of your Service for any reason except gross misconduct. this is a COBRA qualifying event. For a covered Dependent. a qualifying event includes termination of your Service, reduction in your hours of employment. your becoming entitled to Medicare, and your death, divorce or legal separation. The date a Dependent no longer meets the definition of Dependent is also a qualifying event.

When the qualifying event is termination of your Service or a reduction in your hours of employment, COBRA coverage may be extended for a Member who qualifies for Social Security disability benefits. However, the Member's disability must have existed on the date of the qualifying event or have begun within the first 60 days of COBRA coverage.

When a qualifying event occurs, the Employer or a representative of the Employer must give you the necessary COBRA election form You must complete and return this form to the Employer or his or her representative within 60 days of the later of the date the Member loses coverage or the date the Member receives the COBRA election forms.

If a Member receives a Social Security disability determination, the Member must notify the Employer or his or her representative within 60 days of the determination and before the end of the initial 18 month COBRA coverage period in order to extend COBRA coverage to 29 months.

You are also eligible for COBRA if you experience an increase in your contribution for coverage as a result of a qualifying event. If you have questions about COBRA, see the Plan Administrator.

Extension of Medical and Prescription Drug Benefits

A Member who is Totaify Disabled on the date he or she becomes ineligible for continuation of coverage or continuation under COBRA may still be eligible for extended benefits for the disabling condition only. These benefits are extended:

- During the course of that Total Disability.
- Under the same benefit provisions as if coverage had not ended.
- Upon termination of the Member's coverage under this Plan, for 90 days, as long as this Plan is still in force.

Benefits for prescription drugs will be payable under the Medical Benefit and not the Prescription Drug Benefit.

You do not have to pay for extended benefits.

Conversion of Life Insurance Benefits

If all or part of your group term life insurance ends, you may apply for an individual life insurance policy.

Proof of Good Health is not required. You must apply for the fife conversion coverage within 31 days after your Hfe insurance coverage ends. You are entitled to written notice of your right to convert. If you do not receive written notice within 16 days of the dale your coverage ends, the 31 days will be extended to the earlier of:

- 91 days after the date coverage ends; and
- 15 days after the date on which you receive written notice.

The policy will be a standard conversion policy and will not contain a disability benefit or an accidental death benefit. The amount of coverage chosen can never be more than your current amount of insurance. The amount of the premium will depend on your age and class of risk.

You are allowed 31 days to appfy for the individual policy. If you die within this period, your beneficiary will receive a death benefit. The amount of this benefit will be the maximum amount of group term life insurance which you would have been eligible lo convert under this provision.

However, if the ainouht of your ihsiirance had been reduced diiihg this 31-day period because of age or retirement, the death benefit will be the amount of your group term life insurance before the reduction. This death benefit is payable even if you had not applied for an individual policy.

Employee Conversion of Life Insurance Benefits

If the group policy is still in force, you may convert all or part of your insurance to an individual policy if your coverage ends. If your coverage reduces due to age, retirement or a change in coverage you may convert up to the amount of the reduction.

If the group policy is terminated or amended you may convert your life insurance if all or part of your coverage ends. However:

- You must have been insured under your Employer's present or prior group policy for at least five consecutive years; and
- The amount of the individual policy will be the lesser of $2,000.00 and the current amount of your group term life insurance.

If your insurance is being continued under the disability benefit, you may convert your coverage if your coverage ends or reduces due to age or retirement. You may convert this coverage even if the group policy is not in force.

Conversion of AD&D Benefits

Conversion coverage is not available for AD&D benefits.

■ Can Coverage Be Reinstated?

If your coverage ended because of termination of your Service, it will be reinstated on the date you return to work with the Employer You must return within 3 month(s) to be reinstated.

On the date you return to work, coverage for you and your eligible Dependents will be on the same basis as that provided for any other active Employee and his or her Dependents as of that date. However, any restrictions on your coverage that were in effect before your reinstatement will still apply.

Reinstatement of Coverage for a Military Reservist

Coverage for an Employee who returns from a qualified military leave of absence will be reinstated as required by the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Alta PPO MEDICAL BENEFITS

■ How Does the Plan Work?

The PPO plan includes a network of Hospitals and Doctors and a Medical Management Program. Care given by network providers is payable at a higher level than care given by non-network providers.

A Member can call Member Services for the names of network providers or access the on-line directory at www.onehealthplan.com. Network Doctors will submit Member's claims and take care of getting Medical Management approval when necessary.

Members who use a non-network Doctor will need to file their own claim and make sure treatment is approved by Medical Management.

Members who use a non-network provider may reduce their out-of-pocket expenses by choosing a provider participating in the MultiPlan network. MulliPlan is a supplemental network available to Members who choose to use a provider outside the network. Call Member Services for the names of providers who are participating in the MultiPlan network, or access www.multiplan.com. MultiPlan providers are considered non-network providers under this Plan, therefore, the Member is responsible for pre-treatment approval for hospital admissions and surgery outside the Doctor's office.

Out of Town Care

If a Member is out of town and needs non-emergency care, the Member should contact Member Services for help in locating a network provider.

If a Member is outside the PPO network area, benefits will be payable as shown on the Summary of Medical Benefits.

Emergency Care

If emergency care is needed, go to the nearest medical facility. Coverage for emergency care is available 7 days a week, 24 hours a day. Members are not required to request pretreatment authorization prior to receiving care in an emergency room.

Alta administers a prudent layperson emergency policy. You are experiencing an emergency if you have a sudden onset of acute symptoms and believe that if you don't get immediate care, it may result in serious jeopardy to your health. Some examples are chest pain, difficulty in breathing and uncontrolled bleeding.

Special Services

Some services are payable at the network level even when not performed by a network provider. These services include:

- X-rays or lab tests performed while inpatient in a network Hospital.
- Services of an anesthesiologist or assistant surgeon when the surgery is performed by a network Doctor in a network Hospital.
- Ambulance services.

Medical Management (MM) Program

Medical Management will review and make an authorization determination for urgent, concurrent and prospective medical services and prescription drugs for Members covered under the Plan. Your Doctor must call Medical Management (MM) for pretreatment authorization.

Certain services require pretreatment authorization including, but not limited to, inpatient hospital care, surgery outside the Doctor's office and prescription drugs that exceed a recommended dosage or need to be reviewed for medical necessity based on recommendations from medical experts and the FDA. If a Member uses a non-network Doctor, the Member must make sure that treatment is approved by Medical Management For a complete list of services that require pretreatment authorization, call Member Services. The MM telephone number is on the ID card.

If a pretreatment request does not follow the Medical Management procedures, the provider will be notified of the established procedures no later than 5 days after receipt of the request

Medical Management will determine:

- The medical necessity of the care;
- The appropriate location for the care to be provided; and
- If admitted to a Hospital, the appropriate length of stay.

Medical Management will review and render an authorization determination as described below.

- Urgent Care Requests

  For an urgent care request, MM will notify the Member and the provider of the authorization decision:

  - no later than 24 hours after receipt of a request involving concurrent care, if the request is made at least 24 hours prior to the expiration of the previously approved care; and
  - no later than 72 hours after receipt of any other urgent care request.

  If MM does not have all the information needed to process an urgent care request, MM will notify the Member or provider within 24 hours after receipt of the request and give details as to what additional information is required. The requested information should be provided within 48 hours or the authorization request may be denied. MM will notify the Member and provider of the authorization decision within 48 hours after the requested information has been received.

  MM will provide either verbal or written notice of the decision. When verbal notice is provided, a written notice will be sent within 3 days.

- Non-urgent Care Requests

  For a non-urgent care request MM will notify the Member and provider of an authorization decision no later than 15 days after receipt of the request If an authorization decision cannot be made within the 15-day period, an extension of up to 15 days may be requested. If additional information is needed, the Member or provider will be notified within the initial 15-day period and given details as to what information is required. The requested information should be provided within 45 days after receipt of the request or the authorization request may be denied.

  An authorization decision will be made no later than 15 days after MM receives the requested information, unless the Member or provider agrees to a voluntary extension of time.

  Medical Management will send the Member and the provider written notice of all authorization determinations.

If previously authorized benefits are reduced or terminated, MM will send notice of this decision *prior* to any reduction or termination of benefits.

If a Member receives notice of an adverse determinadon, in whole or in part, the Member or the Member's Authorized Representative can appeal the decision.

An ***Authorized Representative*** means a person or health care provider authorized in writing by the Member to represent the Member's interests for claim submission, pretreatment and appeal requests. The Member's health care provider will be automatically recognized as the Member's Authorized Representative for pretreatment requests and appeals. For requests involving urgent care, any health care professional with knowledge of a Member's medical condition will be automatically recognized as the Member's Authorized Representative for pretreatment requests and appeals.

Adverse determination means a determination of non-approval, in whole or in part, of a pretreatment or claim payment request.

If the MM derision is an adverse determination, tite Member will be sent written notice that will include tiie reason(s) for tie denial, reference to die Plan provision(s) on which the denial is based, whether additional infonnation is needed to process tiie request and why tiie infonnation is needed, tiie appeal procedures and time limits, including procedures and time limits for urgent care appeals, and the Member's right to bring civil action under ERISA section 502(a).

The adverse determination notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making tiie adverse decision and tiiat tiiis information is available to the Member upon request and at no charge; and
- tiiat an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to die Member upon request and at no charge.

Medical Management (MM) Non-Compliance Penalty

Network Doctors have agreed to contact tiie MM Program for pretreatment authorization. However, if a non-network Doctor does not get pre-treatment autiiorization or if a Member does not follow the recommended care plan, covered expenses will be reduced by a 50% non-compliance penalty. The non-compliance penalty cannot be applied toward the calendar year deductible or breakpoint

Medical Management Case Management Program

The MM Program also provides Hospital discharge planning and identifies patients who might benefit from the Case Management Program.

The Case Management Program (CM) helps Members with serious illnesses manage their health care. The goal of die CM program is to develop alternative treatment plans diat will help tiiese Members obtain tiie type of care needed *outside* of a Hospital setting. Members who choose to participate in diis program are assigned a case manager to help coordinate care.

If a Member and the Member's Doctor decide that tiie recommended alternative treatment plan is right for the Member, it will be covered on die same basis as die care and treatment for which it is substituted. This will be die case even if tiie alternate treatment plan includes care that is not otherwise covered under die Plan.

Appeal of Medical Management Decision

Appeal of a Medical Management decision should be requested witiiin 180 days after receipt of an adverse determination. You have die right to review and/or request copies of relevant documents, free of charge, and to submit written comments, documents and issues.

One level of appeal must be completed for appeals involving urgent care and two levels of appeal must be completed for all odier appeals involving a MM adverse determination, before a Member may bring civil action under ERISA for an adverse determination. (See Statement of ERISA Rights in die CLAIMS & LEGAL ACTION section of the booklet.) The appeal review will consider written comments, documents and any otiier information submitted by tiie Member, Autiiorized Representative or Doctor, regardless of whether the documentation was reviewed as part of the initial determination.

- **Level I Appeal**

  The first appeal level is an internal review by MM. Upon receipt of an initial appeal of a denied request for medical services, MM will assign tiie review to a board certified Physician Reviewer who is in tiie same or similar specialty tiiat typically manages the service under review and *who was not involved in the prior adverse determination and is not a subordinate of the individual who made the prior determination.*

  The Member and the Audiorized Representative or provider will be sent written notice of an appeal determination:

  - no later than 72 hours after receipt of an appeal involving urgent care; and
  - no later tiian 15 days after receipt of an appeal involving non-urgent care; and
  - no later than 30 days after receipt of a request for autiiorization of services tiiat have already been provided.

  If die appeal decision upholds an adverse determination, and you decide to appeal die decision, you may proceed to Level II. For appeals involving urgent care, Level II is voluntary.

- **Level II Appeal**

  If die first level internal review denies authorization, in whole or in part, a second level appeal review may be requested. The second level appeal is an external review by an independent review entity and is binding on die Plan. The written request for external review must be submitted to Medical Management widiin 60 days after receipt of the first level appeal determination. An external review will be provided at no cost to die Member.

A Doctor or a group of Doctors in the same or similar specialty that typically manage the service under review and who is not affiliated with Medical Management will conduct the external review.

The Member and the provider will be sent a written notice of the external review determination:

- no later than 15 days after receipt of the second level appeal request for preauthorization of services; and
- no later than 30 days after receipt of the second level appeal request for authorization of services that have already been provided.

If the external review results in a denial of the requested service, the Member has the right to bring civil action under ERISA section 502(a).

Members will be sent written notice of an adverse determination upon completion of a Level I appeal and upon completion of a Level II appeal. The notice will include:

- the reason(s) for the determination;
- reference to the Plan provision(s) on which the determination is based;
- the Member's right to review and request copies of all relevant documents, free of charge;
- whether an internal rule, guideline, protocol or other criterion was relied upon in making the adverse decision and that this information is available to the Member upon request and at no charge;
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge;
- that the Member may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office and the state insurance regulatory agency; and

The notice will also include the Member's right to bring civil action under ERISA section 502(a).

Appeal of an adverse determination involving urgent care may be submitted either orally or in writing and will be expedited.

Calendar Year Deducdble and Copay

A calendar year deductible is the amount of covered medical expenses that must be satisfied before the Plan begins to pay benefits.

Network expenses will not apply to a non-network deductible .

Any expenses that were incurred in the last three months of a calendar year and used to satisfy the deductible for that year will also be applied to the deductible for the next calendar year.

A copay is an amount a Member pays for care at the time of service.

Allowable Covered Expenses

All medical benefits are subject to allowable covered expense guidelines.

Network providers have agreed to a set fee schedule. Members are not responsible for expenses over the scheduled amount for covered services. Members are responsible for any applicable copays, deductibles, and coinsurance.

For services provided by a non-network provider, the allowable covered expense is based upon the average contracted rates (ACR) for network providers in the area where the care is provided. The covered amount for each service or supply will be the lesser of the fee usually charged by a provider and the ACR for that service or supply. The Member is fully responsible for any amount over the ACR, in addition to any applicable copays, deductibles and coinsurance.

With Medical Management approval, hospital admissions resulting from emergencies may be exempt from the ACR. Pretreatment authorization is required on all hospital admissions. In the event of an *emergency admission*, it is imperative to initiate the pretreatment authorization process. Without pretreatment authorization, Medical Management will not approve exemption from ACR.

■ What's Covered?

The Summary of Medical Benefits located in the from of the booklet shows the payment percentage, deductible and copay amounts applicable to various covered expenses. Any benefit maximums applied to specific covered expenses and calendar and lifetime benefit maximums for *all* covered expenses are also shown on the Summary of Medical Benefits.

If the Plan pays benefits at less than 100%, you must pay the remaining percentage of covered services. This amount is in addition to any deductible or copay amounts.

Services must be Medically Necessary as defined in the Glossary. Unless otherwise noted for a particular service, services must be required as a result of symptoms of Illness. Expenses are covered only if incurred while the Member is covered for these medical benefits.

Hospital Care and Surgery

The Plan covers semi-private room and board and ICU expenses as well as other inpatient and outpatient services, supplies and Doctor's charges. Hospital and Doctor charges for infant care through the first seven days of life are covered if you have elected Dependent coverage.

Skilled Nursing Facility

The Plan covers care in a licensed skilled nursing facility. Care must be such that it requires the skills of technical or professional personnel, is needed on a daily basis and cannot be provided in the patient's home or on an outpatient basis. Care must be required for a medical condition which is expected to improve significantly in a reasonable period of time and the Member must continue to show functional improvement.

Coverage is limited to the usual charge of the facility for semi-private care. This amount includes room and board and all other services.

Office Visits

The Plan covers most services and supplies in a Doctor's office, including the cost and fitting of FDA-approved contraceptive devices. X-rays and lab tests ordered or performed during an office visit are considered separate from the office visit and are subject to the calendar year deductible and payment percentage as shown in the Medical Summary of Benefits.

Certain procedures, such as surgery in a Doctor's office, are considered separate from the office visit. These expenses are subject to the calendar year deducdble and payment percentage shown in the Medical Summary of Benefits.

Preventive Care

The Plan covers periodic physical exams by a Doctor for a Member who is at least eight days of age. This includes x-ray and lab services if part of the annual physical exam, necessary immunizadons and booster shots. X-rays and lab tests are subject to the payment percentage as shown in the Medical Summary of Benefits. For a Member over the age of two, benefits are payable for one exam per year.

The Plan covers an annual pelvic exam, Pap smear and mammogram. Colorectal cancer screening and prostate specific antigen (PSA) screening are also covered.

Reconstructive Surgery following a Mastectomy

The Plan covers reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications related to all stages of mastectomy, including lymphedemas.

Treatment is to be determined by the attending Doctor, in consultation with the patient. Benefits will be payable on the same basis as for any other surgery covered under the Plan.

Other Reconstructive Surgery

The Plan covers reconstructive surgery when the primary purpose is to improve function of the underlying structures or to restore large skin defects due to port wine stain. Surgery to correct significant congenital defects is covered only if the defect interferes with bodily function (not psychological function). Reconstructive surgery performed as a result of trauma or disease is covered when reconstruction begins within one year of the trauma or illness (except for reconstructive surgery as a result of a mastectomy). Subsequent surgical reconstructive procedures integral or linked to the covered reconstruction, that cannot be performed within the year due to medical considerations, may be covered more than one year later, but only if the planning for these procedures (as noted in the Member's medical records) takes place within one year of the trauma or illness.

Maternity Coverage

The Plan covers prenatal, childbirth and postnatal care. Coverage for you and your baby, if dependent coverage is elected, includes a Hospital stay of 48 hours following a normal vaginal delivery and 96 hours following a C-section. The 48/96 hours begin following delivery of the last newborn in case of multiple-births. When delivery takes place outside a hospital, the 48/96 hours begin at the time of inpatient admission. The Hospital stay may be less than the 48-hour or 96-hour minimum if a decision for early discharge is made by the attending Doctor in consultation with the mother.

Pre-authorization is not required for the 48/96-hour Hospital stay. However authorization is needed for a longer stay than as described above.

As soon as a Member finds out that she is pregnant, she or her Doctor should contact Member Services so they can help her identify and avoid risks during pregnancy and obtain the prenatal care she needs. They can also direct her to appropriate facilities.

Family Planning

The Plan covers tubal ligations and vasectomies and elective abortions.

Infertility Treatment

The Plan covers non-experimental infertility testing and treatment procedures that are recognized as non-experimental by the American College of Obstetrics and Gynecology or the American Fertility Society.

Treatment of TMJ and Related Disorders

The Plan covers treatment of temporomandibular disorders and craniofacial muscle disorders.

Treatment of Mental Health Conditions and Chemical Dependency

The Plan covers inpatient and outpatient treatment of mental health conditions, alcoholism, drug addiction and other chemical dependency.

Spinal Adjustment and Treatment

The Plan covers expenses for services related to spinal adjustment.

Home Health Care

The Plan covers home health care visits when services are provided by a licensed home health care agency. Services must be prescribed as an alternative or a follow-up to inpatient Hospital care. The Member must be restricted from leaving home due to a medical condition.

Care must be such that it cannot be learned or performed by the average, non-medically trained person. Care must be provided by technical or professional personnel or by home health aides working along with technical or professional personnel. Care must be required for a medical condition which is expected to improve significantly in a reasonable period of time.

Hospice Care

The Plan covers hospice care if prescribed by a Doctor and the Member's life expectancy is six months or less.

Other Medical Services and Supplies

The Plan covers:

- Non-disposable medical equipment appropriate for use within a Member's home. Covered equipment must be able to withstand repeated use and be used to treat an Illness. Replacement of equipment is covered only when required as a result of normal usage.
- Nursing services.
- Ambulance services.
- General anesthesia and associated facility charges for dental procedures when determined to be Medically Necessary.
- Custom-designed orthotics when prescribed by a Doctor and required for all normal, daily activities.
- Physical therapy rehabilitation to restore function and prevent disability following acute disease, injury or loss of body part with the expectation of significant improvement within two months. Covered therapy includes exercise, heat, cold, electricity, ultrasound and massage to improve circulation, strengthen muscles, encourage return of motion and train Members to perform the activities of daily living.

Massage is covered only when it is part of a covered course of physical therapy and is provided by or under the direct supervision of a physical therapist.

- Services required for the treatment of diabetes and diabetes self-management education programs.
- Outpatient Occupational, Speech and Hearing Therapy.

  Occupational therapy means rehabilitation to attain the maximum level of physical and psycho-social independence following acute disease, injury or loss of body part with the expectation of significant improvement within two months. This includes fine motor coordination, perceptual-motor skills, sensory testing, adaptive/assistive equipment, activities of daily living and specialized upper extremity and hand therapies.

  Speech therapy means restoration of speech due to impairment following a recent physiological disturbance or injury, such as CVA, tracheostomy, swallowing disorders, laryngectomy and neuromuscular disease, with the expectation of significant improvement within two months.
- Reasonable costs associated with a search for a matched unrelated donor when the transplant is certified by Medical Management as Medically Necessary and is performed at a facility approved by and affiliated with the National Marrow Donor Program.

■ Is There a Limit On My Expenses?

The breakpoint maximums are shown in the Summary of Medical Benefits.

Calendar Year Breakpoint

If in any one calendar year a Member's covered expenses reach the individual breakpoint, all other covered expenses for that Member during the rest of that calendar year will be payable at 100%. No more than the individual breakpoint per Member will be applied to the family breakpoint.

Covered expenses for outpatient care of mental health conditions and chemical dependency treatment will *not* be payable at 100%, even if a Member has reached the breakpoint.

Expenses Excluded from the Breakpoint

Expenses that are not applied toward the breakpoint include expenses:

- for services and supplies not covered under this Plan.
- used to satisfy any deductible or copay amounts.
- for outpatient care of mental health conditions and chemical dependency.
- that are payable at 100%.

PRESCRIPTION DRUG BENEFITS

The prescription drug benefits are provided through two programs. The Performance Pharmacy Program uses a nationwide network of participating PCS pharmacies. The Mail Order Drug Program lets Members order larger quantities of maintenance drugs through the mail to lower their out-of-pocket costs.

The Tier 2 and Tier 3 drugs are subject to change. Contact Member Services or go to www.onehealthplan.com for additional information.

Covered drugs and contraceptive devices require the written prescription of a Doctor and approval by the FDA. Drugs and contraceptive devices must be purchased from a licensed pharmacist or Doctor. Benefits are payable only for drugs required for the treatment of Illness, when received as an outpatient and while covered for these benefits.

New FDA approved drugs are evaluated by the Pharmacy and Therapeutics Committee of our pharmacy benefit management company. Oversight and final approval are given by the Medical Director.

Some drugs may have dispensing limits which are primarily based on FDA recommendations.

The Performance Pharmacy Program

The Performance Pharmacy Program covers charges for prescription drugs, insulin and diabetic supplies.

Benefits are also payable for contraceptive drugs and devices prescribed for the purpose of birth control.

The Performance Pharmacy Program covers a 30-day supply received in any one purchase.

Covered expenses will be limited to the cost of a generic drug if a generic drug is available. However, the brand name drug will be considered a covered expense if a generic drug is not available, or if the Doctor writes DAW (Dispense as Written) on the prescription. If the Member requests a brand name drug when a generic drug is available, and the Doctor has not written DAW on the prescription, then, in addition to the generic drug copay, the Member must pay the difference between the cost of the generic drug and the brand name drug.

When a Member shows their ID card at a participating PCS pharmacy, the pharmacist will collect the appropriate copay and the Member won't have to file a claim.

If a Member buys drugs at a pharmacy that is not a participating PCS pharmacy, the Member must pay the pharmacist the full price of the drug and file a claim with PCS for reimbursement. Reimbursement will be 50% of the network pharmacy cost of the drug, minus the copay amount.

Mail Order Drug Program

The Mail Order Drug Program covers costs for home delivery and expenses for prescription maintenance drugs required for treatment of Illness. Prescription maintenance drugs are drugs prescribed by the Doctor on an ongoing basis. This includes expenses for diabetic supplies and insulin.

Benefits are also payable for contraceptive drugs and devices prescribed for the purpose of birth control.

With this program, a Member may buy through the mail up to 90-day supplies of insulin and covered maintenance prescription drugs. Ask the Employer for a mail order drug brochure.

Ask the Doctor to prescribe needed medications for a 90-day supply, plus refills. If a Member is presently taking medications, the Member should ask the Doctor for a new prescription.

If a Member's prescription is for a brand name drug but a generic equivalent is available, the Member will be sent the generic drug unless the Doctor has written DAW (Dispense as Written) on the prescription.

If Medication is Needed Immediately

If medication is needed immediately, the Member should ask the Doctor for two prescriptions. The first should be for a 14-day supply that the Member can have filled at a local PCS pharmacy. The second prescription should be mailed to the Mail Order Drug Program with the copay.

DENTAL BENEFITS

Allowable Covered Expenses

All dental benefits are subject to allowable covered expense guidelines.

The allowable covered expense is determined by usual and customary guidelines. The usual and customary charge for each service or supply received will be the lesser of the fee usually charged by a Dentist and the fee usually charged by other Dentists in the same geographical area for these services and supplies. The Member must pay any amount over usual and customary charges.

For specialist care and any other dental care expected to cost $300 or more, Members are encouraged to ask their Dentist to prepare a treatment plan and send it to the address shown on the ID card.

■ What's Covered?

The Summary of Dental Benefits located in the front of the booklet shows the payment percentage and deductible amount applicable to various covered expenses.

If the Plan pays benefits at less than 100%, you must pay the remaining percentage of covered services.

Services must be necessary for the diagnosis, prevention or correction of dental disease, defect or injury. Services must be recommended or prescribed by a licensed Dentist or Doctor, or performed by a dental assistant or dental hygienist working under the direct supervision of a Dentist

The Plan covers only the least costly procedure that will produce satisfactory results. Expenses are covered only if incurred and completed while a Member is covered for these dental benefits.

Preventive Care

Members may receive the following services twice each calendar year, but not more than once in any five-month period:

- Oral examination.

- Cleaning of teeth.
- Bite wing x-rays.
- Topical application of fluoride solution for Dependent children.

Preventive treatment also includes:

- Sealants for children; and
- A full-mouth series of x-rays once in any 36-month period.

Basic Care

Basic care includes:

- Extractions and alveolectomy at the time of tooth extraction.
- Amalgam, silicate, acrylic, and composite fillings. Silicate, acrylic, and composite fillings are covered only for teeth in front of the first bicuspid.
- Dental surgery.
- X-ray and lab services required for dental procedures.
- General anesthesia required for dental surgery.
- Care for relief of dental pain.
- Drugs that require a Dentist's written prescription, including medication given at the Dentist's office.
- Consultations required by the attending Dentist.
- Relines and rebases to existing dentures.
- For Members age 14 and under, habit-breaking appliances.
- For Members age 14 and under, space maintainers for missing primary teeth.
- Endodontic and Periodontic Care.

Major Care

Major care includes:

- Crowns, inlays and onlays.
- Fixed bridge restorations.
- Removable partial or complete dentures.
- Repairs to existing dentures.
- Initial placement of full or partial dentures or bridgework, including abutments.
- Replacement of existing full or partial dentures, bridgework or crowns; or the addition of teeth, inlays, onlays, crowns or gold restorations to these appliances only if:
  - The existing appliance cannot be repaired or restored to use; and
  - The Member has been covered at least 12 months.
  - At least five years have passed since the last placement: or
  - The replacement:
    * Replaces an existing temporary appliance that was placed after the date on which the Member became covered; and
    * Is placed within 12 months after a temporary appliance was placed; or
    * The replacement:
      - Is needed because of the pulling of additional natural teeth or accidental injury to natural teeth (except for chewing injuries); and
      - Is completed within 12 months of the extraction or Accidental Injury.

If a Member has a partial denture, and a natural tooth adjacent to that denture is pulled, the addition of another tooth to the Member's denture is covered.

VISION BENEFITS

The Summary of Vision Benefits located in the front of the booklet shows the payment percentage applicable to various covered expenses.

If the Plan pays benefits at less than 100%, you must pay the remaining percentage of covered services.

Eye Exams

The Plan covers eye exams.

Eyeglass Lenses and Frames or Contact Lenses

The Plan covers eyeglass lenses and frames or contact lenses. Maximum amounts payable includes the cost of tinting, photograying and hardening of lenses.

LIFE INSURANCE BENEFITS

■ Standard Life Insurance

If you die from any cause while covered under the life insurance Plan, your amount of standard life insurance will be paid to your beneficiary. The amount will be based on the schedule shown in the front of this booklet.

■ How Do I Name a Beneficiary?

A beneficiary is the person who will receive payment of the life insurance amount if you die. You should name a beneficiary when you first apply for insurance. Unless legally restricted, you can change the beneficiary at any time by giving Alta written notice. The beneficiary's consent is not required unless the designation of the beneficiary is irrevocable.

Naming or changing a beneficiary must be in writing, signed by you and filed with Alta at its Administrative Services Offices.

If a named beneficiary dies before you, the amount of the life insurance that beneficiary would have received will be paid to any remaining named beneficiaries who survive you, unless you have specified otherwise on your application or state law does not allow this.

When there are two or more named beneficiaries the life insurance will be divided in equal shares, unless you have specified otherwise.

Subject to state law, if no named beneficiary survives you or if you have not named a beneficiary, the amount of insurance will be paid to your surviving spouse; if none, then to your surviving child or children; if none, then to your surviving parent or parents; if none, then to your surviving brothers or sisters; if none, then to your estate.

■ How Will Benefits Be Paid?

Proof of death must be sent to Alta. Alta will pay the amount of insurance (the death benefit) to the beneficiary.

- If any person has incurred expenses related to your last Illness or death, Alta can deduct up to $500.00 from the death benefit to pay the person who incurred these expenses.
- The life insurance will be paid to the beneficiary. Prior to your death, you may elect to have your life insurance paid to your beneficiary in any manner to which Alta agrees.
- If you do not elect an optional payment method prior to your death, then after your death the beneficiary may elect to have the life insurance paid to him or her in any manner to which Alta agrees.

~~Payments will not be made more than once a year unless each payment is at least $25.00.~~

■ What If I Become Disabled?

After you have been Totally Disabled for 9 consecutive months, insurance for yourself may be continued without further premium payment. To qualify for this benefit:

- Your Total Disability must continue without interruption for at least 9 months;
- You must be under age 60 when you become Totally Disabled;
- You must send proof of your Total Disability to Alta within 12 months of the start of the disability; and

- If you have converted to an individual policy under this life insurance Plan as a result of your Total Disability, you must surrender it. See "Conversion of Life Insurance Benefits" in the section entitled When Coverage Begins & Ends. All premiums paid for the individual policy after you have been Totally Disabled for 9 months will be returned. If you should die during this 9 month period, the amount of insurance will be paid under either this life insurance Plan or the individual policy but *not* under both.

  You do not need to surrender any individual conversion policy you have which resulted from a change in class.

If you qualify for this disability waiver of premium benefit, you must send proof of the continuance of your Total Disability to Alta when requested.

The amount of life insurance continued will be the amount in effect under this Plan on the date you became disabled. However, the amount of insurance may reduce or terminate due to age or retirement according to the provisions of the Plan that were in effect on the date you became Totally Disabled.

This life insurance Plan does not have to be in force at the time of death for life insurance to be paid.

Your disability waiver of premium benefit will terminate:

- On the date you recover from your Total Disability; or
- If you do not send Alta proof of the continuance of your Total Disability when requested.

■ Is the Amount of My Insurance Reduced As I Grow Older?

Your amount of standard life insurance will be reduced according to the schedule shown in the front of this booklet.

■ Life Insurance Benefits If Terminally Ill

Any Accelerated Benefit that you receive may be treated as taxable income and may affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax and/or legal advisor before you apply for an Accelerated Benefit.

If you are terminally ill, you may apply to receive a portion of your life insurance as an "Accelerated Benefit". In order to do this, you must be covered under this Plan and you must give Alta satisfactory proof of having a "Qualifying Medical Condition".

"Qualifying Medical Condition" means you are terminally ill, with a life expectancy of 12 months or less. In considering a request for an Accelerated Benefit, Alta at its expense, may require that you be examined by a Doctor of its choice.

There is no additional cost or premium if you choose to request an Accelerated Benefit.

To apply for an Accelerated Benefit you must:

- contact your Employer for the appropriate application form; and
- send your application to Alta along with a statement from your Doctor certifying the Qualifying Medical Condition.

  For purposes of this benefit, the Doctor cannot be:
  - yourself; or
  - a person who is part of your immediate family (your parent, spouse, sibling or child); or
  - a person who lives with you.

The request for an Accelerated Benefit must be made by the terminally ill insured person. However, if he or she is legally incapacitated or a minor child, the request must be made by a person with legal authority to act on the insured person's behalf.

You may request an Accelerated Benefit of up to 50% of the amount of your life insurance to a maximum of $100,000.00. The minimum Accelerated Benefit is $1,000.00.

The amount of the Accelerated Benefit available to you will be based on the amount of life insurance coverage provided to you by Alta under this Plan when you request the Accelerated Benefit.

If your life insurance is scheduled to reduce within 36 months of the date you apply for the Accelerated Benefit, then the amount of the Accelerated Benefit will be based on the reduced amount.

You may only request an Accelerated Benefit one time while covered by Alta. If you recover from your Qualifying Medical Condition after receiving an Accelerated Benefit, Alta will not ask you for a refund of the Accelerated Benefit. However, your amount of life insurance will be reduced as described in below.

After you have applied for an Accelerated Benefit. you may change your mind. If you decide not to accept an Accelerated Benefit. you must notify Alta by returning the uncashed payment to Alta. If you have chosen to receive payment in installments, you may still cancel the Accelerated Benefit by returning uncashed payments. The total amount of your life insurance will be reduced by the amount of any payments you have already received.

If your benefit.terminates due to non-payment of premium, you may reinstate the Accelerated Benefit on the same terms under which you would reinstate the group life benefit.

You may choose the method in which your Accelerated Benefit is paid. You may select:

- a lump sum;
- a fixed number of installments which provide for payment of the full amount of the Accelerated Benefit; or
- any other manner to which Alta agrees.

If you die before any of the accelerated benefit payments are received, the total amount of your life insurance will be paid to your beneficiary. If you die before all of your payments are received, then the balance remaining will be paid to your beneficiary. The remaining payments may be paid in a lump sum, or by continuing the monthly payments, at Alta's option. The balance of the benefit which was not.accelerated will be paid in to the beneficiary pursuant to the terms of the life insurance benefit.

The Accelerated Benefit will be treated as a lien against your total benefit. After payment of the Accelerated Benefit. the amount of your life insurance coverage under this Plan will be reduced by the amount of the Accelerated Benefit. The lien will not accrue any interest.

Anyone approved for an Accelerated Benefit may also be approved for disability waiver of premium. (See "What If I Become Disabled?") Anyone already on disability waiver of premium when approved for an Accelerated Benefit, will continue on premium waiver.

No Accelerated Benefit will be paid if:

- All or part of your insurance must be paid to your children or your spouse or former spouse as part of a court approved divorce decree, separate maintenance agreement. or property settlement agreement.
- You are married and live in a community property state, unless you provide us with a signed statement from your spouse consenting to payment.of the Accelerated Benefit.
- You have made an assignment of all or part of your life insurance, unless you provide Alta with a signed statement from your assignee consenting to payment of the Accelerated Benefit.
- You have filed for bankruptcy. unless you provide Alta with written approval from the bankruptcy court for payment of the Accelerated Benefit.
- You have previously received an Accelerated Benefit while covered under this Plan.

■ Other Information About Life Insurance

Absolute Assignment

You can transfer all your rights of ownership in your life insurance. This is known as absolute assignment. Alta is not responsible for the validity or effect of any assignment.

To assign your life insurance, notify your Employer, who will contact Alta for an assignment form. Alta will not recognize an assignment.until the original assignment form has been noted at its Administrative Services Offices.

Collateral Assignment

You cannot assign your insurance as collateral for a loan.

Proof of Age

Before benefits are paid, Alta may request proof of age. An adjustment may be made if:

- The Member's age was misstated; and
- A different premium rate would have been charged for the person's true age.

The difference between the premiums actually paid, and those that should have been paid, will be calculated. Any difference will be paid:

- By your Employer to Alta, if the age was understated; and

- By Alta to your Employer, if the age was overstated.

AD&D BENEFITS

Your AD&D benefits are payable if you are in an Accident while covered under this AD&D Plan and suffer a loss:

- Within 90 days of the Accident and
- As a result of the Accident.

Neither termination of this Plan nor termination of your coverage under this Plan will affect the settlement of any claim where the accident causing the loss occurred on or before the date of termination.

The amount of AD&D benefits that you may receive is based on a Principal Sum. The amount of your Principal Sum is equal to the amount of your Standard Life Insurance. (See "Standard Life Insurance" in the Life Insurance section of this booklet.) Alta will pay all or part of the Principal Sum according to the AD&D Benefit table shown in the front of this booklet.

Only one of the amounts, the largest, will be paid for all injuries that result from any one Accident.

Loss of hands and feet means permanent dismemberment by severance through or above the wrist or ankle joints. Loss of sight means total and permanent loss of sight beyond remedy by surgical or other means.

If you die, the benefit will be paid to the beneficiary you name for life insurance. If you suffer any other loss, the benefit will be paid to you.

To claim AD&D Benefits, written proof of loss must be sent to Alta as soon as reasonably possible. You have at least 90 days from the date of loss to submit proof of loss. Failure to furnish proof of loss within 90 days will not invalidate or reduce any claim if the proof is submitted as soon as reasonably possible.

Your amount of AD&D Principal Sum is subject to the same age-based reductions as your life insurance.

BENEFIT LIMITATIONS

Pre-Existing Conditions Limitation for Medical Benefits

This section will *not* apply to a child placed with you for adoption.

A pre-existing condition is an Illness or any related condition for which a Member received services, supplies or medication during the 3 months before the enrollment date of the Member under this medical Plan.

A pre-existing condition is not:

- A pregnancy existing on the enrollment date
- Genetic information.

Benefits are payable for services, supplies and medication received for a pre-existing condition if they are received 12 months after the enrollment date for the Member.

For a late applicant as described in the section, "What If I Don't Apply On Time?", benefits will be payable for services, supplies and medication for a pre-existing condition only if they are received on or after the date which is 18 months after the person's enrollment date.

"Enrollment date" means:

- The first day of the Employee's Service with the Employer, if you apply for coverage for yourself and/or your eligible Dependents within the 31-day period when you are first eligible.
- The date the person becomes covered under this Plan, if you apply for coverage for yourself and/or your eligible Dependents after the 31-day period when you are first eligible. This will also be the case for any newly acquired Dependents.

Portability of Coverage

A person will receive credit toward this Plan's Pre-Existing Condition Limitation periods for the time covered under another health plan, but only if the person was covered, under another health plan that meets the definition of "Creditable Coverage", within the 63-day period just before his or her enrollment date under this Plan. Any eligibility waiting period that the person must satisfy under this Plan will not be considered in determining the 63-day period.

If the person was covered:

- For a period of time under Creditable Coverage that is greater than the time periods referred to in the Pre-Existing Conditions Limitation, then the Pre-Existing Conditions Limitation periods will not apply to the person.
- For a period of time under Creditable Coverage that is less than the time periods referred to in the Pre-Existing Conditions Limitation, then the Pre-Existing Conditions Limitation periods will be reduced by the number of consecutive days that the person was covered under Creditable Coverage.

  However, for a child who became covered under Creditable Coverage within 31 days of birth, the Pre-Existing Conditions Limitation periods will not apply regardless of how long the child was covered under Creditable Coverage.

It is your responsibility to provide information about Creditable Coverage in order for the Pre-Existing Conditions Limitation under this Plan to be reduced or waived.

Dental Limitations for Late Applicants

If dental coverage starts more than 31 days after the Member became eligible, then no benefits are payable for Basic and Major treatment received within 12 months after coverage starts.

Benefits are payable for Accidental Injury to natural teeth.

Medical Benefit Limitations

No amount will be payable for:

- Services that are not Medically Necessary.
- Custodial care of a Member whose health is stabilized and whose current condition is not expected to significantly or objectively improve or progress over a specified period of time. Custodial care does not seek a cure, can be provided in any setting and may be provided between periods of acute or intercurrent health care needs.

  Custodial care includes any skilled or non-skilled health services or personal comfort and convenience services which provide general maintenance, supportive, preventive and/or protective care. This includes assistance with, performance of, or supervision of:

  - walking, transferring or positioning in bed and range of motion exercises;
  - self-administered medications;
  - meal preparation and feeding, by utensil, tube or gastronomy;
  - oral hygiene, skin and nail care, toilet use, routine enemas;
  - nasal oxygen applications, dressing changes, maintenance of indwelling bladder catheters, general maintenance of colostomy, ileostomy, gastronomy, tracheostomy and casts.
- Special nursing services if those same services could be provided by the regular nursing staff of any Hospital in which the Member is confined.
- Charges by a Doctor for any phone call or interview during which the Member is not examined.
- Confinement, treatment, services or materials for educational or training problems or learning disorders.
- Outpatient physical, occupational or speech therapy for non-acute injuries, diseases or conditions that are not reasonably expected to result in significant clinical improvement within two months. This includes developmental progress in skills such as sitting, walking, talking and learning that compare unfavorably to measured results from standardized tests of others of the same age.
- Services or supplies which are primarily for the Member's education, training or development of skills needed to cope with an injury or sickness, except as specifically provided in the Plan.
- Any expense or charge associated with exercise equipment.
- Travel or transportation expenses, except for ambulance services, even if to reach a network facility.
- Plastic or reconstructive surgery that is not done to repair congenital defects, trauma, or an organ or tissue damaged by cancer, as defined in the section "What's Covered". Surgery to improve psychological function alone is not covered.
- Gene manipulation therapy.
- The reversal of any sterilization procedure.

- Massage, except when it is part of a covered course of physical therapy and is provided by or under die direct supervision of a physical tierapist.
- Surgical procedures for die improvement of vision when vision can be corrected tiirough die use of glasses or contact lenses.
- Eyeglasses, contact lenses, eye exams to assess visual acuity or the fitting of glasses and lenses.
- Dental services otiier dian treatment of Accidental Injury to natural teeth widiin six mondis after die Accident. Chewing injuries are not considered an Accidental Injury.
- Non-prescription dmgs or medicines, or drugs or medicines that are not approved by die Food and Dmg Administration.
- Treatment for tiie purpose of weight loss, unless die Member is morbidly obese.
- Programs related lo smoking cessation.
- Osteotomy, ortiiognatiiic surgery, maxillofacial orthopedics or related treatment for deformities caused by anything otiier dian cancer or trauma.
- Services received as a result of an intentionally self-inflicted injury unless such injury is the result of a medical condition or domestic violence.
- Hearing aids or die fitting of hearing aids.
- Dmgs, medicines or insulin which are received as an outpatient.

Prescription Drug Benefit Limitations

No amount will be payable for:

- Therapeutic devices and appliances, except as specifically provided under die Plan.
- Over-die-counter dmgs and supplies, except as specifically provided under die Plan.
- The administration of dmgs.
- More tiian one purchase of a drug or insulin during die dosage period recommended by die prescribing Doctor
- Allergy semms.

Dental Benefit Limitations

No amount will be payable for:

- Dental appliances which have been lost. mislaid or stolen.
- Dental care tiiat does not have ADA endorsement.
- Dental care provided to correct any birth defect or developmental malformation which does not interfere witii function.
- Care of craniofacial muscle disorders and temporomandibular disorders.
- That part of any covered dental expense diat is payable under any otiier section of diis booklet, unless:
  - Benefits are payable under botii diis dental benefit and any medical benefits; and
  - It is to die Member's advantage to have benefits paid under dental benefits ratiier dian under medical benefits.
- Ortiiodontic treatment.
- Dental care diat is cosmetic in nature.
- Services not necessary for die diagnosis, prevention or care of dental disease, defect or injury.
- Dental care provided for dietary planning for the control of dental disease or for plaque control or for oral hygiene instmctions.
- Custontized dental procedures.
- Crowns for teeth that are restorable by odier means or for die purpose of periodontal splinting.
- Take-home fluoride solutions.
- Local analgesics.

Vision Benefit Limitations

No amount will be payable for:

- Safety glasses.
- Radial keratotomy.

- Medical or surgical treatment of the eye.
- Artificial eyes.

AD&D Benefit Limitations

No amount will be payable for any loss caused by or in connection with:

- Intentionally self-inflicted injury.
- War or any act relating to war.
- Any form of disease.
- Physical or mental infirmity.
- The medical or surgical treatment of a disease or infirmity.
- Suicide.
- Ptomaine poisoning.
- Bacterial infections.
- Commission of a felony.

General Benefit Limitations

No amount will be payable for:

- Experimental or Investigational treatment or procedures.
- Vision therapy or orthoptic treatment
- Anti-obesity drugs and formulas.
- Broken appointments.
- Care provided by a government health plan or for which there would be no cost if the Member did not have coverage. If the Member is entitled to benefits under a state-sponsored medical assistance program, benefits under the Plan will be paid to the state.
- Expenses incurred for care provided by your or your spouse's immediate or extended family.
- Care received for an Illness that is a result of war or engaging in a riot or insurrection.
- An Accidental Injury that occurs while working for pay or profit.
- A sickness for which the Member can receive benefits under any Workers' Compensation or similar law.

CLAIMS & LEGAL ACTION

How To File Claims

A claim for benefits and services that have been provided may be filed by a Member, beneficiary or Authorized Representative. An *Authorized Representative* means a person or health care provider authorized in writing by the Member to represent the Member's interests for claim submission, pretreatment requests and appeals.

The Member's health care provider will be automatically recognized as the Member's Authorized Representative for pretreatment requests and appeals. For requests involving urgent care, any health care professional with knowledge of a Member's medical condition will also be automatically recognized as the Member's Authorized Representative for pretreatment requests and appeals.

All claim forms include instructions on how to complete and submit a claim. Members can request a claim form from the Plan Administrator or go to www.onehealthplan.com to print a copy of a claim form. Complete and accurate claim information is necessary to avoid claim processing delays. Claim decisions will not exceed the time frames described below, unless the Member, beneficiary or Authorized Representative agrees to a longer period of time.

Health Benefits

- Medical, Dental and Vision Benefits

  Members who present their ID card when using a network provider will not have to file a claim. The ID card contains all the information network providers need to directly bill Alta for the balance.

For other services, Members must file a claim. Sign the complete form, attach the itemized bill and mail both to the address on the Member ID card.

An Explanation of Benefits (EOB) will be sent to the Member showing how the claim was paid.

For expenses incurred outside the United States, the Member must pay the bill and file a claim.

- Prescription Drug Benefits

A prescription given to a pharmacist is not a claim for benefits under the Plan. A Member may submit a claim for Prescription Drug Benefits if:

- the pharmacist will not fill a prescription and the Member believes that he or she is entitled to receive the drug or supply and that benefits have been wrongfully denied; or
- a copay amount was charged that the Member believes to be incorrect; or
- all or a portion of the cost of a prescription drug or supply is paid by the Member at the time the drug or supply is dispensed and the Member wants to request reimbursement for the amount paid; or
- prescription drugs or supplies are purchased at a pharmacy that is *not* a PCS pharmacy.

Claim forms are available from Member Services and from the Employer. If a Member decides to pay full price to purchase a drug or supply, the Member should submit a claim to the prescription drug benefits manager for processing. Benefits will be processed subject to the provisions of the Plan. This includes any deductible, copayment percentage, coverage limitations and benefit maximums.

With the first Mail Order drug order, the Member should complete the member profile form found in the Mail Service brochure. Ask the Employer for a copy of this brochure.

Claims for health benefits and services provided to a Member will be processed within 30 days of the date the claim is received by Alta. If a claim decision cannot be made within the 30-day period, an extension of up to 15 days may be requested. Before the end of the initial 30-day period, Alta will send the Member written or electronic notice of the reason(s) for the delay.

Request for Additional Information

If the time to process a health claim is extended because the Member has not submitted requested information, the time period requirements for claim processing will be tolled from the date the notice of requested information is sent to the Member until the date Alta receives the Member's response. Alta will make a claim decision within 15 days after receipt of the requested information. Members should submit the requested information within 45 days of receipt of the request. If the Member does not respond within the 45-day period, the claim may be denied.

Life Insurance Benefits

The beneficiary should contact the Employer for the claim form. Proof of death must be sent to Alta. After the claim is processed, Alta will pay the amount of insurance (the death benefit) to the beneficiary(ies).

AD&D Benefits

You or your beneficiary should contact the Employer for the claim form.

If you or your beneficiary have not received your claim forms within 15 days after notifying Alta, you may file the claim as soon as you receive the claim forms from Alta. Failure to submit the claim forms on a timely basis does not invalidate or reduce any claims if such proof is furnished as soon as reasonably possible.

■ If A Claim Is Denied

If any insured benefits are denied the Member will be sent a written notice. This notice will state the reasons for the denial, the reference to the Plan provisions on which the denial is based and what is needed to complete the claim.

If any self-funded benefits are denied, in whole or in part, Alta will send the Member a written or electronic notice within the established time periods described in the section How to File Claims. The Member or Authorized Representative may appeal the denial as described below. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provision(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim appeal procedures and time limits, and the Member's right to bring civil action under ERISA section 502(a).

If the denial involves a health or disability claim, the notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Member upon request and at no charge.
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

For insured benefits, the Member must be given notice of claim denial within 60 days.

Appeal of a Denied Claim for Insured Benefits

The Member can request a review of any denied claim or the status of a pending claim by contacting the Benefit Payment Review Department located at Alta's Administrative Services Office in Greenwood Village, Colorado.

The Benefit Payment Review staff may consult with Alta's Law Department to assist them in the claims review process.

If a Member is not satisfied with the final disposition of the claims review process, the Member can initiate an appeal by giving written notice within 60 days after receipt of the written claim denial. This appeal must be filed before the Member may file a lawsuit

The Member or anyone authorized to act on the Member's behalf may appeal the claim and ask to examine any pertinent documents. The Member should submit in writing the reasons why the claim should not have been denied, as well as any other information, questions or comments.

Appeals must be submitted in writing to Alta.

The Member will be notified of the final decision within 60 days after receipt of a request for review. If special circumstances require an extension of time for processing, a further 30 days will be allowed.

Appeal of a Denied Claim for Self-Funded Benefits

After receiving notice of a claim denial, in whole or in part, the Member, beneficiary, provider or Authorized Representative can appeal by submitting a written request to Alta. The appeal will be reviewed by an individual *who was not involved in the prior adverse determination and is not a subordinate of the individual who made the prior determination.* An appeal includes the right to review and request copies of relevant documents, free of charge, and to submit issues and comments in writing.

An appeal of a health claim should be submitted within 180 days after receipt of a claim denial. If the first level appeal review results in an adverse determination, a request for a second level appeal review should be submitted within 60 days after receipt of the Level I appeal determination

Health Claim

To appeal a health claim denial, a written appeal request must be submitted to Health Claim Appeal, P.O. Box 22222, Fort Scott, KS 66701. The appeal request should include the Member's and the Employee's name and identification number, the date of service, address and telephone number of the Member and the provider, and a description of the appeal.

Health Claim Appeal

The Alta claim appeal process must be completed before a Member may bring civil action under ERISA for an adverse determination. (See Statement of ERISA Rights in the CLAIMS & LEGAL ACTION section of the booklet.)

- For appeal of a health claim that involves Medical Management, the first level of appeal is an internal review. The second level of appeal is an external review. The external review decision is binding on the Plan.
- For appeal of a health claim that does *not* involve Medical Management, both the first and second levels of appeal are subject to internal review. Voluntary appeals are available at the Member's request when new information is provided.

Each level of a health claim appeal will be processed within 30 days of the date the request for appeal is received by Alta.

In the case of an adverse decision of a health appeal, the notice will specify the reason(s) for the denial, the Plan provision(s) on which the denial is based and the Member's right to review and request copies of all relevant documents, free of charge, and the Member's right to bring a civil action under ERISA section 502(a).

The notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the adverse decision and that this information is available to the Member upon request and at no charge.
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

- that the Member and the Member's Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor office and the state insurance regulatory agency.

■ Final Appeals Process

For insured benefits, Alta has full discretion and authority to determine the benefits and amounts payable and to construe and interpret all terms and provisions of this booklet This provision applies only where the interpretation of this Policy is governed by the Employee Retirement Income Security Act (ERISA).

For self-funded benefits, the Plan Administrator has complete authority to control and manage the Plan. For initial claim determination, the Plan Administrator has full discretion to determine eligibility and to interpret the Plan. For claim appeals, the Plan Administrator has designated Alta as the appeals fiduciary. Alta will have full discretion and authority to interpret the Plan and to determine whether a claim should be paid or denied on appeal and according to the provisions of the Plan as set forth in this booklet

■ What If a Member Has Other Health Coverage?

A Member may be covered under more than one health plan. For example, coverage may be under this Plan and also under a group health plan sponsored by the Employee's spouse's employer. If this type of duplicate coverage occurs, this Plan uses a method called Coordination of Benefits (COB) to determine which plan pays benefits first on a claim (is primary) and which plan pays second (is secondary). Under COB, total payments from both plans will never be more than the expenses actually incurred.

The benefits provided by the plans listed below are considered in coordinating benefits:

- This Plan;
- Any other group insurance or prepayment plan, including automobile fault or no-fault insurance; Health Maintenance Organizations (HMOs); Blue Cross/Blue Shield;
- Any labor-management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan;
- Any government plan or statute providing benefits for which COB is not prohibited by law;
- Any individual automobile no-fault insurance plan.

Which Plan Is Primary?

Certain rules are used to determine which of the plans will be primary. This is done by using the first of the following rules that applies:

- A plan with no COB provision will determine its benefits before a plan with a COB provision.
- A plan that covers a person other than as a Dependent will determine its benefits before a plan that covers the person as a Dependent
- When a claim is made for a Dependent child who is covered by more than one plan, in most cases the birthday rule will be used to determine the order of benefits. Under the birthday rule:
  - the plan of the parent whose birthday falls earlier in a year will be primary; but
  - if both parents have the same birthday, the plan that covered the parent longer will be primary.

  However:
  - If the other plan does not have the birthday rule, then the plan that covers the child as a Dependent of the male parent will be primary.
  - If the parents are legally separated or divorced, benefits for the child will be determined in this order:
    * first the plan of the parent with custody of the child will pay its benefits;
    * then, the plan of the spouse of the parent with custody of the child will pay its benefits; and
    * finally, the plan of the parent not having custody of the child will pay its benefits.

    However, if there is a court decree stating which parent is responsible for the health care expenses of the child, then a plan covering the child as a Dependent of that parent will be primary.

If a court decree states that the parents have joint custody of the child, but does not specify which parent has responsibility for the child's health care expenses, benefits will be determined on the same basis as for a child whose parents are not separated or divorced.

- A plan that covers a person as:
  - a laid-off or retired employee; or
  - a Dependent of such an employee; or
  - a continuee under a state or Federal law;

  will determine its benefits after the benefits of any other plan covering that person as an employee.

  If one of the plans does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.
- When a claim is made for an Employee's Dependent who is also covered under Medicare and as a retiree under his employer's plan:
  - the plan covering the person as a Dependent will determine its benefits prior to Medicare; and
  - the plan covering the person as a retiree will determine its benefits after Medicare.
- If none of the above rules establishes the order of payment the plan covering the person for a longer period of time will be primary.

What If This Plan Is Primary?

If this Plan is primary, it will determine its benefits without considering other coverage. The Member should submit the claim first to the Benefit Payment Office listed on the claim form. When the explanation of benefits is received from this Plan, send it, along with the claim and itemized bills, to the secondary plan.

What If This Plan Is Secondary?

Submit the Member's claim first to the primary plan. After the other plan has determined its benefits, send the explanation of benefits from the other plan, along with the Member's claim, to the Benefit Payment Office listed on the claim form.

If this Plan is secondary, it pays the lesser of:

- the allowable expenses that were not reimbursed under the other plan; and
- the amount this Plan would have paid if there were no other coverage.

The COB provision is applied throughout the calendar year.

When the COB provision reduces the benefits payable under this Plan:

- each benefit will be reduced proportionately; and
- only the reduced amount will be charged against any benefit limits under this Plan.

A credit savings may be established if this Plan is secondary. A credit savings is the difference between the benefits this Plan would pay if there were no other coverage and the benefits this Plan actually paid. Credit savings may be used to provide 100% rather than partial payment of allowable expenses that are incurred by the same person within the same calendar year.

Allowable expenses for a Member are any necessary, usual and customary items of expense, at least part of which is covered under at least one of the plans covering the person.

Allowable expenses will not include the difference between the cost of a private Hospital room and a semi-private Hospital room unless the patient's stay in a private Hospital room is Medically Necessary.

When the benefits of a government plan are taken into consideration, the allowable expense is limited to the benefits provided by that plan.

■ How Will Benefits Be Affected By Medicare?

The following applies to you if you are an active Employee and you or your spouse becomes eligible for Medicare due to age. You and your Dependents will continue to be eligible for the benefits provided under this medical Plan. This Plan will coordinate benefits with Medicare. If:

- Your Employer employed at least 20 full-time or part-time employees during at least 20 calendar weeks of the preceding or current calendar year, then this medical Plan will be considered the Member's primary coverage, and Medicare will be considered the Member's secondary coverage. This means that benefits under this medical Plan will be payable first and then Medicare will determine the remaining expenses it will pay.
- Your Employer employed fewer than 20 full-time or part-time employees during at least 20 calendar weeks of the preceding or current calendar year, then Medicare will be considered primary, and this medical Plan will be considered secondary.

The following applies to you if you are an active Employee and you or your Dependents become eligible for Medicare **due** to **disability.** You and your covered Dependents will continue to be eligible for the benefits provided under this medical Plan. This Plan will coordinate benefits with Medicare. If:

- Your Employer employed at least 100 full-time or part-time employees during 50% or more of the Employer's business days during the previous calendar year, then coverage under this medical Plan will be considered the primary coverage, and Medicare will be considered the secondary coverage. This means that the benefits payable under this medical Plan will be payable first, and then Medicare will determine the remaining expenses it will pay.
- Your Employer employed fewer than 100 full-time or part-time employees during 50% or more of the Employer's business days during the previous calendar year, Medicare will be considered the primary coverage, and coverage under this Plan will be considered the secondary coverage.

If A Member Becomes Eligible for Medicare Due to End-Stage Renal Disease (ESRD)

Under Medicare law, a Member must complete a waiting period, typically three months, before becoming eligible for Medicare solely because of ESRD. During this waiting period, this Plan will pay benefits and Medicare will not pay any benefits.

After the waiting period, for the first 30 months of eligibility for Medicare Part A benefits solely due to ESRD, this Plan will pay its benefits first (primary payer) and Medicare will pay its benefits second (secondary payer). After that if the Member is still eligible for Medicare due to ESRD, Medicare will be the primary payer and this Plan will be the secondary payer

In certain circumstances, such as a kidney transplant, the 30-month time frame that this Plan will be the primary payer may be less as defined by the Medicare guidelines for determining primary payer

If the Member becomes eligible for Medicare due to ESRD after Medicare became the primary payer under any other provision of Medicare law or this Plan, Medicare will be the primary payer and this Plan will be the secondary payer.

Treatment must be rendered in a Medicare-approved facility in order to be covered under this Plan.

A Member is eligible for Medicare when:

- the Member is covered under Medicare; or
- the Member is not covered under Medicare due to:
  - the Member's refusal of Medicare coverage;
  - the Member's voluntary termination of Medicare coverage; or
  - the Member's failure to apply for Medicare coverage.

■ How Will Benefits Be Affected If a Member is Eligible to Receive Treatment in an Uniformed Services Facility?

A Member who is a uniformed services beneficiary is eligible to receive reimbursement under the Plan at the highest coinsurance level shown on the Summary of Benefits for the covered services provided by a uniformed services facility or provided indirectly by a federal government entity.

For benefits to be paid under this Plan, the Member is required to:

- disclose to the uniformed services provider, information about his or her coverage under the Plan and any pre-treatment requirements.
- make sure that the uniformed services provider calls Medical Management for pre-authorization and that the medical treatment has been approved by Medical Management.
- submit a claim for reimbursement of a prescription drug dispensed by the uniformed services facility. Some drugs may require prior approval.

■ Provision for Subrogation and Right of Recovery

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an Illness incurred by a Member (i.e. a Covered Person). A Covered Person is defined to also include the Member's legal representative.

An Other Party is defined to include, but is not limited to, any of the following:

- the party or parties who caused the Illness;
- the insurer or other indemnifier or guarantor or indemnifier of the party or parties who caused the Illness;
- the Covered Person's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage);
- a Workers' Compensation insurer;
- any other person, entity, policy or plan that is liable or legally responsible in relation to the Illness.

Benefits may also be payable under the Plan in relation to the Illness. When this happens, Alta may, at its option:

- subrogate, that is, take over the Covered Person's right to receive payments from the Other Party. The Covered Person will transfer to Alta any rights he or she may have to take legal action arising from the Illness to recover any sums paid under the Plan on behalf of the Covered Person;
- recover from the Covered Person any benefits paid under the Plan from any payment the Covered Person is entitled to receive from the Other Party.

The Covered Person must cooperate fully with Alta in asserting its subrogation and recovery rights. The Covered Person will, upon request from Alta, provide all information and sign and return all documents necessary to exercise Alta's rights under this provision.

Alta will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration, that the Covered Person receives or is entitled to receive from any of the sources listed above. This lien will not exceed:

- the amount of benefits paid by Alta for the Illness, plus the amount of all future benefits which may become payable under the Plan which result from the Illness. Alta will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- the amount recovered from the Other Party.

If the Covered Person:

- makes any recovery from any of the sources described above; and
- fails to reimburse Alta for any benefits which arise from the Illness;

then:

- the Covered Person will be personally liable to Alta for the amount of the benefits paid under this Plan; and
- Alta may reduce future benefits payable under this Plan for any Illness by the payment that the Covered Person has received from the Other Party.

Alta's first lien rights will not be reduced due to the Covered Person's own negligence; or due to the Covered Person not being made whole; or due to attorney's fees and costs.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on behalf of:

- an Employee's minor covered Dependent;
- the estate of any Covered Person; or
- on behalf of any incapacitated person.

■ Other Information A Member Needs to Know

Incontestability of Life Insurance and AD&D Benefits

After the Plan has been in force for 2 years, its validity can only be contested due to non-payment of premiums. During the first 2 years a Member is covered under this Plan, only a written statement signed by the Member can be used to contest the validity of the coverage. After the Member's coverage has been in force for 2 years during the Member's lifetime, no statement by the Member can be used to contest the validity of the Member's coverage.

Proof of Claim

Send written proof of claim to Alta within 90 days from the date of loss. Failure to furnish such proof within such time will not invalidate or reduce any claim if such proof was furnished as soon as reasonably possible.

Complaint Process

For concerns or complaints, call Member Services at (800) 663-8081. Whether the issue involves health care or the administration of coverage, Alta's representatives will do what they can to make sure it's addressed. No retaliatory action will be taken by Alta against the Member because of a complaint. Alta's goal is for the Member to be completely satisfied with the measures taken to resolve the issue. However, if a Member is not satisfied, Alta's representatives can help the Member begin the formal complaint process. If the issue is not resolved to the Member's satisfaction, the Member may appeal.

If the Member's complaint is in regard to:

- A preauthorization determination, see Medical Management (MM) Program, within the MEDICAL BENEFITS section.
- Timely claim payment or a denial of a claim, see How to File Claims, within the CLAIMS & LEGAL ACTION section.

For all other complaints, including those related to availability, delivery or quality of a health care service, contact Member Services for an explanation of the complaint process.

Payment Of Claims

Benefits payable under this Plan will be paid not more than 60 days after written proof of loss is received.

For life insurance, the death benefit will be paid to the beneficiary(ies).

For other benefits, the benefits will be paid to the Member, if living. If not, benefits will be paid to the Member's estate. If any benefit is payable to the Member's estate or to a person who cannot give a valid release, then Alta can pay up to $500.00 to any relative it considers to be entitled to such payment. The Member may request in writing that payments under the Plan be made directly to the person providing the services.

Legal Actions

A Member may bring a legal action to recover under the Plan. Such legal action may be brought no sooner than 60 days, and no later than 3 years, after the time written proof of loss is required to be given under the terms of the Plan. This applies only to AD&D benefits.

Physical Examinations

Alta, at its own expense, has the right to have the person for whom a claim is pending examined as often as reasonably necessary.

Autopsy

Alta may also have an autopsy done where it is not against the law. This applies only to AD&D benefits.

Benefit Payments to a Representative of a Minor

In the case of a minor child who otherwise qualifies as a Dependent under the Plan, if the child designates a representative, then the Plan must pay benefits on behalf of that child to his or her representative, even if that person is not covered under the Plan. The person must:

- Submit written notice that he or she is the representative of the child on whose behalf the claim is made; and
- Provide evidence that the person qualifies to be paid the benefits.

Relationship Between Alta and Network Providers

Providers under contract with Alta are independent contractors. Network providers are neither agents nor employees of Alta, nor is Alta, or any employee of Alta, an agent or employee of Network providers. Alta will not be responsible for any claim or demand on account of damages arising out of, or in any way connected with, any injuries suffered by the Member while receiving care from any Network provider or in any Network provider's facilities.

■ ERISA General Information

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA).

This summary plan description describes the benefits available to employees electing the PPO CA plan of Guarantee Records Managment, Inc , the Plan Sponsor/Employer

The address of the Plan Sponsor/Employer is 215 Coles St, Jersey City, NJ 07310. The telephone number is (201) 659-2801.

The Employer Identification Number (EIN) is 13-3468713. The Plan Number assigned by the Plan Sponsor is 501.

The Agent for Service of Legal Process is the Plan Trustee or the Plan Administrator, Allison Parker, HR Manager.

The Plan provides Life and AD&D Insurance, Medical, Dental Prescription Drug and Vision Benefits.

See the section, "About This Plan" for more information about the Insured and Self-Funded benefits.

Alia Health & Life Insurance Company provides Contract Administration.

The eligibility requirements, termination provisions and a description of the circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are described in this booklet.

Contributions are determined by the Employer. Employee contributions, if any, for a time period for which the Employee is not covered under the Plan may be refunded by the Employer. Please see your Plan Administrator for details.

The fiscal records of the Plan are maintained on the basis of Plan years ending December 31.

Claims

Procedures to be followed in presenting claims for benefits and what to do when claims are denied in whole or in part are described in the "How To File Claims" section of this booklet.

■ Statement of ERISA Rights

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Receive Information About Your Plan and Benefits.

  You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest Annual Report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

  You may obtain, upon written request to the Plan Administrator copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

  - You may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

  However, Employers with fewer than 100 Participants at the beginning of the Plan Year are not required to:

  - **furnish statements of the plan's assets and liabilities and receipts and disbursements or allow examination of the Annual Report; or**
  - **furnish copies of the Annual Report or any Terminal Report.**

- Continue Group Health Plan Coverage.

  You may be eligible to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or your Dependents may have to pay for such coverage. You may review this summary plan description and the documents governing the Plan or the rules governing your COBRA continuation coverage rights.

  There may be a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months if you are a late enrollee) after your enrollment date in your coverage.

- Prudent Actions by Plan Fiduciaries.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

- Enforce Your Rights.

  If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain without charge copies of documents relating to the decision and to appeal any denial, all within certain time schedules.

  Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in federal court In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- Assistance With Your Questions.

  If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GLOSSARY

The following defined terms have a special meaning with respect to the benefits outlined in this booklet On each page where they appear throughout this booklet they are capitalized.

Accident/Accidental Injury

A sudden and unforeseen event from an external agent or trauma, resulting in injuries to the physical structure of the body. It is definite as to time and place and it happens involuntarily or, if the result of a voluntary act, entails unforeseen consequences. It does not include harm resulting from disease.

Actively at Work

Employment on an active and full-time basis at the Employer's usual place of business.

Creditable Coverage

Coverage under a group health plan, individual health insurance coverage, Medicare, Medicaid or other public health plans, CHAMPUS, a medical program of the Indian Health Service or of a tribal organization or the Peace Corps, state health benefit risk pools and the Federal Employee Health Benefit Plan (FEHBP).

Dentist

A person licensed to practice dentistry.

Dependent

- Your legal spouse;
- Your domestic partner. Domestic partner means the person, regardless of gender, named in the Affidavit of Domestic Partnership that has been submitted and approved by the Employer;
- Any unmarried child under the age of 19; or

- An unmanied child under die age of 23 if he or she is a full-time student. Before paying a claim, the Plan may require proof diat dtis child is a fitll-time student.

For medical, prescription drug, dental and vision benefits, die age limits do not apply to a child who cannot hold a self-supporting job due to a permanent physical handicap or mental retardation if:

- die child becomes and remains handicapped while covered under the Plan; or
- die chtid vras covered under the Employer's prior plan diat diis Plan replaces.

At reasonable intervals, but not more often tiian annually, the Plan may require a Doctor's certificate as proof of die child's handicap.

"Physical handicap/mental retardation" means permanem physical or mental impainnem tiiat is a result of eitiier a congenital or acquired illness or injury leading to tiie individual bclng incapable of independent living.

"Pennanent physical or mental impairment" means:

- a physiological condition, skeletal or motor deficlt, or
- mental retardation or organic brain syndrome.

A non-permanent total disability where medical improvement is possible is not considered to be a "handicap" for die purpose of diis provision. This includes substance abuse and non-permanent mental impairuiems.

The term "child" means:

- Your dependent children. This means a step-child, adopted child or foster child.
- Any natural child of your covered minor Dependent.
- Any child of your domestic partner.

For a chtid to be considered a Dependent he or she must be chiefly dependent upon you for financial support. This requirement is waived if die child is eligible for coverage because of a Qualified Medical Child Support Order, or, if state law so requires, a non-qualifying court order or an administrative order of any state agency.

Your Dependents must live in die Urtited States to be eligible for coverage.

A person who is covered under tiiis Plan as an Employee may not be covered as a Dependent.

Doctor/Physician

A person licensed to practice medicine or osteopathy. This also includes any odier practitioner of the healing arts if:

- He or she performs a sen/ice within die scope of his or her license and for which diis Plan provides coverage; and

A "practitioner of die healing arts" includes a dentist (unless otiierwise defined in any Benefit Provision), a chiropodist, a chiropractor, an optometrist, a podiatrist, and a psychologist.

Employee

A person who is in die Service of die Employer and is a resident of die United States.

Employer

- Guarantee Records Managment, Inc.; and
- Any affiliated companies listed in the application of die Employer. The Employer may add an affiliated company after tiie effective date of the Plan. For diat company only, tiie effective date of tiie Plan wtil be considered to be die effective date of the amendment diat adds dial company.

Experimental or Investigational

A drug, tievice, medical ireaimem or procedure which:

- Cannot be lawfitily marketed widiout die approval of die Food and Drug Administration (FDA) or odier governmental agency and such approval has not been granted at the time of its use or proposed use; or
- Is die subject of a current investigational new drug or new device application on file widi die FDA; or
- Is being provided pursuant to:
  - A Phase I or Phase II clintical trial or as die experimental or research arm of a Phase III clinical trial; or

- A written protocol which describes among its objectives, determinations of safety, toxiclty, effectiveness, or effectiveness in comparison to conventional alternatives;

- Is bclng dclivered, or should be dclivered subject to the approval and supervision of an Instimtional Review Board (IRB) as required and defined by federal regulations particularly those of die FDA or the Departinent of Healdi and Human Services (HHS);
- In die predonuinant opinion among experts:
  - As expressed in die published, audiorihative literature, is substantially confined to use in research settings;
  - Is subject to furdier research in order to define safety, toxicity, effectiveness, or effectiveness compared widi conventional alternatives; or
  - Is experimental, investigational, unpraven or is not a generally acceptable medical practice; or
- Is not a covered service under Medicare because it is considered investigational or experimental as determined by tiie Healdi Care Financing Administration (HCFA) of HHS;
- Is provided concomitantly to a treatment, procedure, device or dmg which is experimental, investigational, unproven Treatinent; or
- Has not been performed at least ten (10) times and reported on in United States peer review medical literature.

The Medical Director may, in his/her sole discretion, determine diat a dmg, device, medical ireaunent or procedure which is deemed experimental or investigational under die above criteria, should nonetiicless not be deemed experimental or investigational.

Hospital

An institution licensed as a Hospital by the proper audiority of die state in which it is located. An institution recogrtized as a Hospital by die Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This does not include any institution diat is used primarily as a place for treatment of alcoholism or substance abuse, unless required by state law, a clinic, convalescent home, rest home, home for die aged, nursing home, custodial care facllity, or training center

Illness

An Accidental Injury, a bodily or mental disorder, a pregnancy, or any birth defect of a newborn child. Conditions diat exist and are treated at die same time or are due to die same or rclated causes are considered to be one Illness.

Medically Necessary

Any service or supply for diagnosis or treatment tiiat is:

- Prescribed by a Doctor to be necessary and appropriate; and
- Non-experimental or non-investigational; and
- Not in conflict widi accepted medical or surgical practices prevailing in die geographic area where, and at die time when, die service or supply is ordered.

To ensure that all Members receive an objective consideration, reviews are based on a variety of criteria. These criteria include relying on accepted medical standards, calting on Medical Management's experience in the review of medical care, and looking to Medical Management's team of providers for guidance.

Medical necessity does not include any service or supply tiiat is for die psychological support, education or vocational training of tiie Member Medical necessity does not include implant of any artificial organ for any reason whatsoever

Medicare

Tide 18 of die United States Soclal Security Act of 1965 as amended from time to time and tiie coverage provided under it. This includes coverage prayided under Medicare+Choice plans.

Member

An Employee and any covered Dependent.

Plan

Guarantee Records Managment, Inc. (die Employer) has established an Employee Welfare Benefit Plan widiin die meaning of die Employee Retirement Income Security Act of 1974 (ERISA). The benefits described in dtis booklet constitute benefits available under die plan and are refen ed to collectively in dtis booklet as "die Plan."

Proof of Good Health

Written evidence that the person meets Alta's general underwriting standards. Such evidence includes but is not limited to medical evidence.

Service

Work with the Employer on an active, full-time and full pay basis for at least 30.00 hours per week.

Totally Disabled and Total Disability

Life Insurance

Being under the care of a Doctor and prevented by Illness from working for pay or profit in any job for which you are or may become suited by reason of education, training or experience.

Employee Medical Benefits

Being under the care of a Doctor and prevented by Illness from performing your regular work.

Dependent Benefits

Being under the care of a Doctor and prevented by Illness from engaging in substantially all of the normal activities of a person of the same age and sex who is in good health.

You and Your

An Employee.

Approved as to Form and Legality

City Attorney

OAKLAND CITY COUNCIL

FILED
OFFICE OF THE CITY CLERK
OAKLAND

2012 JUN 14 PM 1:34

RESOLUTION NO._____C.M.S.

RESOLUTION TO WAIVE THE REQUEST FOR PROPOSAL/QUALIFICATIONS PROCESS FOR A CONTRACT EXTENSION WITH GRM INFORMATION MANAGEMENT SERVICES ("GRM") (FORMERLY SIMMBA SYSTEMS) IN AN AMOUNT NOT TO EXCEED ONE HUNDRED THOUSAND DOLLARS ($100,000) FOR THE CONTINUED RETENTION AND OFFSITE STORAGE OF CITY RECORDS FOR THE PERIOD OCTOBER 15, 2011 THROUGH FEBRUARY 15, 2013

WHEREAS, the City of Oakland recognizes the public need to maintain access to inactive records in a professional, cost effective, and efficient manner; and

WHEREAS, the City lacks the staff and support structure to operate this service with City employees, thus maintaining this contract for this service serves the interest of the economy; and

WHEREAS, the limited extension of the contract ensures that the City is able to comply with state and federal statutory requirements for providing information at the request of the public and organizations; and

WHEREAS, the limited extension of the contract provides for sufficient time to develop the documents for competitive bidding of the services in accordance with City Contracting requirements, and

WHEREAS, the City Council previously approved a contract with SIMMBA Systems, LLC by Resolution No. 75109 C.M.S. and Resolution No. 77481 C.M.S., and

WHEREAS, Oakland Municipal Code section 2.04.051.B permits the Council to waive the request for proposal/qualifications ("RFP/Q") process upon finding that it is in the best interest of the City to do so; and

WHEREAS, staff recommends that it is in the best interest of the city to waive the RFP/Q process so that the City can continue to maintain access to records and comply with state and federal statutory requirements for providing access to city documents; and

WHEREAS, the City of Oakland wishes to extend the agreement with GRM, in the amount not to exceed one hundred thousand dollars ($100,000) for the period October 15, 2011 to February 15, 2013; and

WHEREAS, the City Council finds that the contract shall not result in the loss of employment or salary by any person having permanent status in the competitive service; now therefore be it

RESOLVED, that for the reasons stated above and in the report accompanying this item and pursuant to Oakland Municipal Code section 2.04.051.B, the Council finds that it is in the best interest of the City to waive the RFP/Q process for the services to be purchased under the contract with GRM in an amount not to exceed $100,000, and so waives the requirements; and be it

FURTHER RESOLVED, that the Office of the City Clerk will proceed with preparation and issuance of competitive bidding for the services of retention and off-site storage of City records and will return to Council in the Fall of 2012; and be it

FURTHER RESOLVED, that the City Attorney shall review and approve as to form and legality all documentation with respect to this agreement.

IN COUNCIL, OAKLAND, CALIFORNIA, _____

PASSED BY THE FOLLOWING VOTE:

AYES – Brooks, Brunner, De La Fuente, Kaplan, Kernighan, Nadel, Schaaf, and President Reid -

NOES -

ABSENT -

ABSTENTION -

ATTEST: _____
LaTonda Simmons
City Clerk and Clerk of the Council
of the City of Oakland, California