
**COLLECTIVE BARGAINING
AGREEMENT**

Between

THE CITY OF SAN ANTONIO

And

**LOCAL 624 INTERNATIONAL
ASSOCIATION OF FIRE FIGHTERS**

October 1, 2005 through September 30, 2009

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PURPOSE OF AGREEMENT

It is the intent and purpose of this Agreement, entered into by and between the City of San Antonio, Texas, hereinafter referred to as the "City" or "Employer" and International Association of Fire Fighters Local 624 hereinafter referred to as the "Union" or "Bargaining Agent", to achieve and maintain harmonious relations between the parties, to establish benefits, compensation and other terms and conditions of employment and to provide for the equitable and orderly adjustment of grievances which may arise during the term of this Agreement.

ARTICLE 1.

RECOGNITION

The City recognizes the Union as the exclusive bargaining agent for all permanent paid employees of the City of San Antonio Fire Department, with the sole exception of the Chief of the Department. It is understood that this bargaining unit does not include civilian personnel, including Fire Fighter Trainees enrolled in the initial Fire Academy.

ARTICLE 2.

DEFINITIONS

1. "Employer" means the City of San Antonio.
2. "City" means the City of San Antonio.
3. "Union" means the International Association of Fire Fighters Local 624.
4. "Bargaining Agent" means the International Association of Fire Firefighters Local 624.
5. "Agreement" means the Collective Bargaining Agreement negotiated by and between the Employer and the Union.
6. "Employee" "Fire Fighter" "Bargaining Unit Member" means any full time, permanent, paid employee who has been hired in substantial compliance with Chapter 143 of the Local Government Code.
7. "Civil Service Commission" means the Firefighter and Police Officer Civil Service Commission of the City of San Antonio.
8. "Grievance" is defined as a dispute or disagreement involving the interpretation, application or alleged violation of any provisions of this Agreement, and/or, of any state or federal statute, rule, or regulation dealing with the employer/employee relationship, except as otherwise provided for herein.

9. "Probationary Period" means the twelve (12) month period immediately following the initial date of employment in the Department (excluding time spent on leave in excess of 30 consecutive days) in accordance with Chapter 143 of the Local Government Code.
10. "Regular Rate of Pay" means an employee's salary plus longevity, incentive, educational, and/or assignment pay.
11. "Chapter 143 of the Local Government Code" means Vernon's Texas Code Annotated, Local Government Code, Title 5, Matters Affecting Public Officers and Employees, Chapter 143, Municipal Civil Service.
12. "Base Pay" means an employee's monthly salary as shown in Article 13, Wages of this Agreement.
13. "Employee's Anniversary Date" shall mean the employee's date of employment (in the Academy) in the Department.
14. "Gender". Reference to the male gender throughout this Agreement shall have equal force and include reference to the female gender.

ARTICLE 3.

MANAGEMENT RIGHTS

Section 1.

The Union recognizes the management of the City of San Antonio and the direction of the Fire Department are vested exclusively in the City, subject to the terms of this Agreement, and nothing in this Agreement is intended to circumscribe or modify the existing rights of the City. These rights include:

- A. Direct the work of its employees to include the scheduling of overtime work.
- B. Hire, promote, demote, transfer, assign, and retain employees in positions within the City, subject to Civil Service regulations and/or terms of this Agreement.
- C. Suspend or discharge employees for just cause, subject to Civil Service regulations and/or the terms of this Agreement.
- D. Maintain the efficiency of governmental operations.
- E. Relieve employees from duties due to lack of work, subject to Civil Service regulations and/or the terms of this Agreement.
- F. Utilize the Fire Department in emergency situations to protect life and property.

G. Use civilians in the Fire Department to perform duties which do not require a sworn certified Fire Fighter. In this regard, the City is authorized to civilianize the following positions or units:

1. Fiscal Management
2. Personnel
3. Clerical
4. Emergency Management
5. Delivery
6. Fire Services/Vehicle Maintenance (with exception of not less than one (1) Fire Captain or higher position)
7. EMS Supply (provided the City hires a civilian that has some medical background and/or holds a paramedic certification.)
8. Building Maintenance
9. Information Systems
10. The Union recognizes the City's existing right to transfer personnel who currently are assigned to the Fire Marshall's Office, performing plan checking and review tasks for sprinkler and fire alarms, under the Uniform Building and Fire Codes. Neither the City nor the Union concedes any aspect of its position on civilianization with respect to other tasks or positions as a result of this compromise. This agreement will not be considered a precedent and is not admissible as evidence in any other controversy or proceeding involving civilianization.

Civilians performing duties which do not require a sworn certified Fire Fighter, and civilians performing duties civilianized pursuant to the position/unit list contained herein are not subject to the terms of this Agreement.

H. Determine the methods, processes, means, and personnel by which operations are to be carried out.

THE UNION UNDERSTANDS AND AGREES THAT:

Section 2.

A. Every duty connected with operations enumerated in job descriptions is not always specifically described; nevertheless, it is intended that all such duties relating to the present

mission and concept of the Fire Department, as a public safety organization of the City, shall be performed by the employees.

- B. The City shall have exclusive authority to transfer any City operation now conducted by it to another unit of government, and such transfer shall not require any prior negotiations or the consent of any group, organization, union or labor organization whatsoever. However, the City does agree that prior to any such transfer they will meet and confer with the Union and that the Union may register any objections they have with the City Manager and City Council.
- C. Except as otherwise specifically provided in this Agreement, the City, acting through the City Manager and the Fire Chief, shall retain all rights and authority to which by law it is their responsibility to enforce.

ARTICLE 4.

RULES AND REGULATIONS, SPECIAL DIRECTIVES AND ADMINISTRATIVE ORDERS

Section 1.

The Union recognizes the City's right to establish and enforce reasonable Rules and Regulations, Special Directives and Administrative Orders to conduct the mission of the Fire Department. Likewise, the City recognizes the responsibility of management to a consistent interpretation and application of such Rules and Regulations, Special Directives and Administrative Orders, which governs the conduct of employees on the job. The interpretation and application of Rules and Regulations, Special Directives and Administrative Orders shall be subject to the Grievance and Arbitration procedure.

Section 2.

- A. The parties established a joint committee which completed the revision and redrafting of the Department's Rules and Regulations and recommended the same to the Chief. The Union shall receive the Fire Chief's final proposal of the Rules and Regulations not less than 15 days prior to the Civil Service Commission meeting. If the Chief's final proposed Rules and Regulations differ from the committee's recommendation, the Union shall be entitled to inform the Commission of the differences of the two versions. The Rules and Regulations of the Department will be submitted by the Chief to the Civil Service Commission, and if approved, shall supersede all Department Rules and Regulations. The violation of one of said rules and/or regulations by an employee of the Department shall constitute "cause" for disciplinary action.
- B. If, as some time after the implementation of the Fire Department Rules and Regulations in reference in Section 2 (A) of this Article, the Fire Chief decides to revise a substantial portion of said Rules and Regulations, a joint labor-management committee shall undertake the revision of the Department's Rules and Regulations and recommend the same to the

Chief. The Union shall receive the Fire Chief's final proposal of the Rules and Regulations not less than 15 days prior to the Civil Service Commission meeting. If the Chief's final proposed Rules and Regulations differ from the committee's recommendation, the Union shall be entitled to inform the Commission of the differences between the two versions. The Rules and Regulations of the Department will be submitted by the Chief to the Civil Service Commission and if approved, shall supersede all Department Rules and Regulations.

- C. The City shall be obligated to provide each station and employee with a copy of the Rules and Regulations of the Department approved by the "Civil Service Commission". As Rules and Regulations, Special Directives, Temporary Orders, and/or Administrative Orders are promulgated and/or amended from time to time hereafter, a copy will be provided to the affected employee and to the Union. When providing a copy to the employee, acknowledgment of receipt shall be the burden of the superior officer.

Section 3.

It is mutually agreed by the parties that the rules and regulations of the Department and/or amendments thereto that are hereinafter approved by the Civil Service Commission shall be made a part hereof and therefore are not subject to Maintenance of Standards as provided for elsewhere herein.

ARTICLE 5.

CITY PROTECTION FOR FIRE FIGHTERS

Section 1.

The City will defend in or out of court any Fire Fighter who incurs a charge or lawsuit as a result of the lawful performance of his duties pursuant to the provisions of City guidelines as adopted and approved under City Ordinance No. 83927, passed and approved April 18, 1996, attached hereto and incorporated herein for all purposes as Attachment I, save and except Section 3 of said Ordinance which is revised to read as follows:

Defense and Settlement

- (a) The City will represent and defend any claim or suit against a Fire Fighter or former Fire Fighter that results from conduct performed in the course and scope of employment for the City occurring prior to termination of the Plan even if the suit is groundless or fraudulent except as follows:

1. The City has neither the duty to defend or indemnify the Fire Fighter if there has been a finding either by the City, through a disciplinary proceedings, internal investigation, or a Court of Law prior to suit being filed that the conduct of the Fire Fighter falls under an Excluded Action.

2. If in the course of defense of the lawsuit, the City identifies a potential conflict between the City and the Fire Fighter because there is a question of whether the conduct of the Fire Fighter falls under an Excluded Action, the City will select and pay for a separate defense of the Fire Fighter with a reservation of rights letter identifying the potential conflict and limits of indemnification.

3. The City's determination shall be final with respect to both representation and indemnification of the Fire Fighter. However, if defense has been denied and the member is successful in his defense of the claim, the City will reimburse reasonable legal expenses incurred by the member.

(b) The City will notify the Fire Fighter of any potential for a judgment against the Fire Fighter in excess of the City's indemnification obligations, The Fire Fighter may hire, at the expense of the Fire Fighter, the Fire Fighter's own attorney in addition to the provided counsel to protect against any personal liability above the indemnification limits. The provided counsel will, however, remain lead attorney. And any attorney's fees thus accrued are the responsibility of the Fire Fighter and will not be reimbursed.

(c) The City may investigate, negotiate, or settle any claim as the City determines necessary or appropriate.

(d) Said representation and defense of the Fire Fighter, as provided in Sections 1 through 3 above, shall be done in accordance with Ordinance No. 83927, passed and approved April 18, 1996, attached hereto and incorporated herein for all purposes as Attachment I.

Section 2. The City will seek to recover for damaged or lost property of any employee in any suit or claim that is asserted by the City as to its public property, pursuant to procedure established by the Chief and the City Attorney. It is our understanding that the ordinance adopting the proposed contract will reference the HAZ-MAT ordinance. The purpose of this section is to enhance and broaden its range of coverage. The ordinance authorizing execution of this contract will amend the existing HAZ-MAT ordinance to authorize such action by the City Attorney.

ARTICLE 6.

UNION ACTIVITY

Section 1. Union Activity on Department Property.

Union members or officers shall not conduct Union business on City time except as specified by this Agreement or as further authorized by the City Manager or the Fire Chief. The Union may hold meetings pertinent to Union business on Fire Department property, provided that

permission for such meeting is obtained in advance from the Fire Chief or his designated representative.

Union officers and committee members may conduct Union business on City time at their work location as long as such business does not interfere with their Fire Department duties.

Notwithstanding the provisions hereof, political activity shall not be conducted by the Union or any of its members on City time and/or Fire Department property pursuant to this Section.

The determination by the Fire Chief that Union meetings on Fire Department property or the work of an individual Union member on City time as provided herein shall be binding unless or until it has been determined through the Grievance Procedure found in Article 30 , of this Agreement that the Chief has unreasonably exercised his authority granted pursuant to this Article. The Union will be allowed a scheduled four (4) hour orientation class with Fire Cadets within the first two (2) weeks of entering the Fire Academy. The Union shall submit an outline of their presentation to the Chief in advance.

Section 2. Negotiating Committee.

A maximum of three (3) members of the Union Negotiating Committee shall be granted time off with pay (excluding additional pay) for the purpose of attending negotiating meetings between the City and the Union when such meetings occur during the regularly scheduled working time of the employees. Time off shall only be for reasonable transportation time to and from the meeting site, direct route, and the actual time required in the meeting itself. An employee on such administrative leave shall be compensated as though the employee was at work on his regularly-scheduled assignment so that the employee will suffer no reduction in his normal, weekly pay for having participated in negotiations (and/or meetings directly relating thereto and actual travel time--direct route--to and from said meetings) at his regular rate of pay and applicable scheduled FLSA overtime.

Section 3. City Facilities.

Nothing in this Article is intended to prohibit or prevent the Union from utilizing City facilities, available to private organizations on a rental basis, under the same conditions that they are made available to other such private organizations.

Section 4. Union Leave Pool.

A. Effective the first full pay period after October 1, 2002, in accordance with Article 17, Section 2, three (3) additional hours vacation leave per filled Firefighter position per year will be deducted to establish and maintain a pool of leave hours. This leave will establish a pool of paid time to be granted to individuals selected by the Union to conduct Union business hereinafter referred to as "Union Leave." Leave usage will be governed by the following guidelines:

1. No carry over of leave pool hours.

2. Limit to the number of persons off any given time: Fire-3, EMS-2, and 1 each from Services, Arson, Fire Prevention, Training, and Communications.
3. Limit to the number of persons off per Firefighting company-1.
4. Not more than six (6) persons off at the same time.
5. Leave increment must be equal to or greater than eight (8) hours for Firefighting or EMS divisions and four (4) hours for all forty (40) hour divisions.
6. Where leave increments are above the minimum hours, said increments must be not less than two (2) hours.
7. Request for leave must be made by the Union President or his designee.
8. Request for leave must be directed to the Fire Chief or his designee, via e-mail or fax.
9. Request for leave must be received at the Fire Chief's Office prior to 12:00pm, (noon), of the shift prior to the shift of leave usage.
10. Request for leave must be in writing, signed by the Union President or his designee, include the names and assignments of employees selected to be on Union Leave and indicate the duration of leave requested for each employee.
11. Employees participating in initial specialized training, (Paramedic or Arson), shall not be authorized to utilize Union Leave while participating in said training.
12. The number of hours an individual employee may be off on Union Leave in any given calendar year shall be limited as followed: Treasurer, 1st Vice-President, Grievance Chair, Legislative Chair, and PR Chair-20% of their scheduled annual hours; All other members-10% of their scheduled annual hours.
13. The Fire Chief may deny a request for Union Leave where said request is for an employee assigned to the following positions: Special Projects, Professional Standards, Personnel, Training, Services, Fire Prevention, Arson, Special Teams Coordinator, Safety Officer, and personnel performing special projects receiving higher classification. However, members of the Union Executive Board in any such position shall be subject to Section 4.A.14. of this Article.
14. The Fire Chief may deny a request for Union Leave where approval of said request would be operationally detrimental to the Department. In the event that the Chief denies such a request, the Union may request the reason for the denial. If this occurs the Fire Chief shall explain the reason for said denial in writing.
15. The Fire Chief retains the right to recall employees to duty during an emergency or special event involving an overriding need for protection of the citizens of San Antonio.

B. Nothing in this Article has any effect on rights and prerogatives of the Union, employees, or the Fire Chief with respect to employees attending meetings, conventions, conferences, seminars, or other Union functions on the employee's own time or Union lay-off time.

Section 5. Bulletin Boards.

The City shall allow the Union to use the Fire Department bulletin board at each location. These boards shall be used only for the following notices:

- a. Recreation and Social Affairs.
- b. Union Meetings.

- c. Union Elections.
- d. Reports of Union Committees.
- e. International Association of Fire Fighters and State Association Notices.
- f. Legislative enactments and judicial decisions affecting employees.
- g. Minutes of Union meetings which do not violate the provisions of the following paragraph.
- h. Shall not contain any personal caricatures.
- i. Union endorsements of political candidates shall be in accordance with the provisions of the following paragraph:

Notices of announcements, including reports of Union committees shall not contain anything reflecting upon the City, any of its employees, or any labor organizations among its employees. The notice of Union endorsement of political candidates shall consist of a simple, straight-forward listing of the candidates, without editorializing their merits and void of any remarks about their opponents.

The Union President or his designated representative shall be responsible for the contents of the above notices; any violation of the provisions of this article shall entitle the City to revoke this concession and such revocation is subject to the grievance procedure.

Section 6. Radio, MDT, and Electronic Mail Announcements.

The Union will be allowed use of these medias for the purposes of pertinent information, i.e., Union Meetings, Special Announcement, etc. All announcements shall first be approved by the Chief or his designee, which approval shall not be unreasonably withheld if the announcement complies with the provisions of Section 5 above.

Section 7.

The City agrees to provide the Union President with the written copy of announcements intended for dissemination generally to department employees. Copies of such announcements shall be placed in a mail slot to be maintained for the Union President at the Department's Administrative Offices.

ARTICLE 7.

PAYROLL DEDUCTIONS

Section 1. Union Dues.

The City agrees that on each pay day, it shall deduct Union dues from each member of the Union in the amount certified to be current by the Financial Secretary of the Union and the Director of Finance. Dues shall be set in accordance with the Constitution and By-laws of the Union and shall be authorized by each member pursuant to state law. The President and Financial Secretary shall notify the Director of Finance in writing of any certified dues increase election. Within thirty (30) days following notification of approval, the City shall change dues deductions to the notified amount.

Section 2. Special Assessments.

With the sole exception of the Union's death benefit, the City shall deduct special assessments which are duly authorized pursuant to the Constitution and By-laws of the Union and are voluntary and individually authorized by the member. A single authorization shall be utilized for all deductions of the death benefit.

Section 3. Indemnification.

The City will be obligated to remit to the Union only those sums deducted as dues and assessments pursuant to this Section. The Union agrees to promptly refund to the City any amount paid to it in error upon presentation of satisfactory proof by the City. The Union agrees to indemnify, and hold the City harmless from any cause of action instituted by any individual as a result of the City's deduction of dues and special assessments.

Section 4. Application.

This Article shall apply only to payroll deductions authorized for the payment of dues and fees to Local Union No. 624, to the exclusion of any other organization or of deductions for any other purpose provided, however, that no present deduction will be changed or affected.

Section 5. Administrative Fees.

The City shall have the right to charge an administrative fee to recover the cost associated with the administration of any new special assessment(s) or deduction(s) implemented after the effective date of this Agreement requested by the Union. This shall not apply to existing Union dues and PAC contributions. It is also understood and agreed that an increase or decrease in Union dues and/or PAC contributions are not a change under this paragraph. The Director of Finance shall have the right to develop such fee and amend it annually based on any change in the cost of administration. The City shall notify the Union of any change in the administrative charge at least thirty (30) calendar days prior to the implementation of the change. Such administrative charge shall be withheld from the amount collected and remitted to the Union.

The fee shall include the actual cost to set up each deduction plus 15 percent, not to exceed \$300.00.

ARTICLE 8.

SPECIAL ASSIGNMENT OF UNION PRESIDENT

The City agrees that the President of the Union will be placed on special assignment during the term of his presidency. The special assignment will give the Union President the latitude to deal with the duties of his presidency while retaining the privileges of his employment, while the Fire Chief retains the right to recall him to duty during an emergency or special event involving an overriding need for the protection of the citizens of San Antonio.

The Fire Chief reserves his existing authority to revoke special assignment for the Union President during emergencies or when the welfare of the citizens of San Antonio is placed in jeopardy. The Union President, as part of his Union duties, reserves the right, as in the past, to mitigate grievances at all informal and formal levels in order to reduce the number of complaints and, in all cases, reserves the right to speak, visit with the men and women who are members of the Union, as well as to tour existing fire facilities and to review existing equipment toward the goal of improving the quality of worklife for the Fire Fighters of the City of San Antonio whom he represents. In addition, he will participate as the duly-elected representative of men and women of the Union in any discussion that may affect the quality of worklife, health, and well-being of any Union member.

It is understood that the President of the Union shall suffer no loss of longevity, seniority, pension, days off, or any other benefits as a result of and during the term of such special assignment. Provided, however, the President shall be entitled to educational and/or certification pay, if applicable, but shall not be entitled to premium assignment or incentive pay (i.e., overtime) unless directed by the Chief to perform Fire Fighter duties that call for payment of said premium pay. When the term of the President expires, the President shall be eligible to return to his previously-assigned shift and duty assignment, provided any certificate that is required has been maintained.

ARTICLE 9.

MAINTENANCE OF STANDARDS

All standards, privileges and working conditions enjoyed by the City of San Antonio Fire Fighters at the effective date of this Agreement, which are not included in this Agreement shall remain unchanged for the duration of this Agreement.

ARTICLE 10.

NO STRIKES, NO LOCKOUTS

The Union shall not cause, counsel, or permit its members to strike, slow down, disrupt, impede or otherwise impair the normal functions of the Department, nor to refuse to cross any picket line by whomever established, where such refusal would interfere with or impede the performance of the employee's duties as an employee of the City. The City shall not lock out any employee.

ARTICLE 11.

NON-DISCRIMINATION

Section 1.

Both the City and the Union agree that neither shall willfully discriminate against any employee, member, or prospective member, because of race, color, religion, national origin, sex, age, or disability if otherwise qualified to fulfill the duties of the position.

Section 2.

Alleged violations of Section 1, as well as claims of discrimination made under Federal and/or State law, shall not be subject to the grievance/arbitration procedures of this Agreement.

ARTICLE 12.

LABOR MANAGEMENT RELATIONS

Section 1.

The Chief of the Department and the President of the Union shall meet monthly (if requested by either) for the purpose of conferring over issues relating to labor relations, health and safety, and other such matters. Neither shall be required to meet unless a minimum of seven (7) calendar days advance notification be made, in writing, stating the purpose of the meeting and the topics to be discussed.

Section 2.

In the interest of Labor/Management relations, the Chief of the Department and the President of the Union shall convene a Labor/Management Committee Meeting at either party's request. The Fire Chief shall grant administrative leave for up to three (3) committee members. The Union President shall designate personnel for administrative leave that will not create higher classification pay. This shall apply to no more than one (1) meeting per month. Nothing herein shall preclude the Fire Chief and Union President from having additional labor/management meetings. However, these additional meetings shall not be applicable to the administrative leave

allowed herein. At no time shall more than one (1) committee member be qualified for this administrative leave from each of the following Divisions/Sections: Fire Suppression, EMS, Communications, Fire Prevention, Training, Services and Arson. Employees that are on duty and requested by the President to attend such meetings shall be allowed to continue to utilize Union lay-off time. Committee members who are not on duty shall attend on their own time.

Section 3.

The parties hereto shall be authorized to jointly appoint other necessary committees with specific goals and objectives of mutual benefit and concern, including, but not limited to, a vehicle accident committee, occupational safety and health committee, and such other committees as the parties shall choose to establish.

Section 4.

Any committees designated shall meet at times and places authorized by the Chief so as to cause the least possible interference with existing duties. Every reasonable effort will be made to schedule meetings at times agreeable to all members of the Committee. The work of said committees shall be conducted on City time without loss of pay by committee members; except that meetings which are scheduled at times when Union members who work shifts are not on duty, such employees shall attend on their own time.

Section 5.

In addition to the establishment of committees, the Chief and the President shall be at liberty to discuss pending grievances and/or issues of mutual interest and/or concern, even where the same involves an individual claim or claims of one or more employees of the Department.

Section 6.

This Article shall not impair the Chief's rights under Article 3. Management Rights.

ARTICLE 13.

WAGES

Section 1. Wages.

The parties have agreed to the following pay increases during the term of this agreement. These increases are reflected in the wage charts below.

October 1, 2005: 2.5%

October 1, 2006: 2.9%

October 1, 2007: 5%; with FAO Step Adjustment

October 1, 2008: 5%

Section 2. Monthly Base Salaries.

Fire Fighter Rank Step Schedule.

- Step A - Fire Fighters, from Probation through eighteen (18) months after date of employment.
- Step B - Fire Fighters, from the 19th month after date of employment through completion of 60th month after date of employment.
- Step C - Fire Fighters, from the 61st month after date of employment until eligible for Fire Fighter Step D.
- Step D - Fire Fighters with at least ten (10) years seniority in rank and an Associates Degree or higher or Fire Fighters with fifteen (15) years seniority in rank shall be eligible for Fire Fighter Step D.
- Step E - Fire fighters with at least fifteen (15) years seniority in rank and an Associates Degree or higher or Fire Fighters with twenty (20) years seniority in rank shall be eligible for Fire Fighter Step E.

	<u>Step A</u>	<u>Step B</u>	<u>Step C</u>	<u>Step D</u>	<u>Step E</u>
Effective 10/01/05	\$3,438	\$3,816	\$3,889	\$3,967	\$4,046
Effective 10/01/06	\$3,538	\$3,927	\$4,002	\$4,082	\$4,163
Effective 10/01/07	\$3,714	\$4,123	\$4,202	\$4,286	\$4,371
Effective 10/01/08	\$3,900	\$4,329	\$4,412	\$4,500	\$4,590

Fire Apparatus Operator (FAO) Rank Step Schedule

- Step A - FAOs with less than five (5) years seniority in rank.
- Step B - FAOs with five (5) or more years of seniority in rank.
- Step C - FAOs with at least five (5) years seniority in rank and an Associates Degree or higher or FAOs with ten (10) years seniority in rank shall be eligible for the FAO Step C.
- Step D - FAO's with at least ten (10) years seniority in rank and an Associates Degree or higher or FAOs with fifteen (15) years seniority in rank shall be eligible for the FAO Step D.

	<u>Step A</u>	<u>Step B</u>	<u>Step C</u>	<u>Step D</u>
Effective 10/1/2005	\$4,183	\$4,263	\$4,267	\$4,352
Effective 10/1/2006	\$4,304	\$4,387	\$4,391	\$4,478
Effective 10/1/2007	\$4,520	\$4,606	\$4,698	\$4,792
Effective 10/1/2008	\$4,746	\$4,836	\$4,933	\$5,032

Lieutenant Rank Step Schedule

Step A - All Lieutenants not eligible for Lieutenant Step B.

Step B - Lieutenants with at least five (5) years seniority in rank and an Associates Degree or higher or Lieutenants with ten (10) years seniority in rank shall be eligible for Lieutenant Step B.

	<u>Step A</u>	<u>Step B</u>
Effective 10/1/2005	\$4,782	\$4,878
Effective 10/1/2006	\$4,920	\$5,019
Effective 10/1/2007	\$5,166	\$5,270
Effective 10/1/2008	\$5,425	\$5,534

Captain Rank Step Schedule

Step A - All Captains not eligible for Captain Step B.

Step B - Captains with at least five (5) years seniority in rank and an Associates Degree or higher or Captains with ten (10) years seniority in rank shall be eligible for Captain Step B.

	<u>Step A</u>	<u>Step B</u>
Effective 10/1/2005	\$5,466	\$5,575
Effective 10/1/2006	\$5,625	\$5,737
Effective 10/1/2007	\$5,906	\$6,023
Effective 10/1/2008	\$6,201	\$6,325

District Chief Rank Step Schedule

Step A - All District Chiefs not eligible for District Chief Step B.

Step B - District Chiefs with at least five (5) years seniority in rank and a Bachelors Degree or higher or District Chiefs with ten (10) years seniority in rank shall be eligible for District Chief Step B.

	<u>Step A</u>	<u>Step B</u>
Effective 10/1/2005	\$6,257	\$6,382
Effective 10/1/2006	\$6,438	\$6,567
Effective 10/1/2007	\$6,760	\$6,895
Effective 10/1/2008	\$7,098	\$7,240

Section 3. Longevity.

In addition to wages as set forth in the pay schedule above, each Fire Fighter's base pay shall be increased by three percent (3%) for each five (5) years of his longevity, to a maximum of thirty

(30) years, i.e., a thirty-year veteran would receive an additional payment not to exceed eighteen percent (18%). On each Fire Fighter's anniversary date which is not a multiple of five (5), he shall receive an eight dollar (\$8.00) increase in his longevity pay per month, and the eight dollar (\$8.00) interim monthly adjustments will not increase any fifth year levels. The eight dollar (\$8.00) payment as noted herein shall be in lieu of the four dollar (\$4.00) per month per year of service payment called for in Chapter 141.032 Local Government Code.

ARTICLE 14.

OVERTIME

Section 1.

All employees shall be paid at the rate of time and one half (1-1/2) that of their regular rate of pay for all hours worked over their regular scheduled working hours.

Section 2.

All employees who are called back to work when they are off duty shall be paid a minimum of two (2) hours at time and one-half (1-1/2) and shall be paid at the rate of time and one-half (1-1/2) for all hours worked over two (2) hours.

Section 3.

All Fire Suppression employees who are assigned a fifty-six (56) hour work week schedule shall receive time and one-half (1-1/2) their regular rate of pay for all hours worked in excess of one hundred fifty nine (159) hours per twenty-one (21) day work cycle. Accordingly, for each additional hour, or portion thereof, actually worked by said employee in excess of one hundred fifty nine (159) hours during the twenty-one (21) day cycle, that employee shall receive overtime pay based on the following: 1.5 times the number of hours actually worked in excess of 159 hours times the quotient of 159, divided into the employee's three week gross regular salary. Under a twenty-one (21) day cycle, each employee shall lose no more than twenty-seven (27) hours of overtime pay per year as a result of scheduled vacation leave being counted as productive time for F.L.S.A. purposes. For the purpose of computing eligibility for F.L.S.A. overtime and application of the twenty-seven (27) hour limit in this paragraph, all other types of leave will take priority over vacation leave in application of this provision (i.e. when vacation and any other form of leave is used in the same 21 day cycle, the loss of F.L.S.A. overtime shall not apply to the twenty-seven (27) hour maximum. It is intended that a Firefighter will lose only one cycle of F.L.S.A. overtime per scheduled vacation, even if a vacation period splits two cycles. F.L.S.A. overtime will be charged against the first three (3) vacation periods taken in that calendar year. Employees shall, however, be allowed to exempt use of one shift of sick leave and/or military leave each calendar year from the provisions of this paragraph.

Section 4.

When two or more types of overtime or premium compensation are applicable to the same hours of work, only the higher rate(s) of compensation shall be paid. In no event shall overtime or premium compensation be pyramided.

ARTICLE 15.

HOURS

Section 1. General.

The following shall be the regular established work schedule for the employees covered by this Agreement and shall remain in effect, except that the Chief may make no more than one change per section per contract, and then only after sixty (60) days notification in writing to the Union unless exemption to notification is provided herein. Any additional changes must be made by mutual consent between the City and the Union. During a sixty (60) day notification period, the Union shall be given the opportunity to meet and confer with the Chief and register any objection it may have to the change of hours.

Section 2. Emergency Medical Technicians (Regular) and Communications.

Emergency Medical Technicians and Emergency Medical Service Communications Division personnel shall work the following regular hours.

- A. An average 42 hours work week.
- B. The work period is four (4) consecutive weeks or twenty-eight (28) days beginning at 7:00 a.m. Sunday and ending twenty-eight (28) days later. The work shift shall begin at 7:00 a.m. and end at 7:00 a.m. the following day, consisting of twenty-four (24) consecutive hours.

42 Hour Work Week - Schedule for One Employee

S	M	T	W	TH	F	S
17	7	OFF	OFF	17	7	OFF
OFF	17	7	OFF	OFF	17	7
OFF	OFF	17	7	OFF	OFF	17
7	OFF	OFF	17	7	OFF	OFF

One (1) work shift shall equal two (2) twelve (12) hour working days for administrative purposes (sick leave, annual leave, disciplinary action, military leave, etc.)

Personnel may not work more than twenty-four (24) continuous hours, except if personnel are on a response at shift change. Personnel must have twenty-four hours off prior to working. This applies to overtime and trading time.

Vacation scheduling must be equalized throughout the year.

- C. The Chief shall have the right to schedule a separate group of employees on a power shift schedule provided that the schedule does not exceed an average forty-two (42) hour work week. No individual power shift work shift shall exceed twelve (12) hours. No more than four (4) power shift work shifts will be scheduled in any seven (7) calendar day week period. The Chief's right to implement such a shift shall be limited to or by the following conditions:
1. The Fire Chief and the Union shall negotiate on the specific shift schedule to be implemented and the impact of such a schedule. In the event the Fire Chief and the Union do not reach a full agreement on the schedule, the unresolved issues shall be submitted to a binding arbitration procedure as provided in the statutory provision of Sections 174.154, 174.155, and 174.157 through 174.164 (Texas Local Government Code) as such sections exist at the date of this contract. No other provisions in said Chapter shall be applicable to the partial re-opener provided for in this Article;
 2. Additional EMS units must be placed into service by the City beyond twenty-three (23) units prior to establishing a permanent power shift schedule pursuant to this section; and
 3. All slots must represent new positions, and shall be filled from volunteers, or from promotions.

Each paramedic actually working a power shift schedule pursuant to this section and on a straight time basis for one-half (1/2) or more of any calendar month shall be entitled to shift differential pay in the amount of \$350 for the full month. No partial payment shall be made for working less than one-half (1/2) of the calendar month. Time taken by an employee on Sick Leave or LOD Leave while assigned to a power shift work schedule shall not be counted as time working for the purpose of eligibility to receive shift differential pay.

Nothing in this section shall preclude the Fire Chief from establishing or continuing any power shift or peak period staffing schedule on an overtime basis.

Section 3. Specified Employees in the Fire Department Repair Shops.

For employees assigned to the Fire Department Repair Shops, the work day shall begin at 7:45 a.m. and end at 4:30 p.m. each work day, Monday through Friday, with forty-five (45) minutes for lunch, and two (2) 15 minute breaks, one (1) in the morning and one (1) in the afternoon.

Section 4. Fire Fighting.

Employees assigned to the Fire Fighting Division or Aviation Division, shall work the following regular hours:

An average fifty-six (56) hour work week. The work period is three (3) consecutive weeks or twenty-one (21) days beginning at 12:00 noon Sunday and ending twenty-one (21) days later.

- G. Arson investigators who are mandated to serve on scheduled stand-by shall be compensated at the rate of two (2) hours of overtime pay or actual time worked, whichever is greater. This provision applies whether or not the employee is actually called back to work.

Section 6. Employees Assigned to Specialized Training.

- A. Employees assigned or detailed to Emergency Medical Training shall have their hours scheduled at the discretion of the Emergency Medical Service Director as long as the scheduled hours do not exceed a forty (40) hour work week over the duration of the training period. The Emergency Medical director may implement any schedule, provided that it is in accordance with and permitted by the provisions of the Fair Labor Standards Act, and any regulations thereunder.
- B. Employees assigned or detailed to specialized training, i.e., HazMat, National Fire Academy, E.M.T., etc., shall not lose any of their standard rate of pay, i.e., F.L.S.A. overtime, as per their regular assignment. Total hours worked may not exceed current F.L.S.A. cycle average and such employee's schedule will be adjusted to compensate for reasonable travel (most direct route and most expedient mode) and class time required while on specialized training.
- C. Employees assigned or detailed to Paramedic Training are considered part of the E.M.S. Division and are covered by F.L.S.A. guidelines relative to a forty (40) hour work week.

Section 7. Airport Coordinator, and Other Uniformed Employees.

- A. Airport Coordinator and all other uniformed employees not specifically mentioned before shall work the following hours: A forty (40) hour work week, Monday through Friday, beginning at 7:45 a.m. and ending at 4:30 p.m. each day, with forty-five (45) minutes for lunch and two (2) fifteen (15) minute breaks, one (1) in the morning and one (1) in the afternoon.
- B. With regards to any of the employee groups mentioned in A. above, the Fire Chief may, at his discretion, authorize a four (4) day work week. In such an event, said employees shall be scheduled to work a forty (40) hour, ten (10) hours per day, four (4) day work week from 7:00 a.m. to 5:00 p.m., which 4-day period shall be scheduled between Monday and Friday.
- C. The Fire Chief's decision to authorize a 4-day work week to any or all of the employee groups mentioned in A. above, shall not constitute the "one change per section per contract" provision specified in Section 1 of this Article.

Section 8. Fire Prevention

- A. Fire Marshall, Operational Employees (inspectors) and Administrative Employees shall work a forty (40) hour work week, Monday through Friday, beginning at 7:45 a.m. and ending at 4:30 p.m. each day, with forty-five (45) minutes for lunch and two (2) fifteen (15) minute breaks, one (1) in the morning and one (1) in the afternoon.

- B. Effective during fiscal year 2007-2008, the Fire Chief shall implement a four (4) day work week in Fire Prevention for operational employees (inspectors) pursuant to subsection C below. Administrative employees in Fire Prevention shall continue with a forty (40) hour, five (5) day, eight (8) hour work day schedule.
- C. In such event, said employees referenced in subsection B shall be scheduled to work a forty (40) hour, ten (10) hours per day, four (4) day work week, which fall between the hours of 6:00 a.m. and 6:00 p.m., which 4-day period shall be scheduled between Monday and Friday. Employees under such schedule shall be entitled to a thirty (30) minute lunch break under the same provision in Section 5(D). Once the Chief has initially established the schedule, he/she may change the schedule once during this contract term.
- D. The Fire Chief's decision to authorize a 4-day work week to any or all of the employee groups mentioned in A. above, shall not constitute the "one change per section per contract" provision specified in Section 1 of this Article.

Section 9. Transfer from One Shift Schedule to Another.

An employee who is transferred and, as a result, changes from one shift assignment to another (e.g., twenty-four (24) hour shift to eight (8) hour shift) shall have a minimum of eighteen (18) hours off from the time he completes his last shift on his original schedule until the time he must report for duty on the new schedule to which he is assigned. No overtime shall accrue to any individual transferred in conformance with this section.

Section 10. The provisions of this Article can be changed by mutual agreement between the City and the Union.

ARTICLE 16.

WORKING OUT OF CLASSIFICATION

- A. An employee who works in a higher classification shall be paid at the higher classification rate of pay for actual time worked in that classification.
- B. The assigned FAO who works as a District Chief Aide shall be paid at the higher classification rate of pay for actual time worked only in the absence of a District Chief.

It is intended that higher classification pay be given to the FAO that is assigned as a District Chief's Aide only when the District Chief is off on some type of leave (i.e., vacation, sick leave, administrative leave, etc.) or upgraded to Assistant Chief and a Captain is receiving higher classification pay for performing the duties of the District Chief. The contractual wording, "...in the absence of the District Chief..." does not include time where the District Chief is not in physical proximity of the Aide but is otherwise on-duty and not being replaced by a Captain.

ARTICLE 17.

VACATIONS

Section 1. Vacation Accrual.

Non-Forty Hour Employees: The following is a vacation accrual schedule which shall be implemented for non-forty hour employees covered by this Agreement: Employees will accrue vacation days according to the following schedule, minus any vacation days previously borrowed.

Beginning of Probation through 10 years of completed Service - 15 days.

Beginning 11th year through 15th year of completed Service - 18 days.

Beginning 16th year of Service - 20 days.

Effective September 1, 2009:

Beginning of Probation through 10 years of completed Service – 15.25 days.

Beginning 11th year through 15th year of completed Service – 20.25 days.

Beginning 16th year of Service – 25.25 days.

In the future should the number of vacation days provided to San Antonio Police Officers increase, the amount of vacation days will increase to match police department schedules for department seniority, taking into account Association Business Leave hours on both sides.

B. Forty Hour Employees: The following is a vacation accrual schedule which shall be implemented for forty-hour employees covered by this Agreement: Employees will accrue vacation days according to the following schedule, minus any vacation days previously borrowed.

Beginning of Probation through 10 years of completed Service - 15 days.

Beginning 11th year through 15th year of completed Service - 18 days.

Beginning 16th year of Service - 23 days.

Effective September 1, 2009:

Beginning of Probation through 10 years of completed Service – 15.25 days.

Beginning 11th year through 15th year of completed Service – 20.25 days.

Beginning 16th year of Service – 25.25 days.

In the future should the number of vacation days provided to San Antonio Police Officers increase, the amount of vacation days for fire fighters will increase to match police department schedules for department seniority, taking into account Association Business Leave hours on both sides.

Section 2. Additional Vacation Hours.

In addition to the vacation accrual amounts outlined in Section 1 of this Article, beginning the first full pay period after October 1, 2002, each employee shall receive an additional 3 hours of vacation each fiscal year.

Section 3. Floating Vacation Shifts (FVS).

- A. Except as provided in Section 3, Perfect Attendance Leave, an employee may request from his accrued vacation leave, up to three (3) shifts. This leave is to be taken from his scheduled vacation.
- B. An employee must apply in writing no less than prior to the beginning of the shift (or the workday, for 40 hour employees) prior to the shift being taken. Selection will be made on a first-come, first-served basis, by log date and time entry at a location to be designated by the Division Head.
- C. There will be a maximum of the four (4) employees allowed off on FVS per shift (two (2) in Fire Suppression and two (2) in EMS, and one (1) additional FVS per year per paramedic), with the exception of holidays or the day before or after a holiday. If a person requests a floating vacation shift and is denied and the employee calls in sick for that shift, he must provide a physician's certificate signed by a physician upon his return to duty.

Section 4. Perfect Attendance Leave (PAL).

- A. Any employee who achieves perfect attendance over a six (6) month period shall be entitled to utilize two (2) additional shifts of accrued vacation leave outside of scheduled vacation periods plus may convert one (1) shift of sick leave for use as a floating vacation shift in accordance with the provisions of this section, hereinafter to be called "perfect attendance leave". Employees who have completed their 25th year of service shall be entitled to convert an additional one shift of sick leave, for a total of two (2) per sixth month time frame, for use as a floating vacation shift in accordance with the provisions of this section, hereinafter to be called "Perfect Attendance Leave." Perfect Attendance Leave shall be used during the subsequent six (6) months.
- B. The Chief shall provide a minimum of three (3) slots in Fire Suppression, two (2) slots in EMS, and one (1) slot in each other division which shall be available solely for perfect attendance leave. To utilize a slot, the employee shall provide a minimum of 15 days

notification of the request. In the event more employees request use of leave than there are slots available, the slots shall be allocated in order of seniority in the department.

- C. If the slots are not taken on or prior to the 15th day, based upon seniority, they shall be available on a first comes first entitled basis, provided that written notice shall be turned in to the proper authority, as designated by the Chief, prior to the beginning of the shift (or the work day, for 40 hour employees) prior to the one being requested.
- D. "Perfect attendance" shall mean that the employee has not utilized any of the following types of leave:
 - 1. sick leave,
 - 2. emergency leave (provided that use of bereavement leave, although taken on an emergency leave basis, shall not be a disqualification under this section),
 - 3. line of duty leave (provided that use of LOD leave for a portion of a shift, as to those employees that return to work on of the following shift, shall not be a disqualification under this section),
 - 4. leave without pay, and
 - 5. suspensions.
- E. For purposes of this section, six (6) months shall be defined as consecutive calendar months, beginning the first shift hour in October, and the first shift hour in April.
- F. There shall be no restricted days at the beginning of October or April that are off limits for PAL conversion. Current eligibility time frames coinciding with the first half and second half of the fiscal year remain in place. A fire fighter that meets eligibility requirements prior to the current 15-day request cutoff may apply for a PAL conversion on these currently restricted dates. If said fire fighter becomes ineligible within 15 calendar days of the scheduled PAL shift, his PAL conversion shall be cancelled and he shall be required to make other arrangements to cover that shift.

Section 5. Bonus Days Leave.

- A. Each employee shall be entitled to two (2) additional leave days for each six months of "perfect attendance".
- B. Employees not working for one of the following reasons are not eligible to receive the two (2) days perfect attendance bonus:
 - 1. sick leave,
 - 2. LOD (provided that the use of LOD leave for a portion of a shift, as to those employees that return to work in the following shift, shall not be a disqualification under this section),
 - 3. emergency leave,
 - 4. leave without pay, and
 - 5. suspensions.

- C. The types of leave that will not adversely affect the employee's entitlement to the perfect attendance bonus are:
1. LOD (provided that the use of LOD leave for a portion of a shift, as to those employees that return to work on the following shift),
 2. properly scheduled and authorized vacation days,
 3. holidays,
 4. compensatory time,
 5. bereavement leave,
 6. administrative leave,
 7. time restored by the commissioner or an arbitrator (hearing examiner); and
 8. military leave..
- D. Bonus day leave shall be taken at the employee's choice of either pay or FVS. If the employee elects to receive pay in lieu of time, the City shall pay the employee his amount at the same time each year as the City pays other City employees their sick leave buy back, but no later than Christmas Eve day. Beginning in Fiscal Year 2003, if the employee elects to receive pay in lieu of time, the City shall pay the employee his earned Bonus day leave at the employee's regular rate of pay. This amount shall be paid at the same time each year as the City pays other City employees their sick leave buy back, but no later than Christmas Eve day. If the employee elects to use Bonus Leave as time off, the employee must schedule the time off in accordance with Department policy. The City shall compensate each employee who received a Bonus Days Leave check in December, 2001 the difference between what the employee would have received if said payment had been calculated at the regular rate of pay instead of at base pay plus longevity.
- E. The end of the fiscal year (September 30th) will be the cut-off for reporting bonus leave eligibility. If the employee has not chosen to take bonus days earned in a fiscal year as time off by October 15th of the next fiscal year, the employee will be paid for earned bonus leave. All bonus days earned in a fiscal year that have not already been taken as time off will be paid as outlined in Section 5 D. of this Article unless the employee elects to take the bonus days as time off in the following fiscal year.

Section 6.

This Article is intended to supersede the Terms of any statutory provisions including Section 142.0013(c) of the Texas Local Government Code, pursuant to Section 174.006 of the Texas Local Government Code. The parties further agree that this provision was mutually intended by the parties in the prior agreement to override inconsistent provisions under state law. The Association agrees to deny any grievance filed by a class or individual against the City asserting that the City owes the fire fighter or class additional vacation days under the prior or current agreement as not stating a valid contract claim. The Association additionally agrees that the City has a complete defense to any lawsuits for past claims or claims during the contract term, and agrees to provide non-economic support to the City in its defense of any such claims because said claims are barred under the terms of the agreements and other legal defenses.

ARTICLE 18.

HOLIDAYS

Section 1.

All employees covered by this Agreement shall be granted twelve (12) legal holidays. On September 1, 2009, one (1) additional holiday will be earned annually which will be included with vacation accrual effective January 1, 2010. All holidays shall be accrued and taken in accordance with departmental policy. In the future should the number of holidays provided to San Antonio Police Officers increase, the amount of holidays for fire fighters will increase to match police department schedules.

Section 2.

All employees who work on a shift during a Premium Holiday listed below shall be paid an additional one-half (½) time that of his/her regular rate of pay for the actual hours worked during the Premium Holiday. Actual hours paid for both shifts working a Premium Holiday will not exceed 24 hours. Holiday pay shall not apply to those employees who are working an overtime opportunity.

Premium Holidays shall commence at 12:01 a.m. and end 24 hours later at 12:00 a.m. and shall include the following eight (8) holidays:

New Year's Day
Easter Sunday
Independence Day
Veteran's Day
Thanksgiving Day
Christmas Eve
Christmas Day
New Year's Eve

Section 3.

This Article is intended to supersede the Terms of any statutory provisions including Section 142.0013(c) of the Texas Local Government Code, pursuant to Section 174.006 of the Texas Local Government Code. The parties further agree that this provision was mutually intended by the parties in the prior agreement to override inconsistent provisions under state law. The Association agrees to deny any grievance filed by a class or individual against the City asserting that the City owes the fire fighter or class additional holidays under the prior or current agreement as not stating a valid contract claim. The Association additionally agrees that the City has a complete defense to any lawsuits for past claims or claims during the contract term, and agrees to provide non-economic support to the City in its defense of any such claims because said claims are barred under the terms of the agreements and other legal defenses.

ARTICLE 19.

BEREAVEMENT LEAVE

Section 1.

In the event of death in the immediate family of an employee who is otherwise assigned to duty, the employee shall be granted time off with pay as follows:

- A. Employees working Fire Suppression, Communications and EMS employees working forty-two (42) hour work week shall be granted two (2) shifts off following the death. Unless exclusive permission is received from the Fire Chief, the working days as outlined by this Section shall be taken within fourteen (14) calendar days from the date of the death of the family member. Such permission shall not be unreasonably withheld.
- B. Other employees shall be granted four (4) working days off following the death. Unless exclusive permission is received from the Fire Chief, the working days as outlined by this Section shall be taken within fourteen (14) calendar days from the date of the death of the family member. Such permission shall not be unreasonably withheld.
- C. In conformity with the current practice, employees who experience a family emergency shall be placed on FMLA upon compliance with the statutory requirements, until such time the employee indicates that the family member dies. At such time the employee is placed on bereavement leave.

The immediate family shall be defined as the employee's mother, father, legal spouse, child, brother, sister, half-siblings, grandmother, grandfather, mother-in-law, and father-in-law, spouse's grandparents, grandchildren, step-parent, step-children or other members of the immediate household.

Section 2.

Employees in the Firefighting Division may use one (1) shift of Bereavement Leave without loss of FLSA overtime. However, employees who use their second bereavement leave shift shall lose FLSA overtime for both bereavement leave shifts. In the event a Fire Fighter uses bereavement leave on more than three (3) occasions in any one year, FLSA overtime shall be lost for such leave and each occasion thereafter.

Section 3.

In the event an employee is on military leave during the occurrence of a death in the immediate family and, as a result, is required by the military to make up the time taken off from military leave, he shall be entitled to bereavement leave as provided in this Article.

Section 4.

The Chief shall have discretion in cases that are found to be fraudulent requests or use of bereavement leave to deny any employee such bereavement leave provided, however, that such denial shall be subject to the grievance and arbitration procedures of this Agreement.

ARTICLE 20.

UNIFORM ITEMS AND PERSONAL PROTECTIVE EQUIPMENT

Section 1. Uniforms.

A. Uniform Commissary

1. At the time of the signing of this Agreement, the parties acknowledge that the City has provided the employees an initial issue of uniforms, as such term is defined by the Commissary System Contract. The City agrees to make available uniforms to employees, on an as-needed replacement basis, in accordance with the generally prevailing operational policies and practices in effect at the time of the signing of this Agreement, except as specifically modified herein; and with the full understanding that the City would not be obligated for anything beyond such generally prevailing operational policies and practices in effect at the time of the signing of this Agreement, except as specifically modified herein; and with the full understanding that the City would not be obligated for anything beyond such generally prevailing operational policies and practices in effect at the time of the signing of this Agreement, except as specifically modified herein; and with the full understanding that the City would not be obligated for anything beyond such generally prevailing operational policies and practices in effect at the time of the signing of this Agreement unless expressly set forth in this article.

B. Acquisition of Uniform Items

1. Beginning with the execution of this agreement and throughout its term, it is the City's responsibility to make uniform items available at the commissary location from 7:45 a.m. to 4:30 p.m., Monday through Friday, except City Holidays.
2. It is the employee's responsibility to acquire the necessary uniform items from the commissary or otherwise and present themselves properly attired for work under Department policies. The City shall have no duty to pick up or deliver uniform items to employees.

C. Uniform Credit System

1. The City shall establish a uniform credit system under a revised commissary contract whereby each employee shall have a five hundred dollars (\$500.00) credit assigned to that employee to allow the employee to acquire and maintain his/her uniform items, not classified as PPE. Each employee shall be assigned a \$500.00 credit each fiscal year

thereafter. "Fiscal year" shall hereinafter refer to the period from October 1st through September 30th.

2. Existing minimum specifications for uniform items available to employees under the Commissary System in effect on September 30, 2002 shall remain available for purchase by the employee throughout the life of this agreement.
3. Uniform items not required by Department policy at the time of the signing of this Agreement, shall not be mandated unless by mutual agreement or legislative change.
4. In the event an employee enters the bargaining unit some time after October 1, 2002 or after October 1st of any fiscal years during the term of this Agreement, the employee will receive a limit or credit for a prorated amount of the designated limit or credit. The prorated amount shall be equal to one twelfth (1/12) of the designated limit or credit amount times the number of full or partial months left in the fiscal year on the date that the employee enters the bargaining unit.
5. Employees shall only use the designated credit to acquire and maintain uniform items used in the performance of their duties. All uniform items purchased by the employee using said credit must meet the requirements set forth in the Department's uniform policies.
6. In the event an employee's designated credit is exhausted during the fiscal year and said employee needs or is required to purchase a uniform item(s), the employee shall be responsible for acquiring the uniform item(s) at their own expense.
7. Any unused credit shall not be carried forward to the following fiscal year.

D. Cleaning of Uniform Items

The employee shall continue to be responsible for routine cleaning of uniforms items in accordance with generally applicable policies and operational practices in effect at the time of the signing of this Agreement; and with the full understanding that the City would not be obligated for anything beyond such generally applicable operational policies and practices in effect at the time of the signing of this Agreement unless expressly set forth in this article.

E. Modification of Amount

The parties have negotiated this Article in recognition of the City's interest in achieving fiscal certainty in its obligation under this Agreement. If changes in the law, rules or agency interpretation occur under this Agreement which result in new or increased City costs related to reclassifying current employee uniform items as of the signing of this agreement into PPE, the City shall be entitled to reduce the amounts of any limit or credit as follows:

1. Reclassification of uniforms shall reduce the amount by the actual increased cost resulting from reclassification but not more than \$225 per year;

2. Reclassification of shoes shall reduce the amount by the actual increased cost resulting from reclassification but not more than \$120 per year.

F. Each of the City's obligations in this Article which involve any change in existing agreements or funding levels are conditioned upon City Council approval of amended agreements and appropriation of funds in future fiscal cycles, and, absent same, such obligations shall not become effective or applicable. In the event that City Council fails to approve any agreements, employees shall be entitled to the credit amount upon presentation of actual expense receipts for approved uniform items.

Section 2. Personal Protective Equipment (PPE).

The City acknowledges and accepts its obligations under state and federal law pertaining to Personal Protective Equipment (PPE). The City agrees to meet or exceed the City's specifications for PPE in place on January 1, 2002. Any disputes concerning compliance with state or federal law shall be resolved by resorting to the appropriate state or federal agency. Any disputes concerning specifications for PPE shall be subject to the grievance and arbitration articles of this agreement as contractual issues.

ARTICLE 21.

PARKING

The City shall provide, without cost to the employees assigned to Fire Station Number 1, Fire Department Administration Building, Communications, and Arson, adequate parking space adjacent to or near those work locations.

ARTICLE 22.

INCENTIVE PAY

Section 1. Educational.

A. Fire Fighters holding certain Associates, Bachelors, or Masters degrees shall receive educational incentive pay. The degrees shall be from an accredited learning institution of higher education recognized by the State Board of Education in the State in which the college resides and accredited by the Southern Association of Colleges and Schools or a similar regional association recognized by the United States Department of Education.

1. Fire Fighters holding an Associate's Degree shall receive one hundred seventy dollars (\$170.00) per month.
2. Fire Fighters holding a Bachelor's Degree shall receive two hundred seventy dollars (\$270.00) per month.

3. Fire Fighters holding a Master's Degree shall receive two hundred ninety dollars (\$290.00) per month.

Effective October 1, 2007:

1. Fire Fighters holding an Associate's Degree shall receive one hundred eighty five dollars (\$185.00) per month.
 2. Fire Fighters holding a Bachelor's Degree shall receive two hundred ninety dollars (\$290.00) per month.
 3. Fire Fighters holding a Masters Degree shall receive three hundred and ten dollars (\$310.00) per month.
- B. Employees may submit degrees by January 1, April 1, July 1, and October 1 of each year to be eligible for the educational incentive payments the beginning of the following quarter (Jan. 1, Apr. 1, July 1, and Oct. 1). Payments called for hereunder shall be made in accordance with current payroll policies of the City.
- C. Beginning in FY 08, the City shall provide \$75,000 each year to fund a Tuition Reimbursement Program. Tuition reimbursement funds shall not carry over to the next fiscal year. The Tuition Reimbursement Program shall be implemented and administered in accordance with Department policy or its successor. In the event that employees have received or will receive funding from another source such as grants, scholarships, etc., including receipt of state funding for fire science courses, tuition reimbursement shall become a secondary source of funding and shall not serve as double payment for tuition expenses.

Fire Fighters shall be entitled to receive reimbursement for tuition, fees, on-campus parking and the price of required text(s) at a college or university for course hours in an accredited degree program. Reimbursement shall be made in accordance with the following schedule:

Course Grade	Amount of Reimbursement
A	100%
B	90%
C	80%
D or F	0

Such reimbursements for tuition and fees shall not exceed amounts set by Texas state-supported institutions for similar or related courses and shall only be paid at Texas residency rates.

Section 2. HAZ-MAT Incentive.

Personnel assigned to the Hazardous Material (Haz-Mat) Team shall receive a \$100.00 per month incentive during their active assignment.

Section 3. E.M.T. Certification Pay.

A. Employees holding a Basic E.M.T. certificate obtained from the State and as a result of having completed a City-approved course of instruction shall receive the following incentive payments based upon years of service as a Basic E.M.T. (EMT-B) with the City for as long as certification is maintained and the employee is authorized to perform by the Medical Director:

Beginning of certification through 4 years of service as a Basic E.M.T. \$50.00 per month

Beginning of 5th year through 8th year of service as a Basic E.M.T. \$100.00 per month

Beginning of 9th year of service as a Basic E.M.T. \$150.00 per month

Effective October 1, 2007:

Beginning of certification through 4 years of service as a Basic E.M.T. \$ 60.00 per month

Beginning of 5th year through 8th year of service as a Basic E.M.T. \$110.00 per month

Beginning of 9th year of service as a Basic E.M.T. \$160.00 per month

B. If a paramedic transfers out of paramedic duties in EMS, Communications or Aviation to function as a Basic E.M.T., and has continuously maintained his or her certification as a paramedic or obtains a Basic E.M.T. certification, then all prior service as a paramedic in EMS, Communications, or Aviation shall be counted toward determining the level of incentive to which he or she would be entitled.

Section 4. E.M.T. Training for Non-Certified Employees.

The City shall train sixty (60) employees in E.M.T. certification whose initial employment date was prior to January 1, 1979, or who do not currently possess an E.M.T. certification. Training will be offered in order of seniority and will be paid for by the City. The Chief shall have the right to adjust work schedules of employees receiving training in order to best accomplish this mission.

Section 5. Paramedic Certification Pay.

A. Effective October 1, 2003, employees attending the initial paramedic training course shall receive \$50 per month until such time they become eligible for paramedic incentive pay. The

employee must be assigned to the class for more than one-half of the month to qualify. No partial payment shall be made for attending one-half (1/2) or less of the first calendar month of the initial paramedic training course.

- B. All employees who are certified by the State and as a result of having completed a City-approved course of instruction as Paramedics and who actually work in EMS, Communications, and/or Aviation, and maintain authorization by the medical director shall receive the following incentive payments based upon years of service as a Paramedic with the City:

Beginning of assignment through 4 years of service as a Paramedic \$150.00 per month

Beginning 5th year through 8th year of service as a Paramedic \$200.00 per month

Beginning 9th year of service as a Paramedic \$250.00 per month

Effective October 1, 2007:

Beginning of assignment through 4 years of service as a Paramedic \$200.00 per month

Beginning 5th year through 8th year of service as a Paramedic \$250.00 per month

Beginning 9th year of service as a Paramedic \$300.00 per month

- C. Unless otherwise specified in this Article, these amounts shall be paid to the Paramedic for so long as the individual is employed by the Department and actually works as a Paramedic in EMS, Communications, and/or Aviation. (The use of administrative leave shall not be cause to deny incentive pay under the previous sentence. However, a Paramedic who has expended all available sick leave and is thus either eligible for or actually utilizing the provisions of Article 24, Volunteering for Injured Firefighters, will no longer be entitled to receive incentive pay.)
- D. Should a Paramedic transfer or be assigned to a position outside of EMS, Communications, and/or Aviation and yet maintains his Paramedic certification, he shall be entitled to E.M.T. certification pay but not Paramedic certification pay.
- E. Should a Fire Fighter receive training on his own time and at his own expense at a City-approved school, he shall be eligible for E.M.T. certification pay.
- F. If a Paramedic leaves EMS, Communications, and/or Aviation and later returns, and if said employee has continuously maintained his certification as a Paramedic, then all prior service as a Paramedic in EMS, Communications, or Aviation shall be counted toward determining the level of incentive to which he would be entitled.
- G. Each E.M.T. or Paramedic assigned to EMS, Communications, or Aviation working an applicable shift for one-half (1/2) or more of any calendar month shall be entitled to the

incentive pay as previously provided for that assignment for the full month. No partial payment shall be made for working less than one-half (1/2) of the calendar month.

Section 6. Authorization by the Medical Director and Maintenance of Certification.

- A. Any EMT or Paramedic who scores less than that score set by the Medical Director on the State certification examination will be provided an opportunity to retake the examination. If the employee scores less than that score set by the Medical Director the examination on the second attempt, said employee shall no longer be entitled to EMT or paramedic incentive pay as of the date of scoring less than that score set by the Medical Director.
- B. Any EMT or Paramedic who is de-authorized by the Medical Director shall no longer be entitled to EMT or paramedic incentive pay until such time he is re-authorized by the Medical Director.
- C. The parties agree that any EMT or paramedic de-authorized by the medical director shall have the right to receive designated tutorial assistance, as designated by the medical director, on City time and expense.
- D. Any paramedic transferred to fire suppression as a result of de-authorization shall lose years of service credits for the years of paramedic service, for the purpose of computing EMT incentive pay.

Section 7. Special Duty Pay.

- A. The Fire Chief may assign personnel to special tasks or duties, i.e., computer analyst, video specialists, etc., and when doing so will agree to compensate them at the next-higher rank than the rank they occupy for the duration of the assignment. This special duty does not create a position.
- B. The Fire Chief may assign an employee as airport coordinator; and, when doing so, will compensate him at the rate of the next higher rank above that held by that employee so designated for the duration of the designation.

This Section of the Agreement may not be used to eliminate classified positions (ranks).

Section 8. Arson Assignment Pay.

- A. Effective October 1, 2003, all employees selected for assignment to the Arson Division shall receive \$50 per month beginning the first full month after the start of the Police Training Academy program until such time they receive their arson investigator certification.
- B. All certified arson investigators assigned to the Arson Division shall receive three hundred fifty dollars (\$350.00) per month assignment pay during each month of actual assignment.

- C. Each certified arson investigator assigned to Arson working an applicable assignment for one-half (1/2) or more of any calendar month shall be entitled to assignment pay for that assignment for the full month. No partial payment shall be made for working less than one-half (1/2) of the calendar month.

Section 9. Aviation Incentive.

- A. Effective October 1, 2003, employees initially assigned to the Aviation Division or assigned to Station 22 in support of Stinson Municipal Airport, said employee shall receive \$50 per month until such time they receive their Crash Rescue Fire Fighter certification. The employee must be assigned for more than one-half of the month to qualify for this incentive. No partial payment shall be made for working one-half (1/2) or less of the calendar month.
- B. Each certified Crash Rescue Fire Fighter assigned to the Aviation Division or assigned to Station 22 in support operations at Stinson Municipal Airport shall receive a \$100.00 per month incentive pay during his or her active assignment.

Section 10. Technical Rescue Team Incentive.

- A. Effective October 1, 2003, employees initially assigned to the Technical Rescue Team shall receive \$50 per month until such time the employee is deemed qualified by the Fire Chief. The employee must be assigned for more than one-half of the month to qualify for this incentive. No partial payment shall be made for working one-half (1/2) or less of the calendar month.
- B. Each Fire Fighter assigned to the Technical Rescue Team determined to be qualified by the Fire Chief shall receive a \$100 per month incentive during his or her active assignment.

Section 11. Training Instructors Incentive.

- A. Effective October 1, 2003, employees initially assigned to the Training Division shall receive \$50 per month until such time they receive their Instructors Certificate. The employee must be assigned for more than one-half of the month to qualify for this incentive. No partial payment shall be made for working one-half (1/2) or less of the calendar month.
- B. Each employee assigned to the Training Division who holds an Instructors Certificate shall be entitled to receive \$350 per month incentive during his or her active assignment to Training.

Section 12. Fire Inspectors Incentive.

- A. Effective October 1, 2003, employee initially assigned to the Fire Prevention Division shall receive \$50 per month until such time they receive their Inspectors Certificate. The employee must be assigned for more than one-half of the month to qualify for this incentive. No partial payment shall be to employees made for working one-half (1/2) or less of the calendar month.

B. Each employee assigned to the Fire Prevention Division who holds an Inspectors certificate shall be entitled to receive \$100 per month incentive during his or her active assignment to the Fire Prevention Division.

Section 13. Language Skills Pay.

Employees shall be entitled to Language Skills Pay upon satisfactory completion of the testing requirements for proficiency as set forth in Administrative Directive 4.38. The amount shall not be less than the amount payable to other City employees.

Section 14. Services Division Incentive.

Each employee assigned to the Services Division shall be entitled to receive \$100 per month incentive during his or her active assignment to the Services Division.

Section 15. Fire Certification Pay.

Fire fighters who hold a Basic, Intermediate, Advanced or Master Certification issued by the Texas Commission on Fire Protection shall receive Fire Certification pay based on the following monthly schedule:

	Basic	Intermediate	Advanced	Masters
Effective April 1, 2005	\$50	\$80	\$120	\$160
Effective October 1, 2007	\$65	\$ 95	\$135	\$175

Certification payments shall be made monthly at the same time that EMT and Paramedic incentive pays are made. The Fire Chief shall have the right to require the Fire Fighter to produce a copy of the certification or other valid verification prior to approval for the employee to receive such payment.

Section 16. Field Training Officer (FTO)

The Fire Chief shall have the authority to establish an FTO program and to set an amount for FTO incentive pay during the term of this agreement.

ARTICLE 23.

SICK LEAVE

Section 1. Definitions.

A. For purposes of this Article, the following definitions shall be used:

1. "**undocumented absence**" shall mean any absence due to sick leave without a physician's certificate, regardless of duration during any working day. When counting such absences, all or part of each working day or shift shall count as a separate absence.

2. **"physician's certificate"** shall mean a note provided by a physician licensed to practice medicine which states that he or she has examined the employee and that the employee was unable to work due to illness. It is the parties intent that the purpose of the information to be provided by the physician's certificate is to document the physician's determination that the employee has a bona fide illness, injury, or disability, which has existed for the entire period of the leave being claimed.
3. **"physician licensed..."** shall mean and include medical doctors (M.D.), osteopaths (D.O.) chiropractors (D.C.) and dentists (D.D.S.) who have met applicable licensing requirements, as the context of the condition or illness requires.
4. **"voluntary overtime"** shall mean overtime which is neither holdover time nor when an employee is ordered to work overtime.

Section 2. Circumstances Requiring Physician's Certificate.

- A. All employees shall be required to submit a physician's certificate under the following circumstances:
 1. All twenty-four (24) hour shift employees using more than two (2) consecutive working days of sick leave shall be required to provide a physician's certificate. All other employees using more than three (3) consecutive working days of sick leave shall be required to provide a physician's certificate.
 2. All employees who use sick leave by leaving during a shift and returning during that shift or by reporting for duty after the shift begins shall be required to provide a physician's certificate.
 3. All employees who utilize sick leave in conjunction with his/her scheduled work day or work shift immediately preceding or following any other form of leave, excluding Bereavement Leave, (i.e. annual leave, military leave, administrative leave, leave without pay) shall be required to provide a physician's certificate. Undocumented sick leave and military leave may not be taken together during the same shift.
 4. All employees who utilize sick leave on the following holidays shall be required to provide a physician's certificate: New Year's Day, Independence Day, Thanksgiving Day, Christmas Eve, Christmas Day, New Year's Eve.
 5. Once an employee has had six (6) undocumented absences in a fiscal year, he/she is required to provide a physician's certificate for any absence thereafter for the remainder of the year unless the employee has sick leave accrued but unused in an amount equal to or exceeding 50% of the total amount of sick leave he/she has accrued during his/her service in the Fire Department.

Section 3. Timeliness of Issuance of Physician's Certificate.

- A. A physician's certificate must have been issued within 24 hours of the date on which the obligation arises.
- B. If an employee is not successful in obtaining a physician's certificate issued within 24 hours from the time the obligation arises, the employee may elect to be treated under either of the following provisions. The election shall be made upon return to work, at the time the physician's certificate is provided:

1. Forfeiture of Annual or Holiday Leave

- a. In the event that the physician's certificate is not issued within 24 hours, as provided herein, each duty hour after the obligation arises -- until the time of issuance, shall be forfeited from either accumulated vacation time, or holiday leave equal to the number of hours.
- b. Failure to provide such documentation shall not be cause for discipline, other than loss of paid leave, unless it can be shown that intentional misrepresentation has occurred.
- c. It is understood and agreed to that annual or holiday leave that is forfeited under this section may not be used as, or in lieu of, scheduled leave. Any employee who intentionally calls in sick for the purpose of taking unscheduled leave is in violation of this provision.

2. Verification of Attempt to See Physician Within 24 Hours

- a. If an employee attempts to see a physician within 24 hours, and is unable to do so, he or she may provide documentation from a licensed medical service provider to that effect to obtain approved leave.
- b. In the event of a subsequent sick leave request during the same fiscal year that is not accompanied by a physician's certificate issued within 24 hours, the employee shall lose sick leave credit for both of the absences, which shall not qualify as sick leave, but shall be forfeited from either accumulated vacation time, or holiday leave equal to the number of hours which the employee was absent. If the period of absence exceeds one shift or one day, the leave forfeited shall be twice the shorter period of time.
- c. Failure to provide such documentation shall not be cause for discipline, other than loss of paid leave, unless it be shown that intentional misrepresentation has occurred.

Section 4. Additional Doctor's Certification and Confidentiality of Medical Information.

- A. Upon request by the Chief, employees shall provide additional (in addition to a physician's certificate) doctor's certification describing the nature of the illness which certification shall be mailed or delivered in a sealed envelope marked "confidential" to the Chief.
- B. The City shall not release any information concerning any condition or diagnosis, or any associated medical information or test result that is non-discloseable or confidential under

state or federal law which may be contained on the physician's certificate to any person or entity without the written consent of the employee, or an order by a court of competent jurisdiction.

- C. If the employee seeks confidential treatment of any matter disclosed by the physician, these certificates shall be delivered or mailed, in a sealed envelope, marked "Medical Information - Confidential" directly to the appropriate office at Fire Administration.
- D. No employee or physician shall be expected to provide any information about conditions which are privileged or confidential by law, or which involve a clearly unwarranted invasion of personal privacy. This would include, but is not limited to STD'S or HIV. If a diagnosis or treatment relates to such conditions, the physician may complete this form with a conclusion that the patient's condition prevented work during the specified time period.

Section 5. Loss of Voluntary Overtime.

- A. After two undocumented absences during any fiscal year, an employee will be ineligible for one (1) voluntary overtime opportunity, which loss shall occur either within two (2) shifts or the next opportunity. For each undocumented absence thereafter, the employee shall lose another overtime opportunity in the same manner.
- B. After six (6) undocumented absences during the fiscal year, the Fire Chief has the right to deny eligibility for voluntary overtime for sixty (60) days, on a reasonable basis. Written guidelines for implementing this provision shall be established and disseminated within the department. The Fire Chief may revise these guidelines from time to time.

Section 6. Other Provisions.

- A. After an employee who is eligible for regular retirement has an absence in excess of thirty (30) consecutive working days, the Chief has the right to require a physician's certificate and may require the employee to submit to a Fitness for Duty Examination.
- B. The Union recognizes the City's existing right to contact or attempt to contact an employee either in person or by telephone in a reasonable manner while he/she is on sick leave. Failure of the employee to be at his/her residence, at a location pre-coordinated with his/her supervisor, or attending medical treatment shall be grounds for disciplinary action in accordance with existing rules and regulations. The Chief will establish a procedure for discretionary exemptions from this rule and the provisions of Section 2 for individuals with long term illnesses, injuries or extended hospitalization.
- C. The Union recognizes the City's existing right to enforce a policy that the provision of fraudulent medical documentation or deliberately erroneous statements in connection with the provisions of this article shall be grounds for disciplinary action in accordance with the rules and regulations.

- D. Nothing in this article shall be construed to limit in any fashion the right of the Chief to enforce rules and regulations or administrative policies that are not in conflict with this Agreement or State Law.

ARTICLE 24.

SICK LEAVE BANK

In the event a Fire Fighter is suffering from an illness or injury which has been diagnosed by a physician as temporary and such diagnosis is provided the City in writing, and in the event the said Fire Fighter has used all of his sick leave, vacation, and all other leaves, he/she may be entitled to the benefits outlined below for a period not to exceed three hundred sixty five (365) calendar days for the same or related illness or injury as per Union policy.

1. a. The City shall draft twelve (12) hours sick leave per Fire Fighter after the employee completes his/her probationary period. Any Fire Fighter who desires not to participate must contact the City in writing prior to the completion of his or her probationary period.
b. The City shall notify the Union after the sick leave bank hours drop below 480 hours, and in concurrence with the Union President, shall be allowed to draft three (3) hours from all Fire Fighters.
2. Fire Fighters may request utilization of the sick leave bank hours by submitting their name to a Committee of three appointed by Local 624.
3. No Fire Fighter judged totally and permanently disabled by a physician shall be entitled to utilize this plan to extend the time of his retirement.
4. The Committee may donate sick leave drafted from each participant in equal amounts up to three (3) employees. If more than three (3) employees are using this, sick leave bank then an amount shall be deducted from the sick leave bank equal to 1.25 times the amount of actual hours used.

ARTICLE 25.

HEALTH BENEFITS

Section 1. Active Fire Fighters Health Benefits.

- A. The City shall provide all active Fire Fighters who are eligible with family medical benefits and shall pay the full cost of said benefits as agreed upon herein. The minimum benefits provided are those as stated in the Master Contract Document for the City of San Antonio, San Antonio Professional Firefighters Association and San Antonio Police Officer's Association Bargaining Unit (hereinafter referred to as "Master Contract Document"), which is attached and incorporated herein as Attachment II. Provisions and benefits specified in the Master Contract Document shall not be reduced during the life of this Agreement; however, the City reserves the right to change carriers or plan administrators at any time at its

discretion. While the City is prohibited from reducing the provisions and benefits specified in the Master Contract Document during the life of this Agreement, a determination of what medical service is medically necessary for a particular patient, or any reduction in the usual and customary charge for that medical service, will not be construed as a reduction in the benefits; provided that the determination is made in accordance with the procedure and criteria described in the Master Contract Document.

- B. Active Fire Fighters covered under this Agreement shall be granted the option of entering into or exiting from the civilian benefits program as provided for by the City to substitute for the basic program as outlined in this Agreement. Said option must be exercised by the active Fire Fighter during the re-enrollment period between the dates of October 1, and December 31, of each calendar year.

Section 2.

This agreement, and the Master Contract Document for health benefits adopted herein, shall control the available health benefits during the term of this agreement, for active fire fighters.

Section 3.

Health care benefits for active Fire Fighters shall not be terminated, altered, modified or reduced, during the term of the Agreement, except by amendments or successors to this Agreement.

Section 4.

It is understood and agreed that the provisions of this agreement and the Master Contract Document for health benefits have been drafted in substantial and material reliance upon existing provisions of federal and state law concerning employee health benefits. Any change in federal or state law or regulations which changes the obligations of either party, or the applicability or extent of Medicare benefits, or materially alters the assumptions relied upon in negotiations shall entitle the City or the Union to reopen negotiations concerning health benefits.

Section 5. Other Benefits.

- A. **Definitions.** The term “Trusts” as used in this Section shall refer to the San Antonio Police Officers and Firefighters Benefit Plan and Trust, which provides optical and dental services, and the San Antonio Police Officers and Firefighters Prepaid Legal Plan and Trust, which provides legal services to members of the San Antonio Police Department and the San Antonio Fire Department.
- B. **Amounts.** During the term of this Agreement, the City will pay a monthly amount for each employee as shown by the schedule below for dental, optical and prepaid legal benefits under the Trusts. Furthermore, neither the City nor the Union may change the amounts paid or allocated for the respective benefits as shown in the schedule during the term of this Agreement.

	Optical/ Dental Plan	Prepaid Legal Plan
Employees with dependents	\$89.50	\$32.00
Employees without dependents	\$43.50	\$32.00

C. **Audits.** The Union shall ensure that the Trusts will conduct annual independent audits at no additional costs to the City. The Union shall further ensure that the Trusts shall provide a copy of each annual independent audited financial report to the City, through its Finance Director, within thirty (30) days of receipt of the audit by the respective Trust.

The City reserves the right, at its sole discretion, to conduct an audit of said benefit plans at the City's expense any time during the term of this Agreement. Should the City decide to conduct such an audit, the Union shall ensure that the Trusts make available to the City all relevant documentation within a reasonable time.

D. **Use of Benefits.** With respect to the prepaid legal benefits, it is understood that no employee may use the benefits for the purpose, in whole or in part, of implementing and/or initiating legal action against the City, any of its agents, officers, and/or assigns.

Exclusive Trust. The Union shall ensure that all funds paid by the City pursuant to this section are used for the exclusive benefit of the employees and that said funds shall not be commingled with the funds of any other organization, entity, or Union, nor shall said funds be used for any other purpose other than that provided for herein.

E. **Payment and Change in Plans.** During the term of this Agreement, the Union may change providers for Supplemental Benefits (Dental/Optical and Legal). In the event that the Union makes a proposal to change benefit providers, the Union shall submit the same in writing to the City.

F. **Copies of Trust Plan.** The Union will provide to each employee a summary of each Trust plan and will provide up-to-date copies of the Trust Plan Documents to the Human Resources Department and the Union Office.

G. **Determination letter.** It shall be the sole responsibility of the Association to maintain the tax-exempt status of the benefit received under this Section. In accordance therewith, the Association shall provide to the City, through its Director of Finance, a copy of the Internal Revenue Service Determination Letter regarding the tax-exempt status of the benefit received under this Section. Said Letter shall be received by the City no later than ten (10) days from commencement of this Agreement.

ARTICLE 26

RETIREE HEALTH BENEFITS

Section 1. Existing Benefits and Transition.

This article assumes the passage and implementation of substantially the same terms and conditions currently set forth in Committee Substitute House Bill (CSHB) 2751 dated April 12, 2007 (hereinafter "pending legislation"). From the date of execution of this agreement until the effective date of such legislation, the contractual provisions previously in effect shall continue in effect. The provisions of the Former Master Contract document, as modified by the pending legislation thereafter apply until the Board of Trustees of the Fire and Police Retiree Health Care Fund, San Antonio (hereinafter the "Board"), shall make further changes as authorized by the Act. (See Former Master Contract Document attached hereto as Attachment III.) Both parties to this agreement contemplate that the Board will adopt a new Master Contract Document in the near future.

Section 2. Pending Legislation and Alternate Agreement.

The City and the Association have agreed upon the terms for providing retiree health insurance, including the contributions, definitions and scope of coverage, and authority of the Board of Trustees as set forth in such pending legislation. In the event that such legislation does not become enacted into law, the parties adopt the provisions of the legislation verbatim as their contractual agreement during the term of this contract, effective on October 1, 2007. Both parties additionally agree to seek and support the implementation of the same terms and conditions for retiree health benefits and fund management by the Board in the next legislative session.

Section 3. Retired Fire Fighters Health Benefits.

A. Retiree Benefits. This Agreement assumes continuing the prefunded retiree benefit program on modified terms of contribution and benefits, as additionally provided for under the pending legislation. The Former Master Contract Document statement of terms of coverage, payments, deductibles and other definitions of benefits applies to retirees, subject to future adjustment under the provisions below. The new provisions in this Agreement and the pending legislation (see identified above) for adjustments have been agreed to in order to assure that the long term cost of the benefits provided do not exceed the agreed contribution levels for the City and fire fighters.

Except as provided elsewhere in this Agreement and under the proposed legislation retiree medical benefits shall be secondary to Medicare benefits, to the maximum extent allowable under Federal law. Retirees shall not be required to purchase Medicare coverage if they have not qualified with the full 40 quarters for Medicare, Part A. Upon reaching the age and established qualification criteria for Medicare eligibility, medical benefits under the Former

Master Contract Document as primary coverage shall no longer be applicable, and medical benefits provided under the Former Master Contract Document shall convert to secondary coverage only, in accordance with the provisions set forth in the Former Master Contract Document. Once the retiree is eligible for Medicare, the retiree is required to apply for, purchase and maintain Medicare, Part B benefits. The benefits provided prior to Medicare eligibility are stated in the Former Master Contract Document.

Provisions and benefits specified in the Former Master Contract Document shall not be reduced during the life of this Agreement; however, the City reserves the right to change carriers or plan administrators at its discretion. While the City is prohibited from reducing the provisions and benefits specified in the Former Master Contract Document during the life of this Agreement, except as provided in the pending legislation; however, any reasonable determination of what medical service is medically necessary for a particular patient, or any reduction in the usual and customary charge will not be construed as a reduction in benefits, provided that the determination is made in accordance with the procedure and criteria described in the Former Master Contract Document and any document authorized by the Board that supersedes it in the future.

B. Spouses of retired Fire Fighters shall be eligible to receive the benefits as set forth in the Former Master Contract Document. Medical benefits shall be secondary to Medicare benefits once the spouse individually qualifies for Medicare coverage. Spouses of retired Fire Fighters shall pay a portion of the annual health plan to retain coverage at a rate based on the tenure of the fire fighter to whom the spouse was married. Beginning with a Fire Fighter, who served 20 years or less, the spousal rate will be 30% of the health plan premium (the COBRA formula premium as enumerated in Chapter 2 of the Former Master Contract Document). From 21 years to 30 years of tenure, for each year of tenure above 20, the spousal rate will decrease by 3% of the health plan premium until it is 0% for a spouse of a Fire Fighter with 30 years of tenure. Once the retired Fire Fighter becomes eligible for Medicare, the spousal rate will become 0% of the annual health plan premium.

C. Spouses of deceased Fire Fighters shall be entitled to benefits provided for spouses of retired fire fighters, in the event that the deceased fire fighter died in the line of duty, or was eligible for retirement at the time of death. Line of duty shall mean any occurrence wherein the officer was exercising the power and authority of a certified fire fighter, whether or not scheduled for duty at the time of death. Spouses of Fire Fighters not eligible for retirement or acting in the line of duty at the time of death shall be entitled to continue coverage by paying the applicable COBRA formula premium (as enumerated in Chapter 2 of the Former Master Contract Document), until death or remarriage.

D. Upon retirement, the Fire Fighter may elect to cover any other eligible dependents (other than spouse) in accordance with the Former Master Contract Document. The retiree shall pay 100% of the health plan premium (the COBRA formula premium as enumerated in Chapter 2 of the Former Master Contract Document) for any such other eligible dependent.

E. Contributions. The City has established a trust fund for prefunded retiree health care benefits for all eligible retired Fire Fighters (hereinafter referred to as “the Fund”) and has

increased its contribution levels for the purpose of establishing an actuarially sound retiree health benefit fund, evaluated over thirty years. The parties agreed in principle, in 1995, that, once an actuarially sound fund was established by current contribution levels, the responsibility for future contributions (made necessary by changes in circumstances, the economy, and the medical care system) would be jointly shared by the parties, and would be quantified and allocated by negotiation in future agreements, as necessary. In keeping with this principle, the contribution levels to the trust fund and their effective dates shall continue at 8.71% (% of base pay + longevity/month) by the City and \$70 per month by each Fire Fighter until October 1, 2007, and thereafter shall be in accordance with the pending legislation.

Section 4.

Medical benefits provided for herein as to retirees and their spouses shall be secondary to Medicare/Medicaid benefits. Once the spouse is individually eligible for Medicare, each such person is required to apply for, purchase, and maintain Medicare benefits. Upon the death of a retired fire fighter who became a fire fighter on or after October 1, 1988, the plan shall pay the applicable Part B Medicare premium for a surviving spouse until death or remarriage. The Plan Administrator may approve any alternate health care coverage provided by the spouse of a retired or deceased fire fighter, in lieu of Medicare coverage to comply with this requirement. The health plan will serve as secondary coverage or coverage levels not otherwise provided by Medicare, to the extent permitted by federal law.

Section 5.

The secondary insurance coverage provisions for retired fire fighters and spouses shall control available health benefits during the term of this agreement for retired fire fighters and spouses, except as provided elsewhere in this Article, or as modified by the Board of Trustees or under the proposed legislation.

Section 6.

Health care benefits for retired Fire Fighters shall not be terminated, altered, modified or reduced, during the term of the Agreement, except by amendments or successors to this Agreement, or as modified by the Board of Trustees or under the proposed legislation.

Section 7.

It is understood and agreed that the provisions of this agreement and the Former Master Contract Document for health benefits have been drafted in substantial and material reliance upon existing provisions of federal and state law concerning employee health benefits. Any change in federal or state law or regulations which changes the obligations of either party, or the applicability or extent of Medicare benefits, or materially alters the assumptions relied upon in negotiations shall entitle the City or the Union to reopen negotiations concerning health benefits.

ARTICLE 27.

MISCELLANEOUS

Section 1.

Should a Fire Fighter be ordered to another station after reporting to his assigned or temporary assigned duty station, mileage will be paid to the next station after reporting to his assigned or temporary assigned duty station. Mileage will be paid to the next station at the existing City rate per mile, or a minimum of \$2.00, whichever is greater. In order to be reimbursed for mileage expenses, a Fire Fighter so affected must turn in to the Chief each quarter on October 1, January 1, April 1, and July 1, of each calendar year expense vouchers requesting reimbursement for mileage expenses during the preceding quarter. Failure of an employee to timely file his voucher request shall result in the employee's waiver and relinquishment of any entitlement to said reimbursement of mileage expense.

Section 2.

Suspensions. Employees suspended up to a maximum of six (6) working days may, at the employee's discretion, forfeit either accumulated vacation time or holiday leave equal to the suspension. The employee shall have ten (10) calendar days from his receipt of notice of the suspension to decide whether or not he wishes to forfeit accumulated leave or exercise his appeal rights pursuant to Local Government Code Chapter 143. The provisions of this Article shall apply solely to suspensions which are agreed to by the employee, and no appeal to the Commission or to arbitration may be instituted on suspensions where the employee has forfeited accumulated vacation or holiday leave.

Section 3.

Except when workload dictates or in the case of regular alarms or Departmental announcements, all stations shall be on selective call for twenty-four (24) hours per day.

Section 4.

The City shall make a copy of this Agreement available at each station and a copy provided to each Fire Fighter.

Section 5.

The Chief shall have the authority at any time to require a Fire Fighter to submit to psychological evaluation or treatment and/or medical evaluation, at the City's expense, to be performed by a qualified psychologist, psychiatrist, counselor, therapist, or medical doctor chosen by the City. It is understood and agreed that should an employee refuse to submit to a psychological and or medical examination, or refuse to provide the results of such examination, such refusal shall constitute a refusal to obey a command, for which discipline may be imposed. To the extent

allowed by law, the City will indemnify the Union from liability in connection with any disciplinary matters arising under this section.

Section 6.

Effective with the execution of this Agreement, the Chief shall have the right to assign (which assignment shall not be unreasonably withheld), a Fire Fighter to light duty not to exceed one (1) calendar year from the date of the assignment based on the recommendation of a qualified physician. The Chief, in his sole discretion, may extend the duration of an employee's light-duty assignment.

Section 7.

After an employee has two (2) uses of emergency leave in a calendar year, for each subsequent use of emergency leave, the Fire Chief shall have the right to deny eligibility for the next voluntary overtime opportunity which would otherwise have been made available to the employee.

Section 8.

In the event of a Firefighter death which occurred in the line of duty, the City shall pay \$5,000 over and above the City's life insurance/accidental insurance benefit to the beneficiary to assist with funeral and/or related costs. The City shall issue payment directly to the beneficiary listed on the employee's life insurance within ten (10) working days of receipt of the proper request for said payment.

Section 9.

Employees separating from the Department shall have their pay for accrued vacation leave calculated at base pay plus longevity.

ARTICLE 28.

EMPLOYEE FITNESS

Section 1. Purpose.

The purpose of the physical fitness plan is to ensure that employees of the Department are physically capable of meeting all of the physical demands inherent in the job. It is the intent of the parties that the elements of the plan be directed to establishing such job-related physical fitness. The City and the Union recognize that each employee of the Department has individual physical characteristics which must be taken into account in assessing and applying the requirements of the plan.

Section 2. Fitness Requirements for New Employees.

- A. Effective with the first class to enter the Fire Academy after the approval of the 2002 Agreement, all new employees must agree to maintain a standard of fitness throughout their careers with the San Antonio Fire Department.
- B. The City and the Union will meet and come to an agreement on the standard of fitness to be maintained and the regulations, policies, penalties, medical considerations, etc. which will be necessary to implement this section.

Section 3. Fitness Program for Existing Employees.

The City and the Union shall meet and come to an agreement on a physical fitness program for existing employees which is not punitive in nature, but is instead aimed at promoting physical fitness among all employees of the Department. Any discipline which may be issued for non-compliance with the physical fitness program or plan must be corrective in nature and must take into account the individual characteristics of the employee involved.

The City agrees to promote compliance with the plan through education, incentives, interdepartmental counseling and other positive approaches.

Section 4.

Nothing in this article or agreement shall require the City or the Union to violate the statutory provisions of the Americans with Disabilities Act.

ARTICLE 29.

DRUGS AND ALCOHOL

Section 1. General.

- A. It is agreed that efficiency and safety in the work place is necessary and required in order to carry out the mission of the Fire Department.
- B. Therefore, it is understood that the use of alcohol, drugs, or other controlled substances by members of the bargaining unit without proper prescription or other authorization while on duty or in the work place is detrimental to the operation of the Department and is clearly prohibited by this Agreement and the rules and regulations of the Fire Department.
- C. The City agrees to form an employee assistance drug committee with the Association. The Fire Chief and the Association President shall designate two individuals to serve on the committee; the committee shall assemble and prepare materials to inform firefighters of the issues and dangers of substance abuse to the firefighters, the colleagues in the department, the public, and their families. The materials shall include an inventory and

presentation of available community and city resources for dealing with emotional issues, depression, family conflict, domestic violence, alcohol abuse, substance abuse, and other mental and medical issues which are a part of the substance abuse paradigm. The committee will make materials and presentations available to all firefighters.

- D. The City and the Union agree that Firefighters may be called upon in hazardous situations without warning, and that it is imperative to the interest of the Firefighters and the public to ensure that no Firefighter is substance impaired. In order to further their joint interest in protecting Fire Fighters and the public, effective October 1, 2003, the City and the Union agree to mandatory random drug testing as described in this section.

Section 2. Reasonable Suspicion Testing.

- A. The Union acknowledges and recognizes the right of the City to investigate possible alcohol or drug abuse by bargaining unit members which impairs job performance and to require employees to submit to various specified, approved and recognized medical procedures, provided reasonable suspicion exists, in accordance with proper procedure and applicable law, as well as the terms of this Agreement. In this regard, it is understood that the City shall adequately train its supervisory personnel who have authority to investigate the reasonable suspicion standard in detecting symptoms and effects of alcohol and/or controlled substance abuse. This Article in no way establishes or permits testing in violation right provided by this Agreement.
- B. In addition to reasonable suspicion testing as provided for above, the parties acknowledge the right of the City to require employees who receive special assignments to be tested. As used herein, special assignments shall include assignments to Haz-Mat, Paramedic, and/or Arson units where the assignment requires (1) the carrying of a firearm; (2) contact with or access to extremely dangerous materials; and (3) the administration of controlled substances. Testing must be approved pursuant to recognized medical procedures in accordance with applicable clinical protocols as well as the terms of this Agreement. Employees applying for such positions must be informed at the outset that such testing will be required prior to promotion/assignment to the position sought. In no event will employees be tested under this subsection as a result of involuntary assignment to an affected position, unless said assignment is the result of a promotion. Employees subject to tests under this subsection will be given a minimum of five (5) days notice of the actual test, and shall take the test, and the City must administer the same, in a manner which assures the employee's privacy to the greatest extent possible consistent with the City's need to preserve the integrity of the test procedures and results.

Section 3. Random Testing.

- A. One Hundred percent (100%) of Fire Fighters of all ranks, including the Chief, shall be susceptible to mandatory testing for illegal drugs and controlled substances, during each calendar year on a fair and impartial statistical basis at the City's expense. The fair and impartial statistical basis (in which each employee has an equal chance of being selected during a calendar year) shall be by a non-discriminatory computerized program operated

and certified as non-discriminatory by an independent firm hired by the City, and the employee shall be tested upon being selected by the computer. The computer program shall be designed to ensure that no employee shall be randomly tested more than once in any 12-month period.

- B. Upon notice of selection for random testing, any employee shall provide a urine sample in accordance with the policy or protocol established by the testing laboratory. Failure to provide a sample may be considered insubordination, and may be the basis for suspension or indefinite suspension. The Medical Review Officer (MRO) shall be contacted for instructions in the event of a claimed inability to provide a sample.
- C. The City and the Union have a mutual interest in ensuring that drug impaired Fire Fighters do not perform fire department duties. The City and the Union agree that the purpose of the mandatory drug testing policy is not to punish an employee who has not violated the Fire Department's rules, regulations, policies or procedures. The City and the Union are committed to the principle that the mandatory drug testing policy for Fire Fighters is designed and shall be administered to result in disciplinary action only against those Fire Fighters who have violated the Fire Department's rules, regulations, policies and procedures.
- D. The City will utilize a U.S. Department of Health and Human Services (DHHS) approved laboratory in performing urinalysis for drug detection. The laboratory will provide chain-of-custody procedures and documentation necessary to meet federal standards. Specimen collection and chain of custody procedures will ensure that specimen security, proper identification, and integrity are not compromised. A MRO will provide oversight to trained personnel on the collection and testing of urine samples. The Medical Review Officer shall be a qualified physician designated by the City.
- E. The employee will provide a urine specimen in a location that affords privacy. The collector will seal and label the specimen, initiate a chain of custody document, and prepare the specimen and accompanying paperwork for shipment to the drug testing laboratory. Each urine specimen will be subdivided into two bottles labeled as "primary" and "split" specimens. Both bottles will be sent to a laboratory where only the primary specimen confirms the presence of illegal, controlled substances, the employee will have 72 hours from the time they are notified by the MRO concerning positive test result to request the split specimen be sent to another DHHS-certified laboratory for a second opinion analysis. If either analysis is below the positive threshold levels, this shall constitute a negative result and the employee shall not be subject to further random testing for at least 12 months. Both the primary and the split specimen shall be maintained for one year to be available in the event of legal or contractual disputes or further questions. In addition, employees may at their own expense request to have another urine specimen administered at a physician's office of the employee's choice and accompanied by the testing personnel provided such testing is administered within four (4) hours of the initial notification for testing. Results of any such test taken at the employee's expense shall be provided to the City only if the employee chooses to release the results to the City.

- F. Sample testing procedures shall conform to scientifically accepted analytical methods and procedures and shall include confirmation of positive test results by gas chromatography/mass spectrometry (GC/MS). Before the results of a drug test may be used as a basis for any action, an MRO will be employed to determine if the test result is positive due to illicit drugs, or prescribed or over-the-counter drugs or food substances. In the event the MRO determines laboratory analysis found the specimen to be positive, but circumstances leading to the test result were other than illicit drug use, the test will be reported as negative to the City.

Section 4. Threshold Levels Revealed by Testing.

The parties have agreed that the following levels shall be determinative in any testing administered under this Article.

- A. The five (5) drugs to be screened and the test cutoff levels in nanogram/milliliter are as follows:

	Drugs	Cutoff Levels
1.	Marijuana metabolite	50 ng/ml
2.	Cocaine Metabolite	300 ng/ml
3.	Opiate metabolite	2,000 ng/ml
4.	Phencyclidine	25 ng/ml
5.	Amphetamines	1,000 ng/ml

- B. Concentrations of a drug at or higher than the above levels shall be considered a positive test result on the initial drug screening test.

- 1. An initial positive test result will not be considered conclusive; rather, it will be classified as “confirmation pending.”
- 2. A positive test result on the initial drug-screening test will automatically require a confirmation drug test be performed.

- C. The same five (5) panel drug screen test will be conducted on each confirmation drug test as was conducted on the initial test. The five (5) drugs to be screened and the test cutoff levels in nanogram/milliliter for the confirmation drug test are as follows:

	Drugs	Cutoff Levels
1.	Marijuana metabolite	15ng/ml

2.	Cocaine metabolite	150ng/ml
3.	Opiates:	
a.	Morphine	2,000 ng/ml
b.	Codeine	2,000 ng/ml
c.	6-Acetylmorphine	10 ng/ml
4.	Phencyclidine	25ng/ml
5.	Amphetamines:	
a.	Amphetamines	500 ng/ml
b.	Methamphetamine	500 ng/ml

D. Concentrations of a drug at or higher than the above levels shall be considered a positive test result on the confirmation drug screening test. A positive test result under this section shall not constitute conclusive proof of impairment or use, but shall create a rebuttable presumption subject to challenge through the grievance procedure. In the event that the employee appeals any disciplinary action to arbitration after a positive test result under this section, the losing party shall pay all costs of the proceeding. The employee is the “losing party” under this section if the arbitrator finds drug or alcohol impairment in violation of department policies, rules or regulations, irrespective of any modification or reduction in discipline.

Section 5. General.

- A. The thresholds listed above shall apply to all testing under this Article. Employees will complete a pre-testing consent form each time a test is conducted as part of drug testing procedure under this Article. Failure to do so may be insubordination, and just cause for discipline. This is in addition to any signed acknowledgement forms which may have been obtained at the time of employment or any other occasion.
- B. In all testing under this Article, only conclusive results are to be reported to the City. A positive urinalysis test will be confirmed by a GC/MS test and reviewed by a Medical Review Officer before considered conclusive. Both tests must be positive or the results are considered inconclusive, thereby causing a negative test result to be reported to the City.
- C. In all testing under this Article, individuals with positive test results for drugs will be notified by the MRO (or a para-professional acting as his delegate) in person or by telephone. An interview will be conducted to determine if there is an alternative medical

explanation of the drugs found in the employee's urine specimen. The employee is entitled to request and receive an in-person interview with the MRO prior to release of a positive result. If the employee provides appropriate documentation and the MRO is satisfied with the explanation, the drug test result is to be reported as negative to the City.

- D. Concentrations less than the thresholds listed herein, or initial positives not confirmed by the confirmatory testing shall be disregarded by the City, and may not be referred to or used at any time for any employment or disciplinary purpose whatsoever by the City.

Section 6. Confidentiality.

All records pertaining to the department required drug tests shall remain confidential to the extent allowed by law, unless offered in evidence in a disciplinary appeal. Drug test results and records shall be stored in a locked file under the control of the Chief or his designee. The Chief will maintain original copies submitted by the laboratory. No access to these files shall be allowed without written approval of the Chief.

Section 7. Rehabilitation and Treatment for Substance Abuse.

- A. The parties have these joint objectives in this Article of the Agreement:
 - 1. To preserve the Chief's right to discipline or terminate an employee for on-duty use or impairment in violation of Fire Department Rules and Regulation;
 - 2. To create disincentives for the use and abuse of substances, and
 - 3. To provide a means, together with incentives, to seek and obtain treatment and rehabilitation for any employee who is involved in off-duty substance abuse.
- B. Any employee who voluntarily seeks rehabilitation and treatment shall be entitled to the same leave and benefits that are otherwise applicable under leave policies and the existing coverage definitions in the Master Contract for Health Benefits, provided, however, that the Chief's right to discipline or terminate for on-duty use or impairment shall not be affected by this provision. An employee entitled to rehabilitation and treatment is not exempted from disciplinary action for violation of any other rules and regulations of the department (e.g. off duty DWI, regulations concerning leave, etc.).
- C. The City shall implement a drug and alcohol abuse education program. As part of that program, information will be provided on the availability of any EAP services under City programs or other outside service providers. The City will provide employees with literature and audio-visual materials and a copy of the drug and alcohol-free workplace policy as well as penalties for violating said policy.

Section 8. Union Representation of Members.

While it is understood that the Union is unequivocally opposed to the use of alcohol or drugs in the work place as well as the abuse of such substances under any condition and further agrees to cooperate toward the prevention of such abuse and strongly supports the prohibition of the use of drugs or alcohol in the work place and the proper enforcement of the Department's rules and regulations, the Union, retains the right to fairly and properly represent any aggrieved member of the bargaining unit by reason of the application of this Article, including but not limited to what the Union may consider as unwarranted or unreasonable investigations, search or the imposition of discipline.

ARTICLE 30.

GRIEVANCE PROCEDURE

Section 1. Scope of Procedure.

The purpose of this Article is to provide a just, equitable, and expeditious method for resolving disputes between the City and the Union (or employees) concerning all aspects of the employment relationship between the City and bargaining unit employees, and concerning the bargaining relationship between the City and the Union. To that end, the parties hereby agree and stipulate as follows:

- A. All disputes concerning the interpretation and/or application of the terms of this Agreement shall be submitted, if at all, to the grievance/arbitration procedure as called for herein. Failure to initially pursue grievance/arbitration in these instances shall be the basis for a plea in abatement in response to any suit or claim filed with a court of law and/or administrative agency.
- B. Employee claims of violation of statutory or constitutional rights may be submitted to the grievance/arbitration procedure or may be pursued by means of judicial and/or administrative appeal; provided that once the employee has elected to file a lawsuit and/or administrative claim, all issues raised by the dispute or claim will be resolved in such lawsuit and/or administrative process, and no grievance may be filed concerning the same subject matter. It is recognized that claims falling under this subparagraph may be included with related claims of contract violations. In such circumstances, the City shall not be entitled to abatement of a suit involving the contract claims, related to the statutory or constitutional claims asserted, for failure to grieve such contract matters initially. If the employee elects to use the grievance/arbitration procedure to raise statutory or constitutional claims, such matters may not thereafter be appealed to court except as provided by this Article.
- C. Claims alleging violation of Article 11, Section 1, or state or federal laws prohibiting employment discrimination including discrimination for having initiated or filed a claim for workers' compensation benefits, as prohibited by Texas Labor Code Section 451.001, shall not be subject to the grievance/arbitration procedure.

D. Disciplinary matters subject to the appeals procedure provided by Texas Local Government Code Chapter 143 shall not be subject to the grievance/arbitration procedure; provided that such matters, at the employee's election, will be subject to the Civil Service Commission or grievance/arbitration procedure under a just-cause standard, if Texas Local Government Code Section 143.057 is repealed or amended to eliminate the optional appeal of disciplinary matters to a Hearing Examiner. If the provisions of Chapter 143 are not repealed, and should the employee elect to proceed to the optional appeal of disciplinary matters to a Hearing Examiner, the examiner shall be one of the six (6) pre-selected, qualified neutrals as called for in Section 5 (A) hereof. The powers, duties, and/or obligations of said arbitrator/hearing examiner shall likewise be as provided for in this Agreement and applicable provisions of the Texas Local Government Code, Chapter 143.

Section 2. Time Limits.

The parties shall act diligently and exercise good faith to adhere to the time limits set forth in this Article, unless such time limits are waived or extended by mutual agreement. In the event the employee or Union fails to meet the time limit at any step of the grievance procedure, the grievance shall be considered satisfied and no further action need be taken; provided, that where the grievance concerns a matter within the jurisdiction of the courts, the employee may file suit if the grievance is rejected due to failure to comply with a time limit set forth in this Article. Failure by the City to meet the time limits at any step shall be considered a denial of the grievance which will allow the Union or employee, at their option, to proceed to the next step. Time limits begin to run on the date of a party's actual receipt of an appeal or response. When either party provides an appeal or response by mail, its timeliness shall be judged by the postmark on the envelope. When either party provides an appeal or response by facsimile transmission or via email, its timeliness shall be judged by the date printed by the facsimile transmission device or email. For any delivery of an appeal or response that is not hand delivered the parties are required to provide written confirmation to the other party. Where a deadline falls on a Saturday, Sunday, or legal holiday, the deadline will be extended to the next day which is not a Saturday, Sunday, or legal holiday.

Section 3. Relief through the Chain of Command.

The Union or any employee covered by this Agreement having a matter which is felt to be a grievance shall make a reasonable effort to resolve the matter through the appropriate chain of command via telephone, email or face to face meetings.

In the event the matter is not resolved through the Chain of Command, the employee may submit a grievance to the Union Grievance Committee.

Section 4. Steps of Grievance Procedure.

A. Initial Filing and Grievance Committee Review

1. In order to be considered, a grievance raising contractual issues must be submitted to the union grievance committee within thirty (30) calendar days of the grievant's actual or constructive knowledge of the event. A grievance raising non-contractual issues must be submitted with the union grievance committee within one hundred eighty (180) calendar days of the grievant's actual or constructive knowledge of the event.
2. The Union or any employee covered by this Agreement having a matter which is felt to be a grievance shall submit the grievance in writing to the Union Grievance Committee. The grievance shall be submitted on a form (FG1) to be provided by the City and must include (a) a brief statement of the grievance and the facts on which it is based; (b) the section of the collective bargaining agreement which has been violated; (c) the remedy or adjustment, if any, sought; (d) the employee's signature; and (e) where "maintenance of standards" is a basis for the grievance, the specific standard(s) alluded to must be identified. As used herein, "maintenance of standards" includes all statutory or other non-contract provisions incorporated herein through the Maintenance of Standards Clause found at Article 9.
3. Within three (3) business days after receipt of a grievance, the Union Grievance Committee shall provide a courtesy copy of the grievance to the Fire Chief. The copy may be delivered via hand delivery, facsimile transmission or email.
4. If the Union Grievance Committee decides in its sole discretion that no grievance is found to exist, no further action shall be required; provided, that if any employee grievance concerns matters appealable to court, e.g., statutory violations, the employee retains the option to file suit if his/her grievance is rejected.
5. The Union Grievance Committee shall review the grievance and if a grievance is found to exist for reasons stated by the employee or reasons known to the Committee, the Committee shall process the grievance by passing the grievance to the Fire Chief within fifteen (15) business days from receipt thereof.

B. Fire Chief's Response.

1. The Fire Chief or his designee shall respond to the grievance and shall render a decision to the Union Grievance Committee, in writing, within fifteen (15) business days from receipt thereof.

C. Appeal to City Manager

1. If a grievance is not resolved the Union Grievance Committee shall submit the grievance, in writing, to the Director of Human Resources within ten (10) business days from receipt

of the decision and a courtesy copy will be provided to the City Manager or his/her designee.

2. The City Manager or his/her designated representative shall review the matter and shall render a decision in writing to the Union Grievance Committee within fifteen (15) business days.

D. Submission to Arbitration

1. If the grievance is not resolved the Union Grievance Committee shall have ten (10) business days from receipt of the City Manager's decision to submit the matter to arbitration.
2. Arbitration will be invoked by delivering a letter to the Director of Human Resources and a courtesy copy will be provided to the City Manager or his/her designee.

Section 5. Arbitrator Selection.

- A. If a grievance is submitted to arbitration or an employee appeal to a Hearing Examiner is requested, within five (5) business days, the City and the Union shall select an arbitrator/Hearing Examiner by order of rotation the name of one of six (6) pre-selected, qualified neutrals.

The panel of six (6) shall have been previously agreed upon by the parties. The arbitrator selected shall be notified promptly in writing by the City or the Union of his appointment and, simultaneously therewith, the parties in agreement with the arbitrator shall select a date for a hearing of the grievance. If the arbitrator cannot begin the hearing within 90 calendar days after being notified, the parties shall select another arbitrator using the procedure prescribed by this subsection. If none of the arbitrators can begin the hearing within 90 calendar days of being notified, within five (5) business days, the City shall request a list of seven (7) qualified neutral arbitrators from the American Arbitration Association or the Federal Mediation and Conciliation Service, or their successors in function. The request shall include that only arbitrators who can schedule a hearing within 90 calendar days after the first arbitrator selected from the standing panel received notice of selection be listed on the list of seven (7). After receiving the list, each party shall alternate striking a name from the list and the name remaining is the arbitrator. The hearing schedule requirement herein (i.e. 90 days) may be shortened or lengthened by mutual agreement.

Within thirty (30) calendar days of the execution of this Agreement, the panel of six (6) arbitrators shall be established by each party alternately striking names from a list of thirty (30) names; fifteen (15) names each being submitted for this list by the City and Union, respectively. The Union will strike the first name. The established panel of six (6) arbitrators shall expire at the end of the term of this contract.

In the event a vacancy occurs on the panel of six (6) arbitrators, the vacancy will be filled by mutual agreement of the parties. In the event mutual agreement is not reached, the remaining

panel members shall be utilized until a second vacancy occurs. The two panel vacancies shall be filled by each party alternately striking names from a list of 20 names, 10 names each being submitted for this list by the City and the Union, respectively. The Union shall strike the first name. The parties by mutual agreement may permanently remove one or more panel arbitrators at any time. The parties will not have ex parte communications with the arbitrator. Communication with the arbitrator will be through the parties, counsel for the parties, or the parties' representative, jointly.

- B. At a date previously agreed upon, the arbitrator shall convene the hearing at a place mutually convenient to all parties. The arbitrator shall hear and take evidence of all issues presented as raised by timely-filed grievances. The hearing shall continue from day to day until all such evidence has been received and all parties have "rested". Transcripts and post-hearing briefs may be utilized at the discretion of the Arbitrator. If a transcript is utilized, a transcript by a duly-authorized court reporter will be taken of the hearing and shall be the only official transcript thereof. Both parties to the proceeding shall be entitled to representation of their own choosing, the expense of which must be borne by the respective party.
- C. The arbitrator shall make a reasonable effort to issue his/her award within thirty (30) calendar days after the date the hearing ends or, if transcripts and/or post-hearing briefs are required, within thirty (30) calendar days of receipt of the transcript or receipt of the parties' post-hearing briefs, whichever occurs later.

Section 6. Witnesses and Expenses.

- A. The following expenses shall be shared equally by the parties: arbitrator's fees and expenses and the cost of the hearing transcript. Each party will bear its own attorney's fees and costs; provided that:
 - 1. Should the arbitrator find that grievance upon which he rules is specious, he may in fact award the "prevailing party" (singularly) "reasonable attorney's fees" as defined in section 2 below.
 - 2. Should the matter proceed to court, the court shall have the discretionary authority to grant attorney's fees, including the costs of the arbitration proceedings (but not the grievance proceedings). A reasonable attorney's fee for the City shall be \$85.00 per hour, and for the employee, shall not exceed the actual rate agreed and charged, not to exceed \$100.00 per hour.
- B. The City shall compensate all witnesses called by either party at their straight-time rate; provided, however:
 - 1. The witness called is scheduled for duty when called to appear:
 - 2. The individual's identity and a brief statement as to the relevancy of his expected testimony has been provided the City five (5) days in advance of the hearing.

Any witness called by the Union and/or the grievant who has not been identified and/or who is not scheduled for duty shall be due no compensation or administrative leave from the City.

- C. Witnesses shall be scheduled by agreement between the parties so as not to unduly interrupt the mission of the Department. The arbitrator shall have the authority, based upon the summary statement of the witnesses, to determine whether or not the testimony of the witness is required or is merely duplicitous or cumulative, then the City shall have no obligation to pay for the witness' appearance
- D. The grievant shall not be compensated for time spent at the hearing and/or in preparation thereof, nor shall he be entitled to administrative leave for any such time.

Section 7. Arbitrator's Authority—Contract Cases.

- A. This section applies to all issues involving the application or interpretation of this Agreement; provided, that where the sole issue of contract interpretation involves the Maintenance of Standards provision, and the underlying standard is a statute or constitutional provision, this section shall not apply.
- B. For issues subject to this section, the award of the arbitrator shall be final and binding upon the City, Union and employees. In making his/her award, the arbitrator shall be limited to interpreting and applying the provisions of this Agreement; he/she shall have no authority to add to, subtract from, or modify the terms of this Agreement as negotiated between the parties.
- C. The arbitrator shall have full power to take steps necessary to ensure a fair hearing for all concerned, which power shall include, but is not limited to: ordering a party to provide information in its possession or control which is reasonably necessary to the other party's prosecution of its case; ordering a party to make available to testify a person within its control; issuance of witness subpoenas; and taking reasonable steps to ensure that no undue delays in the proceedings occur, consistent with the right of all concerned to a full and fair hearing.
- D. The arbitrator shall have the authority to provide in his/her award for such relief as is necessary to make the prevailing party whole for all economic losses suffered as a result of a violation of the terms of this Agreement.

Section 8. Arbitrator's Authority—Non-Contract Cases.

- A. In all cases which present issues, e.g., statutory claims which do not involve interpretation or application of the terms of this Agreement, the procedures specified in this section shall apply; provided, that where a case raises both contract and non-contract claims, the arbitrator's award as to contract claims shall be final and binding on the City, Union, and the employee.

- B. In cases subject to this section, the parties will be entitled to engage in discovery as provided in the Texas Rules of Civil Procedure, and the arbitrator is authorized to issue subpoenas, to resolve disputes concerning the appropriateness of a party's discovery requests, and to enter such other orders as may be necessary to effectuate the discovery process. As soon as practicable after the arbitrator's appointment and agreement to serve, the arbitrator and the parties' representative shall hold a conference, by telephone or otherwise, to set a reasonable period for discovery and a hearing date. In no case shall the period for discovery exceed ninety (90) days, except by mutual agreement of the parties.
- C. The provision of Section 6(C) of this Article are equally applicable to Section 7 cases.
- D. For issues subject to this section, the award of the arbitrator (both as to facts and the law of the contract) shall be final and binding; provided, that either party may appeal such award to state district court pursuant to Texas Local Government Code Chapter 174 on the grounds that it is clearly contrary to the provisions of a statute or the Constitution (state or federal), or is not supported by substantial evidence as indicated in the record made before the arbitrator. Any such appeal must be filed within thirty (30) days of the date of arbitrator's award.
- E. The arbitrator shall have the authority to provide in his/her award for such relief as a court with jurisdiction over such matter would be entitled to award, including injunctive and equitable relief, compensatory and exemplary damages.

ARTICLE 31.

EXHAUSTION OF REMEDIES

Section 1. Exhaustion.

The City, the Union, and the Fire Fighters covered herein, shall be required to exhaust all available remedies through grievance and/or the Civil Service Commission prior to proceeding to a court of law, state or federal administrative agency, or other regulatory body, except as provided in Article 30, Grievance Procedure. Failure to do so will act as a plea in abatement to any such court, administrative body, and/or regulatory agency proceeding until the exhaustion of remedies provided for in this Agreement have been completed to finality.

Section 2.

If, at any time after a decision and/or award of the Civil Service Commission and/or an arbitrator, any affected party contests or challenges the decision or award in any other legal proceeding, the following shall apply:

- A. The decision and award of the arbitrator and/or the Commission must be upheld, unless the contesting party can establish the award was not supported in whole or in part by substantial evidence and/or that the award of the arbitrator and/or the Commission was capricious.

- B. As a condition precedent to the filing of any subsequent action challenging the award of the arbitrator and/or the Commission, the affected party (as used here, "party" shall mean the Union and/or the City) must file a cost bond in the minimum amount of the sum of the arbitrator's fees and expenses and the fees of the court reporter who took the transcript of the arbitration proceeding.

Section 3.

Should any party be a part to any action by any other party contesting and/or challenging the award of the arbitrator and/or the Commission, the party may, pursuant to the terms of this Agreement, request the court or administrative body to which the action has been addressed to reimburse it/them for all costs of court, including but not limited to reasonable attorney's fees, for having to defend said action. This remedy shall be in addition to any other remedy to which the party may be entitled, including but not limited to those as specified above and/or elsewhere in this Agreement. Should either party, after having pursued grievance/arbitration or Civil Service Commission proceedings, sue in a court of law, then that court has the authority to grant as a portion of its award all costs including attorney's fees, including but not limited to the attorney's fees expended and/or generated as a result of the arbitration proceedings (but not the grievance proceedings). It is agreed that as used herein the term "reasonable attorney's fees", shall be in accordance with Article 30. Grievance Procedure, Section 6. Witnesses and Expenses (A)(2).

ARTICLE 32.

PROMOTIONS

Section 1. Definitions.

- A. Seniority - For purposes of this Article, each Fire Fighter shall be given one point added to only the passing score on any written promotional examination for each year as a classified Fire Fighter in the San Antonio Fire Department. In no event shall the number of such seniority points exceed ten (10). "Classified Fire Fighter" is meant to include service as a Fire Trainee and a Probationary Fire Fighter. Seniority is defined as all years of service, whether interrupted or uninterrupted, on the San Antonio Fire Department, and not merely the 1st continuous period of service. Accrual of seniority points shall begin with the first day of employment as a Fire Trainee in the Fire Academy.

B. Eligibility.

1. Fire promotional examinations shall be open to all Fire Fighters who have held a classified position with the San Antonio Fire Department for minimum required continuous years, immediately below that rank for which the examination is to be held. (This period shall consist of time spent by the Fire Fighter in actual service with the Department. Any absences in excess of thirty (30) consecutive days will cause the Fire Fighter to be required to remain in that position and rank for a period of time equal to the time of such absence. Time spent of leave for less than 30 days shall not apply. Example:

A Fire Fighter is an Apparatus Operator as of 1/1/87. He is off work on a Line of Duty injury for thirty-one (31) days. He would be eligible for promotional examination to the position of Lieutenant as of 2/1/89. Fire Fighters who receive a retroactive promotion will be entitled to use the retroactive promotion date for purposes of determining eligibility to take future promotional examinations.)

2. The two (2) year continuous period required for eligibility to take the promotional examination for the rank of Fire Apparatus Operator shall commence with the date the Fire Fighter entered the Fire Academy. If the employee was hired after the execution of this Agreement, the minimum continuous period required for eligibility shall be four (4) years from the date the employee entered the Fire Academy.
3. A Fire Fighter who has completed two (2) continuous years of service as Fire Apparatus Operator shall be eligible for promotion to the rank of Lieutenant. The two (2) year continuous period required for eligibility on promotion shall commence with the date he was promoted to Fire Apparatus Operator. If the employee was hired after the execution of this Agreement, the minimum continuous period required for eligibility shall be three (3) years from the date the employee was promoted to Fire Apparatus Operator.
4. A Fire Fighter who has completed two (2) continuous years service as a Fire Lieutenant shall be eligible for promotion to the rank of Captain. The two (2) year period required for eligibility on promotion shall commence with the date he was promoted to Fire Lieutenant.
5. A Fire Fighter who has completed two (2) continuous years service as a Fire Captain shall be eligible for promotion to the rank of District Chief. The two (2) year continuous period required for eligibility for promotion shall commence with the date he was promoted to Fire Captain.
6. In the event the scheduling of a promotional examination is prior to the ninetieth (90th) day of the vacancy, any Fire Fighter that would become eligible for such exam if it was given on the ninetieth (90th) day would be allowed to take such exam. For the purposes of calculating the ninetieth (90th) day, day one (1) begins from the first day of vacancy. Such Fire Fighter will also need to have met the criteria for eligibility for such exam as if it were given on the ninetieth (90th) day.
7. Promotional examinations for the rank of Fire Apparatus Operator, Lieutenant and Captain shall be administered at the same time each year as shown below:

Fire Apparatus Operator	July 2007
Lieutenant	August 2008
Captain	September 2008

8. In order to implement the above promotion schedule it is agreed that in the event that a vacancy occurs prior to implementation of the above schedules, the time limits under Chapter 143 to hold an exam and make the permanent appointment shall be superseded,

subject to the right to back pay below. This does not include either the required ninety (90) day posting of study material prior to the promotional exam, or the 30 day notice provision for posting notice of the exam. Persons promoted during the implementation of the new schedule above shall retain the right to back pay as provided under Chapter 143, so long as those persons would have been eligible to take the test within ninety (90) days of the vacancy. In the event a person becomes eligible following the 90 day period, that person will only be entitled to back pay back to the date of that person's eligibility.

C. Seniority in Rank.

1. The employee with the most time in a classified rank shall be considered the senior in rank.
2. Where employees of classified ranks other than the rank of Firefighter have been promoted at the same time, seniority in rank shall be determined by the employee's placement on their respective eligibility list.
3. Where employees of the rank of Firefighter have the same amount of time in that classification, seniority in rank shall be determined by their badge number.

D. Return From Military Service.

Effective with the signing of this agreement Fire Fighters who were serving on active military duty as members of the Armed Forces and who were eligible promotional candidates according to the rules as set out by USERRA when a Department promotional exam was offered, who did not take the exam, may apply within thirty (30) calendar days after notice by the City of their rights and obligations under this subsection upon return to the Department from active duty, to take the promotional exam given for that rank. The consulting firm who constructs the promotional exam given for each applicable rank will as part of the exam create an "A" and "B" exam for each test. Each test will be similar in construction and material covered. Fire Fighters covered by this section will be offered the ability to take the "B" test on their return and after being given the same amount of study time as officer who took, the original "A" exam. If the Fire Fighter's score would have resulted in a promotion if it had been achieved on the exam(s) missed due to active military service, the Fire Fighter must be promoted to the next available vacancy in that rank. Seniority in rank and retroactive back pay owed will be established as of the date the Fire Fighter would have been promoted based on the score made at the time, as if he or she had not been on active military service. This provision is intended to comply with requirements of the Federal Uniformed Services Employment and Reemployed Rights Act (USERRA), and to supersede the terms of Section 143.032(b) of the Texas Local Government Code.

Section 2. Study Materials Committee.

Not later than September 1st of each year, the Chief shall establish a committee(s) for the selection of study materials for the written promotional examinations for each rank. Such materials which are selected shall be reviewed by the Chief who shall make the final selection subject to approval by the Civil Service Commission. A listing of all potential materials from which promotional examination questions may be taken shall be posted annually each January

for examinations to be administered within the one-year period beginning the following April. Such material may not be used unless available from publishing companies at the time of the posting of the study materials list.

Section 3. Promotion to Fire Apparatus Operator, Lieutenant, and Captain.

Vacancies in the ranks of Fire Apparatus Operator, Lieutenant, and Captain shall be filled by competitive written examination in accordance with Chapter 143 Local Government Code and the rules established by the Fire Fighter and Police Officer Civil Service Commission not inconsistent herewith; however, a passing score of 70 shall be considered minimum for eligibility for promotion.

Section 4. Promotion to District Chief.

Persons having held the rank of Captain for a period of two (2) continuous years shall be eligible for promotion to the rank of District Chief. In the event all those Captains fail the written portion of the promotion examination which follows, persons holding the rank of Lieutenant for a minimum of five (5) continuous years and all Captains regardless of time-in-rank may be eligible for examination for promotion to District Chief. The promotional examination for the rank of District Chief shall consist of two parts as follows:

- A. Written Examination - Shall consist of questions relating to the duties of the classification of the position to be filled. All notice of written examinations and publishing of study material shall be in accordance with Chapter 143 Local Government Code and the rules established by the Fire Fighter and Police Officer Civil Service Commission. A score of 70% on the written examination shall be considered a passing score. In the event that written examination scores are the same, the ranking of those scores shall be done on the basis of rules established by the Fire and Police Civil Service Commission. All test participants with passing grades, up to a maximum of the top 20 (twenty), shall be allowed to continue on to the next phase of the examination process, the Assessment Center Board.
- B. Assessment Center Board - Shall consist of three members as follows:
 1. Two persons from outside the San Antonio Fire Department who currently hold an administrative position in a Fire Department or fire-related agency in a City of 50,000 or more population or from a state or Federal agency. One such person shall be selected by the City; one shall be selected by the Union.
 2. One person from outside the San Antonio Fire Department who has held an administrative position in the field of personnel management, city management, fire science, or a related field, for a minimum of five (5) years, to be selected by mutual agreement of the City and the Union.
 3. The City and the Union shall agree on guidelines to be presented to the Assessment Center Board for use in their examination.

4. A minimum score of 70% on the composite factors evaluated by the Board shall be required to pass the Assessment Center Board.
5. Failure of an applicant to obtain a passing score on the Assessment Center shall disqualify the applicant from further consideration for one year from the date the written examination was administered, unless the list is exhausted, in which event persons on the list shall be eligible for re-examination. The result of the Assessment Center shall not be appealable to the Civil Service Commission or to arbitration through the grievance procedure.

C. Eligibility List - Within seventy-two (72) hours of the completion of the Assessment Center Process, excluding weekends and holidays, an eligibility list shall be prepared and posted with the respective ranking of all applicants based on the following weights:

1. Written Exam Score 50%
2. Assessment Center Score 50%

Total Score 100%

Section 5. Life of the Eligibility List.

Every promotional eligibility list shall be valid for a period of one (1) year from the day after the date of the written examination, notwithstanding any pending disputes, appeals or litigation concerning an applicant's score or right to promotion.

Section 6. Preemption.

The provisions in this Article shall apply notwithstanding any contrary provisions in Chapter 143, which are expressly preempted.

Section 7. Promotional Probation.

For promotional ranks of Fire Apparatus Operator, Lieutenant, Captain, and District Chiefs there shall be a probationary period of six (6) months. During the promotional probationary period, an employee may be demoted by the Chief to the rank from which promoted, and the decision to demote shall not be subject to disciplinary appeal. Upon demotion while holding a probationary promotion, an employee shall resume the competitive rank from which appointed and the salary shall be in accordance with said competitive rank, with service time credited as continuous time in that competitive rank and with all salary increases to which the employee would have been automatically entitled had the employee continuously remained in said competitive rank. If the probationary period is successfully completed, the probationary period shall count as time in grade in the new rank.

Section 8. Chief's Review of Promotability.

Notwithstanding the provisions of this Agreement, the parties understand and agree that in considering a Fire Fighter for promotion the Chief shall have all rights and privileges as contained in Chapter 143 Local Government Code regarding promotability.

Section 9. Assessment Center Promotional Dispute Resolution Procedure.

- A. The purpose of this Section of this Article is to provide for the exclusive remedy available to officers who question or challenge the Assessment Center process.
- B. Any officer who disputes or challenges the Assessment Center process as contained in this Article as it applies to him shall file a grievance within ten (10) calendar days of the posting of the results of the examination process with the Director of Personnel of the City, which grievance must state in particular and with specifics the officer's objection to said process and/or results. Copies of all grievances so filed shall be provided to the Union.
- C. Within fifteen (15) calendar days of the date of the posting of the results of the Assessment Center process, the City and the Union shall meet to review all such grievances timely filed and shall each designate a representative to act in their behalf. These two representatives shall select and agree upon a third, mutually-satisfactory individual who shall act as an independent arbitrator. Failure of the parties' representatives to agree on this third "neutral" shall result in the parties selecting an arbitrator from the list of six (6) arbitrators previously agreed to in Section 4 of Article 30 . Grievance Procedure. The arbitrator or "neutral" so selected shall be notified promptly of his appointment and, simultaneously therewith, the parties in agreement with the arbitrator or "neutral" shall select a date for a hearing of all the grievances so submitted, which date shall be within thirty (30) calendar days.
- D. At the date previously agreed upon, the independent arbitrator or "neutral" shall convene the hearing at a place mutually convenient to all parties. The arbitrator or "neutral" so selected shall hear and take evidence on all of the grievances that were timely filed by officers as previously described. The hearing shall continue from day to day until all such evidence has been received. A transcript by a duly authorized court reporter will be taken of the hearing and shall be the only official transcript thereof. All parties to the proceedings, including individual officers, shall be entitled to representation of their own choosing, the expense of which must be borne by the respective party.
- E. The arbitrator or "neutral" so selected shall submit a written opinion on each grievance presented and/or heard by him without the benefit of the submission of briefs by the City, the Union, and/or the affected officer. The decision of the arbitrator or "neutral" shall be brief and concise and shall recite:
 1. The name of the grievant;
 2. The issue presented;

3. The decision and award of the arbitrator or neutral.

Unless otherwise mutually agreed by the Union and the City, the decision of the arbitrator or "neutral" shall be rendered within fifteen (15) calendar days of the date the hearing was closed. The decision of the arbitrator shall be final and binding on the City, the Union, and the affected Fire Fighter/grievant.

- F. The fees and expenses of the arbitrator or "neutral" and of the official court reporter shall be borne equally by the Union and the City.
- G. Should at any time after the decision and award of the arbitrator or "neutral" any affected Fire Fighter/grievant contest or challenge the award of the arbitrator in any other legal proceeding, the following shall apply:
1. The decision and award of the arbitrator or "neutral" must be upheld, unless the Fire Fighter/grievant can establish by clear and convincing evidence said award was not supported in whole or in part by substantial evidence and/or that the award of the arbitrator or "neutral" was capricious.
 2. As a condition precedent to the filing of any subsequent action challenging the award of the arbitrator or "neutral", the affected Fire Fighter/grievant must file a cost bond in the minimum amount of the sum of the arbitrator's fees and expenses and the fees of the court reporter who took the transcript of the arbitration proceeding.
- H. Should the Union and/or the City be a party to any action by a Fire Fighter/grievant contesting and/or challenging the award of the arbitrator or "neutral", the City and/or the Union may, pursuant to the terms of this Agreement, request the court or administrative body to which the action has been addressed to reimburse it/them for all costs of court, including but not limited to attorneys fees, for having to defend said action. This remedy shall be in addition to any other remedy to which the City and/or the Union may be entitled, including but not limited to those as specified above and/or elsewhere in this Agreement.

Section 10. Appointment to Assistant Chief and Deputy Chief.

- A. The Chief shall have the right to appoint six (6) Assistant Chiefs which rank immediately above the rank of District Chief and rank below the Deputy Chief in the chain of command. The Chief shall have the right to appoint (2) Deputy Chiefs which rank immediately above the rank of Assistant Chief and rank below the Chief in the chain of command.
- B. All officers who held the rank of Assistant Chief on or before October 1, 1988 shall remain grandfathered into their positions and shall maintain all rights and privileges currently enjoyed by virtue of holding that rank. No additional positions within the rank of Assistant Chief shall be created other than by this Article.
- C. Hereinafter, no position in the rank of Assistant or Deputy Chief shall be filled other than by appointment. As vacancies occur in the rank of Assistant Chief, the Chief shall have the right

to appoint to the position in accordance with this Section. Appointments to the rank of Assistant or Deputy Chief shall be by the Chief at his sole discretion, provided that the employee promoted is a classified, sworn member of the San Antonio Fire Department and occupies a rank of either Assistant Chief, District Chief, or Captain.

- D. Persons appointed to the rank of Assistant Chief or Deputy Chief shall be subject to overall City policies and regulations and while appointed to this rank shall not be subject to the provisions of Chapter 143 Local Government Code or any of the provisions of this Agreement, unless specifically so provided in this Article.
- E. Any person appointed to the rank of Assistant Chief or Deputy Chief may be suspended or demoted to the rank from which he was promoted at the sole discretion of the Chief without appeal to the Commission and/or Arbitration. Any person appointed to either rank may, further, voluntarily return to the rank from which he was promoted at any time. Upon demotion or voluntary return to the previously-held rank pursuant hereto, the employee shall receive thereafter the full benefits provided in Chapter 143 Local Government Code and this Agreement as if he had served in either rank on a continuous basis throughout his tenure as either Assistant or Deputy Chief.
- F. A person appointed to the rank of Assistant or Deputy Chief may be terminated for cause, provided that such termination shall be subject to appeal in the same manner as applicable to all classified, uniformed employees in the Department.
- G. Except for the positions of Assistant or Deputy Chief, nothing in this Article shall be construed to require the City to create the rank or establish and fill the maximum number of positions authorized herein. Further, nothing in this Article shall be construed to limit any existing right of the City to create ranks and establish positions in accordance with State law and the City Charter.
- H. Assistant or Deputy Chiefs appointed by the Chief pursuant to this Article may receive administrative leave time for work performed in excess of their regularly-scheduled duties. Said leave time may be granted at the discretion of the Chief, subject to scheduling and manpower contingencies that may arise. Said discretionary leave time shall, in no event, exceed that amount of time that said Assistant or Deputy Chiefs have accumulated in excess of their regularly-scheduled work week.
- I. Salary and Benefits for Assistant Chiefs and Deputy Chiefs
 - 1. The pay provisions outlined in Article 13, Wages, of this Agreement for the classification of Assistant Chief are applicable to only those officers who held the Assistant Chief rank as of October 1, 1988.
 - 2. Fire Fighters appointed to the Assistant Chief position by the Chief as provided for in Article 32, Section 8, of this Agreement, shall be compensated at an annual salary of not less than fifteen percent (15%) above the base salary of a District Chief plus thirty (30) years longevity.

3. The Fire Fighters appointed to the Deputy Chief position by the Chief shall be compensated at an annual salary of not less than twenty-four (24%) above the base salary of a District Chief plus thirty (30) years longevity.
4. The Fire Fighters holding appointed positions shall be entitled to all benefits as contained in the following specified Articles of this Agreement: Articles 1. Recognition; 2. Definitions; 4. Rules and Regulations, Special Directives, and Administrative Orders; 5. City Protection of Fire Fighters; 7. Payroll Deductions; 10. No Strikes, No Lockouts; 17. Vacations; 18. Holidays; 19. Bereavement Leave; 20. Uniform Items and Protective Equipment; 23. Sick Leave; 25. Benefit Plans; 27. Miscellaneous, Section 5; 28. Employee Fitness; 29. Drugs and Alcohol; 32. Promotions, Section 10; Appointment to Assistant Chief and Deputy Chief; 35. Agreement Binding; 36. Savings Clause; 37. Declaration of the Full Scope of the Agreement; and 38. Duration of Agreement.
5. The Fire Chief, at his discretion, may grant incentive pay as outlined in Article 22. Incentive Pay to qualified appointed personnel. In the event the Chief grants such discretionary incentive pay, all appointed personnel eligible shall receive such incentive pay. To ensure appointed personnel are equally compensated, appointed personnel with paramedic certifications and assigned to the EMS Division shall not receive Paramedic incentive pay but will receive EMT incentive pay.

ARTICLE 33.

FIRE FIGHTER TRAINEES AND FIRE FIGHTER PROBATION

Section 1.

Persons enrolled in the initial Fire Academy shall hold the position of Fire Fighter Trainee. As such, he shall be considered a civilian employee and is not a member of the bargaining unit covered by this Agreement nor shall he be subject to any of the terms of this Agreement or of Chapter 143 Local Government Code.

Section 2.

Upon completion of the Academy, an employee shall be certified as a Fire Fighter and shall hold the rank of Fire Fighter (Probationary). The probationary period shall be extended by a like period if an employee covered by the provisions of this Article is on leave for a period of thirty (30) consecutive calendar days or more. During this probationary period, excluding time spent as a Fire Fighter Trainee as described in Section 1 of this Article, the employee shall be subject to all provisions of this Agreement and of Chapter 143 Local Government Code with the exception that the Chief, in his sole discretion, shall have the authority to suspend or discharge said employee without appeal through the grievance procedure or to the Fire Fighter and Police Officer Civil Service Commission.

Section 3.

The provisions of this Article shall be exempt from the Maintenance of Standards Article 9 of this Agreement.

ARTICLE 34.

LIMITATIONS ON ACTS

Except as provided in this section of this Article, the Chief and City are precluded from the introduction of evidence or otherwise complaining of any acts or occurrences earlier than the 180th day immediately preceding the date on which the Chief suspends the employee or as specified in Chapter 143.052 of the Local Government Code. Only upon written notice in the original written statement of the Chief may any act or occurrence be admissible in a disciplinary hearing in accordance with this section. Solely to aid the Commission or arbitrator in the assessment of appropriate discipline and not to prove a charge of a violation of Civil Service Rules or for any other purpose, the Chief and the City may introduce evidence of prior disciplinary actions which have not been set aside on appeal as follows:

- A. Where the Chief's original written charges include alleged violations of Civil Service Rules and/or Department Rules and Regulations, Special Directives, and/or Administrative Orders, constituting acts of violence (exertion of physical force so as to injure or abuse), the Chief and the City may introduce prior discipline on such other violations found to have been committed within five (5) years immediately preceding the date of the act(s) charged as contained in said written charges;
- B. Where the Chief's original written charges include alleged violations of Civil Services Rules and/or Department Rules and Regulations, Special Directives, and/or Administrative Orders, concerning drug or alcohol abuse, any prior discipline on such violations found to have been committed within ten (10) years immediately preceding the date of said written charges;
- C. Where the Chief's original written charges allege acts of incompetence, all prior discipline for acts of incompetence may be introduced by the Chief or the City so long as adequate records are maintained; and
- D. Where the Chief's original written charges allege a violation of any other Civil Service Rules and/or Department Rules and Regulations, Special Directives, and/or Administrative Orders. The Chief and the City may introduce prior discipline for a violation(s) of the same rule within two (2) years immediately preceding the date of the charged act, so long as adequate records are maintained.

ARTICLE 35.

**AGREEMENT BINDING ON SUCCESSORS AND ASSIGNS ON BOTH PARTIES,
REGARDLESS OF CHANGES IN MANAGEMENT, CONSOLIDATION, MERGER,
TRANSFER, ANNEXATION, AND LOCATION**

This Agreement shall be binding upon the successors and assigns of the parties thereto, and no provisions, terms, or obligations herein contained shall be affected, modified, altered, or changed in any respect whatsoever by the consolidation, merger, annexation, transfer, or assignment of either party hereto or by a change geographically or otherwise in the location or place of business of either party hereto.

ARTICLE 36.

SAVINGS CLAUSE

Should any provision of this Agreement be found to be inoperative, void or invalid by a court of competent jurisdiction, all other provisions of this Agreement shall remain in full force and effect for the duration of this Agreement, it being the intention of the parties that no portion of this Agreement or provision herein shall become inoperative or fail by reason of the invalidity of any other portion of provision.

ARTICLE 37.

DECLARATION OF THE FULL AND FINAL SCOPE OF AGREEMENT

Section 1.

The parties agree that each has had full and unrestricted right and opportunity to make, advance, and discuss all matters properly within the province of collective bargaining. This Agreement constitutes the full and complete Agreement of the parties and there are no others, oral or written, except as specified in this Agreement. Each party for the term of this Agreement specifically waives the right to demand changes herein, whether or not the subjects were known to the parties at the time of execution hereof as proper subjects for collective bargaining; however, it is understood and agreed that the contract may be amended by mutual consent of the parties to this Agreement.

Section 2.

Additionally, in the event that any provisions of this Agreement conflicts or is inconsistent with any provision of Chapter 143 Local Government Code, this Agreement shall prevail, notwithstanding any such provision of the Civil Service Statutes.

Section 3.

The parties understand and agree that where they have agreed to a re-opener upon the occurrence of specific events and/or with the passage of a specified period of time, such re- opener provisions are exempt from the provisions of Section 1 above.

ARTICLE 38

DURATION OF AGREEMENT

Section 1.

Except as specifically provided herein, this Agreement shall be effective upon approval and signing by both parties. It shall remain in full force and effect until the 30th day of September, 2009 and shall continue in effect from year to year until replaced by a successor agreement or until terminated by mutual agreement. In no event shall this Agreement continue in effect after September 30, 2019.

Section 2.

Whenever wages, rates of pay, or any other matter requiring appropriation of money by any governing body are included as a matter for collective bargaining pursuant to this Act, it shall not be the obligation of the Union to serve written notice of request for such collective bargaining on the public employer at least 120 days before the conclusion of the current fiscal operating budget, because this Section serves as such notice.

In witness whereof, the City, through its Chief Negotiator acting with full authority and in his representative capacity, and the Union's Chief Negotiator acting with full authority and in his representative capacity hereto execute this Agreement on the dates as indicated below:

FOR THE CITY OF SAN ANTONIO

Lowell F. Denton
Attorney, City Chief Negotiator

Date: _____

Charles Hood
Fire Chief

Date: _____

Michael Bernard
City Attorney

Date: _____

Erik J. Walsh
Assistant City Manager

Date: _____

Sheryl Sculley
City Manager

Date: _____

FOR THE INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS and LOCAL 624:

Louis Hebert
Chief Negotiator, Local 624

Date: _____

Christopher Steele
President, Local 624

Date: _____

**ATTACHMENT 1
ORDINANCE 83927**

JS
4/18/96
#33

AN ORDINANCE 83927

11

ADOPTING THE CITY'S OFFICER AND EMPLOYEE LIABILITY
PLAN POLICY AND REPLACING ORDINANCE NO. 62206,
ADOPTED IN JANUARY 1986.

* * * * *

WHEREAS, the current Ordinance adopted as Ordinance No. 62206, in January 1986, lacks procedural detail and clarity, causing concerns as to "acts" covered and excluded under the Indemnification Policy; lacks detail in procedures that officers and employees need to follow in order to be entitled to indemnification; and causes confusion as to when the City will pay for employee's outside counsel, and

WHEREAS, a new Ordinance is needed to define "acts" and to formalize the procedural process; **NOW THEREFORE**:

BE IT ORDAINED BY THE CITY COUNCIL OF THE CITY OF SAN ANTONIO:

SECTION 1. This Ordinance formally adopts the City of San Antonio Officer and Employee Liability Plan Policy ("the Plan"). It replace Ordinance No. 62206, adopted in January 1986. The Plan indemnifies City officers and employees in connection with legal proceedings arising from the performance of their duties.

SECTION 2. This Policy will clarify the rights and responsibilities of the City, and of the officer or employee, and will simplify the process of responding in a timely manner to the initiation of litigation. The Plan shall consist of the policies, rights, and duties embodied in this Ordinance, and shall be implemented and administered as provided by this Ordinance.

SECTION 3. The proposed Ordinance defines "acts" that are covered and excluded. If the City denies coverage, the Plan member may seek a determination from the court as to whether they are entitled to coverage; it will formalize the procedural process, in that officers and employees are given specific procedures in order to request indemnification.

SECTION 4. The City Attorney or his designee will represent the Plan member unless a conflict arises, then the Plan member must select an approved private attorney for representation. The City will not pay for any costs or legal fees incurred by the Plan member if they utilize an attorney not approved by the City Attorney and Risk Manager, unless required by law.

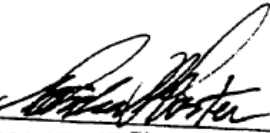
SECTION 5. The Plan does not affect police/fire personnel under their present labor contracts.

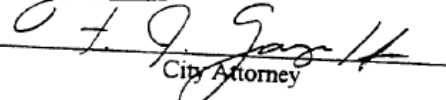
SECTION 6. Formal adoption of this Ordinance will not necessitate a current budget amendment, as expenditures will be approved on a case-by-case basis in connection with each individual lawsuit.

SECTION 7. This Ordinance shall be effective on April 25, 1996.

PASSED AND APPROVED this 11th day of April, 1996.


M A Y O R

ATTEST 
ASSISTANT City Clerk

APPROVED AS TO FORM: 
City Attorney

96-15

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The City of San Antonio Officer and Employee Liability Plan Policy

Section 1. Definitions.

The following terms, as used in this Ordinance, shall have the following meanings unless the context requires otherwise:

1. "Act" includes an omission or failure to Act.
2. "City" means the City of San Antonio, Texas.
3. "City Vehicle" means a vehicle or any mobile equipment leased to, or owned by CITY.
4. "Claim" means any claim made or suit brought against the City and/or a Plan Member for damage or injury alleged to be caused by a Covered Act.
5. "Claims Board" means the CITY's Self-Insurance Claims Board created by the Program Ordinance.
6. "Coverage Determination Action" means an action by a Plan Member to determine coverage under the Plan pursuant to Section 7 of this Ordinance.
7. "Covered Act" means any act or omission of a Plan Member while constituting no waiver of immunities, that:
 - (a) occurs during the discharge of the Plan Member's official duties,
 - (b) is within the course and scope of the Plan Member's office, employment, or assigned work with the CITY, as applicable, or
 - (c) constitutes, or is alleged or asserted to constitute, negligence on the part of the Plan Member.
 - (d) occurs during incidental medical services or first aid (including transportation) at the scene of an accident or injury by any Plan Member not regularly engaged in the medical profession.

- (e) occurs while rendering medical services (including transportation) by emergency medical technicians, paramedics, nurses and aides employed by the CITY while in the course of their employment as such.
 - (f) occurs while a Plan Member is carrying out their authorized duties related to the CITY's public safety activities.
 - (g) occurs while a Plan Member is using a CITY Vehicle, or one hired by or on behalf of the CITY, provided the use is with the permission of the CITY, or
 - (h) arises from the use of a Non-Owned Automobile by a Plan Member while such automobile is being used in the business of the CITY.
 - (i) arises from an act or omission of a Plan Member while they are acting the course of their duties as a member of the Claims Board.
8. "Excluded Action" means any Claim against a Plan Member:
- (a) by the CITY; or
 - (b) that results from (i) an intentional or knowing violation of a penal law (including an administrative agency rule having the force and effect of law) committed by, or with the knowledge and consent of, the Plan Member; (ii) an act of fraud committed by, or at the direction of the Plan Member; (iii) official misconduct, a willful or wrongful act or omission, or an act or omission constituting gross negligence committed by, or at the direction of, the Plan Member; (iv) an act of conspiracy or collusion by the Plan Member against the CITY; or (v) knowing or intentional violation by the Plan Member of any ordinances, policies or procedures of the CITY, or of lawful orders, instructions or directives of CITY management; or (vi) an intentional or knowing violation of employment rules or policies; or
 - (c) that arises while the Plan Member is using or operating a CITY vehicle or other CITY property or equipment with no authority to do so; or
 - (d) that asserts or alleges liability assumed by the Plan Member under a contract, unless the Plan Member is authorized by the CITY to enter into the contract; or
 - (e) that includes a joinder by the Plan Member of a claim or suit of the member against the CITY for benefits under the Plan; or

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- (f) for damages that are not recoverable against the CITY; or
 - (g) for damages the CITY is precluded from paying under Section 102.002, Texas Civil Practice and Remedies Code, Vernon's Texas Codes Annotated, or for payments in excess of the limitations on payments by the CITY prescribed by Section 102.003, Texas Civil Practice and Remedies Code, Vernon's Texas Codes Annotated; or
 - (h) that includes exemplary damages.
9. "Excluded Loss" means any of the following:
- (a) any Loss that arises out of an Excluded Action; or
 - (b) any Loss the CITY is precluded from paying by law; or
 - (c) any Loss arising out of a Claim resulting from a Covered Act that occurred before the Plan took effect, unless the Board at its discretion, extends coverage; or
 - (d) any Loss arising out of a claim resulting from a Covered Act that occurs while the Plan is in effect if (i) the Plan Member experiencing the Loss becomes legally obligated to pay the Loss after the Plan is terminated, and (ii) such Claim or Legal proceeding were barred by any statute of limitations when instituted; or
 - (e) any Loss arising out of a Claim resulting from a Covered Act that occurs after the Plan is terminated.
10. "Loss" means (i) the damages, excluding exemplary damages, that a Plan Member or former Plan Member is legally obligated to pay on account of a Claim; and (ii) amounts paid, or agreed to be paid, by the CITY pursuant to Section 3(b) and 4 of this Ordinance, to compromise or settle a Claim in order to avoid the risk expense and uncertainty of litigation.
11. "Loss Expenses" means any of the following:
- (a) the CITY's expense in investigating or defending a claim that may result in a Plan Claim; and
 - (b) the costs taxed against a Plan Member in a suit that results in a Plan Claim and any pre-judgment or post-judgment interest for which the Plan Member is liable; and

- (c) the reasonable expenses of a Plan Member incurred at the CITY's request in connection with a Claim that may result in a Plan Claim; and
 - (d) any attorneys' fees ordered by a court to be paid by a Plan Member in a suit arising out of a Claim that results in a Plan Claim.
12. "Non-Owned Automobile" means an automobile which is neither a CITY Vehicle nor one hired by the CITY.
 13. "Plan" means the City of San Antonio Officer and Employee Liability Plan, as established by this Ordinance.
 14. "Plan Claim" means any Plan Loss, together with the Plan Loss Expenses that result from the Claim giving rise to such Plan Loss.
 15. "Plan Loss" means any Loss that is not an Excluded Loss.
 16. "Plan Loss Expenses" means any Loss Expenses, except those incurred in connection with an Excluded Action.
 17. "Plan Member" means an individual who at the time of a covered Act is:
 - (a) an employee of the CITY;
 - (b) the Mayor, and any other member of the City Council;
 - (c) a member of (i) a CITY board, commission, or committee created by charter, ordinance, or resolution of the CITY, or (ii) the board of directors of any nonprofit corporation created under the authority of the City Council as an instrumentality of the CITY, unless by specific contract provision the CITY does not provide coverage.
 18. "Program Ordinance" means Ordinance No. 83926 (which establishes the CITY's Self-Insurance), as from time to time amended.

Section 2. Plan Established.

The CITY hereby establishes the "City of San Antonio Officer and Employee Liability Plan" which shall consist of the policies, rights, and duties embodied in this Ordinance. The Plan shall be implemented and administered as provided by this Ordinance.

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Section 3. Defense and Settlement.

- (a) The CITY will defend any suit, except an Excluded Action, against a Plan Member or former Plan Member that results from a covered Act occurring prior to termination of the Plan, even if the suit is groundless or fraudulent. 1
- (b) The CITY may investigate, negotiate, or settle any Claim, as the CITY determines necessary or appropriate.

Section 4. Payment of Plan Claims.

- (a) The funds will pay each Plan Claim subject to any limitations contained in the Program Ordinance No. 83926, subject to the provisions of State law.
- (b) This Ordinance will in no way alter any CITY tort or contract liability existing the date of its' passage. More specifically, this Ordinance will not alter contractual obligations in either San Antonio Firefighters or San Antonio Police, labor contracts existing the date of this Ordinance's passage:
- (c) This Ordinance does not include payment, by the CITY, of exemplary damages on the behalf of a Plan Member.
- (d) **TO BE ENTITLED TO PAYMENT BY THE FUNDS FOR ANY PLAN CLAIM, A PLAN MEMBER MUST:**
 - (1) give notice of loss;
 - (2) notify the Claims Board in writing, within a reasonable time to be determined by the Board, after receipt of any written or oral notice of any Claim that may result in a Plan Claim but in any event not later than two (2) working days after receipt of such notice;
 - (3) cooperate fully with the Claims Board, City Attorney, Risk Management, the CITY and, upon the request of the Claims Board, assist in making settlement, in the conduct of any suit, and in enforcing any right of contribution or indemnity against an individual or organization who may be liable for the Act giving rise to a Claim, or to the CITY because of the payment by the CITY of a Plan Claim;
 - (4) cooperate fully in the investigation and defense of any Plan Claim made against the Plan Member including but not limited to, attendance at any hearing or trial held in connection with a Plan Claim and assisting in discovery, securing and giving evidence and obtaining the attendance of witnesses;

- (5) not give any oral or written statement or enter into any stipulation or agreement concerning a Claim resulting in a Plan Claim, except upon advice of the City Attorney or his designee or when questioned by a police officer at the scene of an accident;
- (6) not, except at the Plan Member's own cost, voluntarily make any payment, assume any obligation, or incur any expense with respect to any Claim resulting in a Plan Claim without the consent of the Claims Board;
- (7) deliver to the City Attorney or his designee, promptly upon receipt, but no later than two (2) working days, any demand, summons, notice, or other process received by the Plan Member in connection with any Claim that may result in a Plan Claim;
- (8) comply with the claims administrative procedure of the Claims Board; and
- (9) perform the duties and comply with the requirements imposed on the Plan member by this Ordinance or by the Program Ordinance.

Section 5. Legal Representation.

- (a) The CITY will provide legal representation for a Plan Member or former Plan Member in a Claim, except an Excluded Action, in which the asserted or alleged liability of the member results from a Covered Act occurring prior to termination of the Plan.
- (b) The City Attorney or his designee, and the Risk Manager, shall select, supervise and/or retain, if applicable, attorneys, experts, and investigators he deems necessary in connection with the defense of any Plan Claim.
- (c) The City Attorney or his designee shall be authorized to pursue all cross-claims, counter claims, and/or affirmative defenses on behalf of a Plan Member or former Plan Member.
- (d) If the City Attorney determines that there exists a potential conflict of interest for the City Attorney to represent a Plan Member (pursuant to Subsection (a) of this Section), the CITY will pay the reasonable fee of an a private attorney approved by the City Attorney and Risk Manager to represent the Plan Member.

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- (e) If the Plan Member utilizes an attorney not selected and approved by the City Attorney and Risk Manager, the Plan Member assumes all responsibility for all associated costs, fees, and expenses, except those required by law that the CITY pay.

Section 6. Assignment.

If payment of a Plan Claim or legal representation is provided to a Plan Member under the Plan, the CITY is assigned the Plan Member's rights of recovery against any individual or organization to the extent of the CITY's payment or liability for payment. A Plan Member shall execute and deliver to the Claims Board such documents as are necessary to secure this right of assignment in the sole opinion of the City Attorney or his designee. A Plan Member shall not do anything after a Plan Claim is incurred to prejudice this right.

The Plan Member shall:

- (a) cooperate fully with the Claims Board and, upon the request of the Claims Board, assist in making settlement, in the conduct of any suit, and in enforcing any right of contributions or indemnity against an individual or organization who may be liable to the CITY because of the payment by the CITY of a Plan Claim;
- (b) attend any hearing or trial held in connection with a Plan Claim and assist in discovery, securing and giving evidence, and obtaining the attendance of witnesses.

Section 7. Determination of Coverage.

If the CITY denies coverage under the Plan to a Plan Member, the Plan Member may seek a determination of whether the member is entitled to such coverage from a court of proper jurisdiction.

Section 8. No Creation of Cause of Action.

NOTHING CONTAINED IN THIS ORDINANCE SHALL BE CONSTRUED AS CREATING A RIGHT OR CAUSE OF ACTION AGAINST THE CITY OR A PLAN MEMBER OR AS GIVING A RIGHT TO A THIRD PARTY TO INSTITUTE OR MAINTAIN A SUIT THAT WOULD NOT OTHERWISE EXIST UNDER LAW AS A LEGAL CLAIM AGAINST THE CITY OR A PLAN MEMBER.

Section 9. Indemnification of Claims Board.

In the course of carrying out its responsibilities, the Claims Board and its members shall be indemnified and held harmless by the CITY for any act or omission and the Program shall pay all attorney fees necessary in its defense and fully recognize the members' official immunity.

Section 10. Administration of Plan.

The Claims Board is responsible for the administration of the Plan in accordance with its terms, subject to the superior authority of the City Manager and approval by the City Council. In the course of carrying out this responsibility, the Claims Board shall interpret and apply the provisions of this Ordinance.

Section 11. Other Insurance.

The Self-Insurance afforded by this Ordinance is primary self-insurance. When this self-insurance is primary and the Plan Member has other insurance which is stated to be applicable to the Plan Claim, the amount of the Fund's liability under this Ordinance shall not be reduced by the existence of such other insurance.

Section 12. Construction, Amendment, Repeal, and Termination.

The Rules of Construction, as found in the Code Interpretation Act, shall apply in interpreting this Ordinance. This Ordinance may be repealed or amended at any time, subject to existing rights of Plan Members under Section 4 of this Ordinance, in which case the provisions of this Ordinance shall govern, all save and except, continuing obligations under prior indemnity ordinances.

Section 13. Conflicts With Other Ordinances.

This Ordinance shall not operate to repeal or affect any other ordinance of the CITY except to the extent that the provisions thereof are inconsistent or in conflict with this Ordinance, in which case the provisions of this Ordinance shall govern.

Section 14. Severability.

That the terms and provisions of this Ordinance shall be deemed to be severable and that if the validity of any section, subsection, sentence, clause or phrase of this Ordinance should be declared to be invalid, the same shall not affect the validity of any other section, subsection, sentence, clause or phrase of the Ordinance.

Section 15. Governmental Regulations.

The regulations provided in this Ordinance are hereby declared to be governmental and for the health, safety, and welfare of the general public.

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Section 16. Payments Subject to Appropriation.

All amounts payable under this Ordinance are subject to available and appropriated funding, and applicable law.

Section 17. No Right to Fund by Plan Member.

This Ordinance does not grant or vest any right to any Plan Member in, or to, the Funds administered by the Program Ordinance or any other funds of the City of San Antonio.

Section 18. Effective Date of Plan.

The program shall become effective on April 25, 1996, 12:01 a.m. and shall continue in effect until terminated by the City Council.

Section 19. Effective Date of Ordinance.

This Ordinance shall become effective upon its final adoption by the City Council.

ATTACHMENT 2
MASTER CONTRACT DOCUMENT

City of San Antonio

Master Contract Document

for the

San Antonio Professional Fire Fighters Association and San Antonio Police Officers Association
Bargaining Units
Health Benefit Program

San Antonio, Texas
June 1, 2007

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Specific Provisions Applicable to the San Antonio Professional Fire Fighters Association and San Antonio Police Officers Association Bargaining Units (Cadets are covered under the Flex Plan Document as those provisions apply to Non-Uniform City Employees) 52

MASTER CONTRACT

INTRODUCTION

The purpose of the Employee Health Benefit Program is to provide the City of San Antonio Uniform Employees with a family health plan, with coverage and benefits defined herein.

This Master Contract defines and provides for coverage and administration for the benefits common to uniform City employees. The variations in coverage applicable to such classes are set forth in specific appendices to this Master Contract, including but not limited to Firefighters and Police Officers. The coverage provisions applicable to a covered person shall collectively be referred to as the Plan, and the provisions of this Master Contract and the applicable appendices for any covered person shall be referred to as the Plan Document.

This Plan Document does not provide for any premium payment or contributions to the cost of coverage. The obligation and amount of such payments are separately determined from the Ordinances of the City Council or any applicable Collective Bargaining Agreements.

This plan is open to uniform City employees.

The benefits provided and defined in this Master Contract are self-funded by the City of San Antonio at the time this document was drafted, but the City of San Antonio is entitled to reinsure any portion of its obligations hereunder, and additionally may contract for any carrier acceptable to the City Council to assume and administer coverage and benefits under this document.

ANY BENEFITS UNDER THE CITY'S INSURANCE OR SELF FUNDED PROGRAMS ARE SUBJECT TO CHANGE AS DETERMINED BY THE CITY COUNCIL IN ANY BUDGET YEAR, OR BY AMENDMENT OR OTHER LAWFUL CHANGE TO THE APPLICABLE BARGAINING AGREEMENTS.

The City of San Antonio may select a claims administrator from time to time, or may elect to administer claims under the plan as an internal function. The City's claim administrator is not an insurer.

GENERAL INFORMATION

NAME OF PLAN: CitiMed

PLAN YEAR: January 1 through December 31.

PLAN SPONSOR: City of San Antonio
P.O. Box 839966
San Antonio, Texas 78283

PLAN ADMINISTRATOR: Employee Benefits Administrator
City of San Antonio

Human Resources Department
P.O. Box 839966
San Antonio, Texas 78283
(210) 207-8705

CLAIMS ADMINISTRATOR:

Community First
4801 N.W. Loop 410 (at Callaghan) Suite 1000
San Antonio, Texas 78229
Local (210) 227-2347 Pre-certification/Claims Inquiry
Out of Area (800) 434-2347
FAX: (210) 358-6199
www.cfhp.com

PREFERRED PROVIDER ORGANIZATION (PPO):
NETWORK: Texas True Choice
P.O. Box 250089
Plano, Texas 75025-0089 (Submit Claims)
Or EDI to: TTCEC
www.texastruechoice.com

PRESCRIPTION NETWORK: Walgreens Health Initiatives
101 North First Avenue, Suite 1900
Phoenix, Arizona 85003
Customer Service (800) 207-2568
RX Group# 274316
www.walgreenshealth.com

EFFECTIVE DATE: The effective date of this plan for uniform City employees is
June 1, 2007

PLAN AND CLAIMS ADMINISTRATION

Administration and payment of claims under the Plan Documents shall be carried out by the Claims Administrator, under the supervision of the Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan Document is carried out as written. The Plan Administrator shall have full power to administer the Plans and all of their details, and to make all final determinations about coverage on behalf of the City of San Antonio.

The Plan Administrator will make available for examination, to each Covered Person, his heirs, and/or assigns, records that pertain to the Covered Person at a reasonable time during normal business hours as established by the Plan Administrator.

The Plan Administrator's powers shall include, but shall not be limited to, the following:

- (a) To make and enforce reasonable rules and regulations as the Plan Administrator deems necessary or proper for the effective and efficient administration of the Plan Document;
- (b) To interpret the contract, including, but not limited to, all questions of coverage and eligibility. The Plan Administrator's interpretations thereof in good faith shall be final and conclusive on all persons claiming Benefits under the Plan Document, subject only to the Review and Appeal Process; and
- (c) To coordinate with and supervise the Claims Administrator, prepare and handle budgetary and contractual relationships involving the plan, distribute information to Covered Persons under the plan, appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan Document.

ELIGIBILITY REQUIREMENTS**Eligible Employee**

Full-time City employees (authorized full-time equivalent) are eligible to participate in the Plan on the date their employment begins. Coverage begins on the date of hire, or upon taking office and performing work for the City of San Antonio, whichever occurs later.

A new employee who is not actively at work for any reason other than due to medical disability on his scheduled effective date of coverage will not become covered under the Plan until such time as the employee returns to active employment.

Eligible Dependent

An Eligible Dependent is:

(1) The Eligible Employee's spouse. A spouse that is legally separated under a court decree under the laws of another state shall not be an eligible dependent,

(2) All natural children including legally adopted, under legal guardianship of the Covered Employee and who have not yet reached their twentieth birthday, provided the children have never been married and are principally dependent upon the Eligible Employee, as directed by court order, for support and maintenance. Foster children are not Eligible Dependents under this Plan, unless there has been an application for adoption accepted by the Texas Department of Human Services. Stepchildren are Eligible Dependents during the marriage between the Eligible Employee and the natural parent of the child, so long as (a) they permanently reside in the employee's household, and (b) are principally dependent on the employee.

In addition to the above, children will be considered as Eligible Dependents from age twenty (20) through age twenty-three (23), if they are full-time students, have never been married, and are principally dependent upon the Eligible Employee for support and maintenance.

The term "Eligible Dependent" shall not include anyone who is covered as an Eligible Employee. An Eligible Dependent shall not be entitled to any additional benefits or coverage by virtue of the fact that both parents, step parents or guardians are employed by the City.

Incapacitated Dependent

An Eligible Dependent child who is physically or mentally incapable of self-support upon attaining the age of twenty (20) years, shall continue to be an Eligible Dependent while remaining incapacitated, unmarried and continuously covered under the Plan. An eligible incapacitated dependent must be solely

dependent on the employee, and must be incapacitated by a disability that arose while such dependent was a covered dependent. To continue eligibility under this provision, proof of incapacity must be submitted by the employee at least thirty-one (31) days prior to such child's attainment of age twenty (20).

Effective Date of Coverage

Coverage does not become effective until the Eligible Employee completes the City's enrollment document.

Newborn infants will be covered from the date of birth as long as the employee is covered under this plan and coverage for the newborn child is requested within 31 days of the child's date of birth. If coverage of a newborn is not requested within 31 days of the child's date of birth, then coverage cannot become effective until the next re-enrollment period.

Eligible Dependents who are enrolled after the effective date of this Plan will become covered on the date such dependent is acquired, provided that the covered Employee enrolls such dependent within 31 days of the date the dependent is acquired. If coverage of a dependent is not requested within 31 days of the date the dependent was acquired, the coverage cannot become effective until the next re-enrollment period.

Change of Family Status

If there is a legal change in family status, the employee has thirty-one (31) calendar days to notify the Employee Benefits Office in writing. The notice may be given by personally appearing in the Benefits Office and completing a change of dependent coverage form.

If there is no change in family status or if notice is not given for additional coverage within thirty-one (31) days after the legal change in status, no change can become effective until the next re-enrollment period, which shall be not less than thirty-one (31) days, occurring during the months of October or November, as the Plan Administrator shall determine, or as otherwise established by the City Council.

A legal change in family status includes: divorce; marriage; birth or adoption of a child, including a child living with the adopting parents during the period of probation; change in employment status for the employee's spouse; or ineligibility of a child due to age, or change in student status.

Termination of Coverage for Individuals

The coverage of any Covered Person under the Plan shall terminate on the earliest of the following dates:

- (1) The date of termination of the Plan;
- (2) The date employment terminates;
- (3) The date all coverage or certain benefits are terminated in a particular class by modification of the Plan; and
- (4) The date an active Eligible Employee is covered under a qualified Health Maintenance Organization (HMO) or any other available alternative health care delivery system for the employee or dependents of the employee.

Termination of Coverage for Dependents

Coverage with respect to the Covered Person's dependents shall terminate under the Plan at the earliest time specified below:

- (1) Upon termination of employment for the covered employee;
- (2) On the date dependents cease to be eligible as defined in the Plan.

Termination of Coverage for Failure to Pay Premium

Coverage with respect to any Covered person for which a premium or contribution is required shall terminate 31 days after the due date for such premium, or as soon thereafter as otherwise allowed by law.

Documentation

The Plan Administrator is entitled to require relevant legal documentation to be furnished with any request for coverage or change in status.

CONTINUATION COVERAGE

On April 7, 1986, a federal law was enacted requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This law is called the Consolidated Omnibus Budget Reconciliation Act of 1985, better known as COBRA. This notice is intended to inform employees, in a summary fashion, of rights and obligations under the continuation coverage provisions of COBRA. The employee and spouse should take the time to read this notice carefully.

"Qualified Beneficiary" means:

- a. you, as a Covered Employee, for termination or reduced hours;
- b. your spouse or your dependent child if he/she was a dependent under the Plan on the day before your Qualifying Event occurred; or
- c. a child who is born to a Covered Employee during a period of COBRA continuation coverage.

"Qualifying Event for a Covered Employee" means a loss of coverage due to:

- a. termination of employment for any reason other than gross misconduct; or
- b. reduction in hours of employment.

"Qualifying Event for a Covered Dependent" means a loss of coverage due to:

- a. a Covered Employee's termination of employment for any reason other than a gross misconduct or reduction in hours of employment;
- b. a Covered Employee's death; a spouse's divorce or legal separation from a Covered Employee;
- c. a Covered Employee's entitlement to Medicare; or
- d. a dependent child's loss of dependent status under the Plan.

"Timely contribution payment" means contribution payment must be made within 30 days of the due date or within such longer period as applies to or under the Plan.

Continuation of Health Coverage. Continuation of health coverage shall be available to you and/or your Covered Dependents upon the occurrence of a Qualifying Event. To continue health coverage, the Plan Administrator must be notified of a Qualifying Event by:

- (a) the Employer, within 30 days of such event, if the Qualifying Event is:
 1. for a Covered Dependent, the Covered Employee's death;

2. the Covered Employee's termination other than for gross misconduct or reduction in hours;
 3. for a Covered Dependent, the Covered Employee's entitlement to Medicare.
- (b) you or a Qualified Beneficiary, within 60 days of such event, if the Qualifying Event is:
1. for a spouse, divorce, or legal separation from a Covered Employee; or
 2. for a dependent child, loss of dependent status under the Plan.

The Plan Administrator must, within 14 days of receiving such notice, notify any Qualified Beneficiary of his/her continuation right. Notice to a Qualified Beneficiary who is your spouse shall be notice to all other Qualified Beneficiaries residing with such spouse when such notice is given.

Upon termination of employment or reduction in hours, to continue health coverage for 29 months, a Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act to be disabled on such date or at any time during the first 60 days of COBRA continuation coverage, must notify the Plan Administrator of such disability within 60 days from the date of determination and before the end of the 18 month period. If a Qualified Beneficiary entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, the non-disabled family members are also entitled to the disability extension.

Qualified Beneficiaries who are disabled under Title II or Title XVI of the Social Security Act must notify the Plan Administrator within 30 days from the date of final determination that they are not longer disabled.

A Qualified Beneficiary must elect Continuation of Health Coverage within 60 days from the later of the date of the Qualifying Event or the date notice was sent by the Plan Administrator.

A newborn child of a Qualified Beneficiary or a child placed with a Qualified Beneficiary for adoption may be added according to the enrollment requirements for dependent coverage under the Eligibility Requirements of the Plan.

Any election by you or your spouse shall be deemed to be an election by any other Qualified Beneficiary, though each Qualified Beneficiary is entitled to an individual election of continuation coverage.

Upon election to continue health coverage, a Qualified Beneficiary must, within 45 days of the date of such election, pay all required contribution to date to the Plan Administrator. All future contribution payments by a Qualified Beneficiary must be made to the Plan Administrator and are due the first of each month with a 30-day grace period.

A Qualified Beneficiary will be notified by the Plan Administrator of the amount of the required contribution payment and the contribution payment options available.

Termination of Coverage. Coverage will end upon the earliest of the following:

- (a) termination or reduction of hours;
1. 18 months from the date of the Qualifying Event; or
 2. 29 months from the date of the Qualifying Event if the Qualified Beneficiary is determined under Title II or Title XVI of the Social Security Act to be disabled on such date or at any time during the first 60 days of COBRA continuation

coverage and provides notice as required by law (including, COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension).

- (b) the day, after the 18 month continuation period, which begins more than 30 days from the date of a final determination under Title II or Title XVI of the Social Security Act that a Qualified Beneficiary, entitled to 29 months, is no longer disabled (including COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension who is no longer disabled).
- c. for a Covered Dependent, 36 months from the date of the Qualifying Event if the Qualifying Event is:
 - 1. the Covered Employee's death;
 - 2. the Covered Employee's entitlement to Medicare;
 - 3. a spouse's divorce or legal separation from a Covered Employee; or
 - 4. a dependent child's loss of dependent status under the Plan.
- d. if any of the Qualifying Events listed in (c) occurs during the 18-month period after the date of the initial Qualifying Event listed in (a), coverage terminates 36 months after the date of the Qualifying Event listed in 1.
- e. the date on which the Employer ceases to provide any group health plan to any employee;
- f. the date on which a Qualified Beneficiary fails to make timely payment of the required contribution;
- g. the date on which a Qualified Beneficiary first becomes (after the date of the election) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary;
- h. the first day of the month in which a Qualified Beneficiary becomes entitled to Medicare; or
- i. the date this Plan terminates.

Continuation of health coverage under this provision shall not duplicate health care coverage continued under any state or federal law.

Any questions about COBRA should be directed to the City's Employee Benefits Office,
506 Dolorosa, Suite 124, San Antonio, Texas 78204, (210) 207-8705.

A. Use and Disclosure of Protected Health Information (PHI)

The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the Plan to determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-insurance as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or review of appropriateness of care or justification of charges;
- utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- reimbursement to the plan.

Health Care Operations include, but are not limited to, the following activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- **rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;**
- underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- business management and general administrative activities of the Plan, including, but not limited to:
 - (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
 - (b) customer service, including the provision of data analysis for management; and
- resolution of internal grievances.

B. The Plan Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary

C. For Purposes of This Section, the City of San Antonio is the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions.

D. With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions

The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the plan document or as required by law;
- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the plan Sponsor with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

E. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, only the following employees may be given access to PHI:

- the staff of the Employee Benefits Division of the Human Resources Department
- the staff of the Finance Department assigned to the Self Insurance Fund and
- the staff of Legal Department assigned to the Employee Benefits Division.

F. Noncompliance Issues

If the persons described in section E do not comply with this plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

"**ACCIDENTAL INJURY**" means a condition caused by an accidental means which results in traumatic damage to the Covered Person's body from an external force that is unexpected at the time, but which occurrence was definite as to time and place. Normal and routine human movements and activities shall not be considered accidents, even though unexpected physiological injury or damage may occur as a result thereof. (Such as bending, stooping or lifting resulting in disc injury; or yawning that damages the temporomandibular joint).

"**ACTIVELY AT WORK**" means the active expenditure of time and energy in the service of the Employer, except that an employee shall be deemed actively at work on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day.

"**ALLOWABLE EXPENSE**" relates to coordination of benefits, under Chapter 13 of this Plan Document. Allowable expenses shall mean any necessary usual, customary and reasonable expenses incurred while eligible for benefits under the Plan, part or all of which would be covered under any of the plans, but not including any expenses contained in the Exclusions chapter.

"**AMBULATORY SURGICAL CENTER**" means a specialized facility which is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures on an outpatient basis and which fully meets one of the following two tests:

- (a) It is licensed as an ambulatory surgical facility in the state in which it is located; or
- (b) Where licensing is not required:
 - 1. it is operated under the full-time supervision of a physician;
 - 2. it permits surgical procedures to be performed only by physicians who are privileged to perform the procedure in at least one local hospital;
 - 3. it requires in all cases, except for those using only local infiltration anesthetics, that a licensed anesthesiologist either administers the anesthetic or supervises an anesthetist who administers it and that the anesthesiologist or anesthetist remains present throughout the surgical procedure;
 - 4. it provides at least one operating room and at least one post-anesthesia recovery room;
 - 5. it is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services;
 - 6. it has trained personnel and necessary equipment to handle emergencies;
 - 7. it has immediate access to a blood bank or blood supplies;
 - 8. it provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating room and post-anesthesia recovery room; and

9. it maintains an adequate medical record for each patient that contains an admitting diagnosis that includes, except for patients undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays, and operative report and discharge summary.

"**ANNUAL MEDICAL CO-INSURANCE OUT OF POCKET**" is the sum of the co-insurance under the Plan Document. When the annual out of pocket is reached (which can be for an individual or a family, cumulative) covered expenses incurred during that plan year will be paid at 100%.

Out of Pocket does not include:

- * Charges beyond usual & customary fees;
 - * Penalties resulting from non-compliance with pre-certification;
 - * Co-insurance for inpatient or outpatient mental & nervous benefits;
 - * Charges not covered under the Plan.
- Pharmacy in or out of network co-insurance

"**ANNUAL PRESCRIPTION CO-INSURANCE OUT-OF-POCKET**" the sum of in-network prescription co-insurance under the Plan Document. When the annual out of pocket is reached (which can be for an individual or a family, cumulative) covered expenses incurred during that plan year will be paid at 100%. Coinsurance amounts paid toward out-of-network prescriptions do not apply to the out of pocket maximum under the group health care coverage. The amount a member pays for any non-covered drug will not be included in calculating the Annual Out-of-Pocket maximum. The member is responsible for paying 100% of the cost for any non-covered drug and the contracted rates will not be available.

"**BODY ORGAN**" means the following (a) a kidney; (b) a heart; (c) a heart/lung; (d) a liver, (e) a pancreas, when the condition is not treatable by use of insulin therapy; (f) bone marrow; and (g) a cornea.

"**CALENDAR YEAR**" a period of 12 consecutive months beginning with January 1 through December 31 of the same year. For new employees and dependents, the calendar year is the effective date of their coverage through December 31 of the same year.

"**CITY**" means the City of San Antonio.

"**CLAIMS ADMINISTRATOR**" means the Third Party Administrator or any City employee or office designated to process claims under the Plan Document.

"**COINSURANCE**" is the Covered Person's obligation to pay a percentage of the costs of care in accordance with the terms and provisions of this Plan document. For example, if this plan provides for payment of 80% of eligible medical expense, the remaining 20% is the employee's obligation, and is referred to as "coinsurance." If the plan provides for out of network payment of 60% of eligible medical expense, the remaining 40% employee obligation is referred to as "coinsurance." If the plan provides for an in-network prescription payment of 80%, the remaining 20% is the employee's obligation and is referred to as "co-insurance."

"COMPLICATIONS OF PREGNANCY" means:

- (a) conditions requiring hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity; or
- (b) non-elective caesarean section; ectopic pregnancy which is terminated; or spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

"Complications of pregnancy" does not mean: false labor; occasional spotting; physician prescribed rest during pregnancy; morning sickness; hyperemesis gravidarum; preeclampsia; or similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

"COSMETIC PROCEDURES" mean any surgical procedure or any portion of a surgical procedure performed primarily to improve physical appearance and does not promote the proper function of the body or treat any illness or injury.

"COVERED PERSON" means an eligible Employee, retiree, official or eligible Dependent covered under this Plan.

"COVERED PROVIDER" means an ambulatory surgical center, a home health care agency, a licensed hospice care center, a hospital, a physician, a surgeon, a psychiatric day treatment facility, a rehabilitation facility and a skilled nursing facility.

"CUSTODIAL CARE" means that type of care or service, wherever furnished and by whatever name called, which is designated primarily to assist a covered person, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in or out of bed, and supervision over medication which can normally be self-administered.

"DEDUCTIBLE" means the amount of Covered Medical Expenses a Covered Person must incur and pay each calendar year before benefits are payable under the Plan.

"FAMILY DEDUCTIBLE LIMIT" means that, once the sum of the family deductible has been satisfied by the cumulative Covered Medical Expenses of the eligible employee and one (1) or more of his eligible dependents in a Calendar Year, no further deductible need be satisfied in that Calendar Year for any other eligible member of the family.

For example (in-network):

Employee	\$ 85.00	
Spouse	\$250.00	Satisfied the Individual Deductible
Child	\$ 90.00	
Child 2	\$100.00	
Total submitted	\$525.00	
Family Deductible Accumulation	\$500.00	
		\$ 25.00 reimbursed at coinsurance level

Where a City employee, by virtue of his relationship to another City employee, would be considered an eligible dependent but for his employment with the City, the higher of the two (2) family deductibles of these two (2) City employees need only be satisfied.

"DENTIST" means a currently licensed dentist practicing within the scope of the license or any physician furnishing dental services which the physician is licensed to perform.

"DIABETES EQUIPMENT" means the following:

- a. blood glucose monitors, including monitors designed to be used by blind individuals;
- b. insulin pumps and associated appurtenances;
- c. insulin infusion devices; and
- d. podiatric appliances for the prevention of complications associated with diabetes.

"DIABETES SUPPLIES" means the following:

- a. test strips for blood glucose monitors;
- b. visual reading and urine test strips;
- c. lancets and lancet devices;
- d. insulin and insulin analogs;
- e. injection aids; syringes;
- f. prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and
- g. glucagon emergency kits.

"DONOR" means a person who undergoes a surgical operation for the purpose of donating a body organ(s) for transplant surgery.

"DURABLE MEDICAL EQUIPMENT" means equipment prescribed by the attending physician which meets each of the following: a) medically necessary; b) is not primarily or customarily used for non-medical purposes; c) is designated for prolonged use; and d) serves a specific therapeutic purpose in the treatment of any injury or illness.

"EFFECTIVE DATE", when applied to an individual's coverage under the Plan, means the first day of the individual's coverage. The individual's effective date may or may not be the same as the individual's enrollment date (as "enrollment date" is defined by the Plan).

"ELIGIBLE EXPENSE" is any expense, which is eligible for payment, in whole or in part under this plan document.

"EMERGENCY SERVICES" Emergency Services are health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions, including a behavioral health condition, of a recent onset and severity including, but not limited to, severe pain that would lead a prudent lay person, possessing an average knowledge of medicine and health to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:

1. placing his or her health in serious jeopardy;
2. serious impairment to bodily functions;

3. serious dysfunction of any body organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

This definition is only for purposes of determining whether out of network emergency services will be paid at in-network benefit levels.

"EMPLOYEE" means a person who is directly employed by the City of San Antonio and is regularly scheduled for a full shift or schedule in like manner as other similarly situated workers in the department or division. "Employee" shall also include employees on Worker's Compensation, Disability, or Non-Paid status.

"EMPLOYER" means the City of San Antonio.

"FIRE FIGHTER" means any full time, permanent, paid Employee who:

- (a) Is employed by the City's Fire Department;
- (b) Has been hired in substantial compliance with Chapter 143 of the Local Government Code;
- (c) Has successfully completed the Fire Academy; and
- (d) Has received his or her certificate from the Fire Chief.

"FULL TIME STUDENT" means a participant's dependent child who is enrolled in and regularly attending an accredited college, university or institution on a full time basis as determined by the institution attended by the student. Evidence of the child's status as a full time student satisfactory to the claims administrator must be furnished by the covered person in the event of a claim or enrollment. A person ceases to be a full time student at the end of the month during which the person graduates or otherwise ceases to be enrolled and in attendance at the institution on a full time basis. A person continues to be a full time student during periods of vacation established by the institution, unless the person does not continue as a full time student immediately following the period of vacation.

"HOME HEALTH CARE AGENCY" means an agency or organization which meets all of the following requirements:

- (1) It is licensed and primarily engaged in providing skilled nursing care and other therapeutic services;
- (2) It has policies established by a professional group associated with the agency or organization and includes at least one physician and one registered graduate nurse (R.N.) who provide full time supervision of such services;
- (3) It maintains complete medical records on each individual;
- (4) It has a full time administrator.

"HOSPICE" means an agency which:

- a. is primarily engaged in providing counseling, medical services or room and board to terminally ill persons;
- b. has professional service policies established by a group associated with it. This group must include one (1) Physician, one (1) Registered Nurse (RN) and one (1) social service coordinator;
- c. has full-time supervision by a Physician;
- d. has a full-time Administrator;
- e. provides services 24 hours a day, seven (7) days a week;
- f. maintains a complete medical record of each patient; and
- g. is licensed in accordance with state law.

"HOSPITAL" means only an institution constituted and operated pursuant to any applicable law, engaged in providing, on an inpatient basis at the patient's expense, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick individuals by or under the supervision of a licensed physician or surgeon and continuously providing 24-hour-a-day services by registered nurses. The term "hospital" shall not include any institution or part thereof which is other than incidentally a place for rest, a residential treatment center, or a nursing home or convalescent hospital.

"INTENSIVE CARE UNIT OR CARDIAC CARE UNIT" means a clearly designated service area which is maintained within a hospital and which meets all of the following tests:

- (a) It is solely for the treatment of patients who require special medical attention because of their critical condition;
- (b) It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the hospital;
- (c) It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area; and
- (d) It provides at least one professional registered nurse who continuously and constantly attends to the patient confined in such area on a twenty-four (24) hour a day basis; or
- (e) An alternate hospital that is approved by the Plan Administrator, as long as the cost of care does not exceed the cost of care at a hospital that substantially meets subparagraphs (a) through (d) above, in accordance with one or more of the following criteria:
 - (i) to facilitate provision of medical services by a particular physician;
 - (ii) the covered person's physician certifies in writing to the Plan Administrator before services are rendered that the hospital is equipped to provide needed intensive or cardiac care;
 - (iii) proximity of the covered person's immediate family members;

- (iv) the medical condition of the covered person indicates that it would be inadvisable to transfer to another hospital.

"**LIFETIME MAXIMUM**" is the cumulative maximum amount payable during the lifetime of the covered person, during periods of eligibility, as set forth in the Schedule of Benefits.

"**MASTER CONTRACT**" means and refers to this Plan Document, which sets forth the provisions of universal applicability to the City's various health benefit plans.

"**MEDICALLY NECESSARY**" means any care, treatment, service or supply provided for the diagnosis and treatment of a specific illness, injury or condition which meets all of the following.

- (a) The care and treatment is appropriate given the symptoms, and is consistent with the diagnosis, if any. "Appropriate" means that the type, level, and length of service and the setting are needed to provide safe and adequate care and treatment;
- (b) It is rendered in accordance with generally accepted medical practice and professionally recognized standards in the United States medical community;
- (c) It is not treatment that is generally regarded as experimental, educational or unproven; and
- (d) It is specifically allowed by the licensing statutes that apply to the provider that renders the service.

With respect to confinement in a hospital "medically necessary" further means that the medical condition requires confinement and that safe and effective treatment cannot be provided as an outpatient.

The Claims Administrator may require satisfactory proof in writing, that any type of treatment, service or supply received is Medically Necessary. The Claims Administrator may also specifically require the prescribing physician or consulting board or committee of any facility to provide a written analysis of the necessity and acceptability of the methods, process or procedure under this paragraph, taking into account the criteria set forth above. The fact that a physician may prescribe, order, recommend or approve care, treatment, service or supply does not, in itself, make them Medically Necessary.

Medical necessity specifically does not include any:

- (a) Repeated test which would not be necessary if initially done correctly, or is not necessary at current intervals;
- (b) Care, treatment, service or supply which is for the psychological support, education or vocational training of the Covered Person;

Criteria used in determining that a procedure is experimental includes:

- (a) Whether there is an appropriate rationale for the treatment;
- (b) Whether there is evidence that the treatment is effective;

- (c) Whether there is evidence that the treatment is harmful;
- (d) Whether the benefits justify the immediate and delayed risks of treatment;
- (e) Whether the treatment has been endorsed or approved by the appropriate medical authorities, such as the FDA, the AMA or other medical specialty societies or specialists or whether the treatment is covered by Medicare or other public programs;
- (f) Whether the device or treatment is the subject of ongoing investigation or research;
- (g) Whether the treatment is legal;
- (h) Whether controlled medical trials have been carried out that demonstrate the treatment's efficacy.

"**NEWBORN CARE**" charges for the routine care of a newborn child, while hospital confined, are covered by the Plan on the same basis as an illness of such newborn child. Such charges will be considered separate from the mother's charges and subject to the deductible and the applicable benefit percentage payable as shown in the Schedule of Benefits. All such newborn coverage shall include circumcision. Well baby care is covered for three days after birth, before an individual dependent deductible is applicable to the newborn.

"**OTHER COVERAGE**" means any other contract or policy under which the Covered Person is enrolled, such as:

- * Group or blanket insurance;
- * Group practice, group Blue Cross, group Blue Shield, individual practice offered on a group basis, or other group prepayment coverage;
- * Labor management trustee plans, union welfare plans, employee organization plans, or employee benefit organization plans;
- * Government programs, such as Medicare, or coverage required or provided by statute;
- * Any group coverage of a child sponsored by, or provided through, any educational institution;
- * Group arrangements for members of associations or individuals.

"**OTHER COVERED PROVIDER**" means a certified social worker (CSW) licensed professional counselor (LPC), licensed occupational therapist (LOT), certified nurse midwife, licensed speech therapist, licensed physical therapist, registered nurse, licensed vocational nurse, or licensed practical nurse.

"**PHYSICIAN OR SURGEON**" means any professional practitioner who holds a lawful license authorizing the person to practice medicine or surgery in the locale in which the service is rendered, limited to a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Podiatric Medicine (D.P.M.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Chiropractic (D.C.), a Clinical Psychologist (Ph.D), who has met the standards of the National Register of Health Service Providers in Psychology.

"**PLAN**" whenever used herein without qualification means this Plan Document.

"**PLAN ADMINISTRATOR**" means the City of San Antonio's designated Employee Benefits Administrator.

"**PLAN DOCUMENT**" means this Master Contract and any Addendum, which collectively provide and define coverage for particular employees and dependents.

"**PLAN SPONSOR**" means the City of San Antonio.

"**PLAN SUMMARY**" is the information provided to City employees concerning coverage and benefits to assist in understanding and using available benefits. **THE PLAN SUMMARY DOES NOT DEFINE COVERAGE, WHICH IS THE SOLE PURPOSE OF THE MASTER CONTRACT. ANY STATEMENT ABOUT COVERAGE IN THE SUMMARY IS A GENERAL INTERPRETATION ONLY, AND IS NOT MADE FOR SPECIFIC APPLICATION TO ANY COVERED PERSON, ILLNESS, OR EXPENSE.**

"**POLICE OFFICER**" means any full time, permanent, paid employee who:

- (a) Is employed by the City's Police Department;
- (b) Has been hired in substantial compliance with Chapter 143 of the Local Government Code;
- (c) Has successfully completed the Police Academy; and
- (d) Has received his or her certificate from the Police Chief.

"**POST DELIVERY CARE**" means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. Post Delivery Care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests.

"**PRINCIPALLY DEPENDENT**" shall have the meaning defined in Sections 151 and 152 of the Internal Revenue Code and the regulations thereunder.

"**PSYCHIATRIC DAY TREATMENT FACILITY**" means an institution which meets all of the following requirements:

- (a) It is a mental health facility which: provides treatment for individuals suffering from acute mental, nervous or emotional disorders, in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program; and is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.
- (b) It is accredited by the Program for Psychiatric Facilities or its successor, or the Joint Commission on Accreditation of Hospital; and

- (c) Its patients are treated for not more than eight (8) hours in any twenty-four (24) hour period.

"QUALIFIED INSURED" means an individual eligible for coverage under the Plan who has been diagnosed with:

- a. insulin dependent or non-insulin dependent diabetes;
- b. elevated blood glucose levels induced by pregnancy; or
- c. another medical condition associated with elevated blood glucose levels.

"RECIPIENT" means an insured person who undergoes a surgical operation to receive a body organ transplant.

"REHABILITATION FACILITY" means a facility that provides services of acute rehabilitation. All services are provided under the direction of a physician with a specialty in rehabilitation and physical medicine. The facility is staffed around the clock by registered nurses and it does not provide services of a custodial nature. The facility must be Medicare certified, licensed by the State Department of Health as a "special hospital" and accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is also accredited by the Commission on Accreditation of Rehabilitation Facilities.

"SKILLED NURSING FACILITY" means a legally operated institution, or a distinct part of an institution, primarily engaged in providing skilled nursing care to patients recovering from injury or illness and which:

- (a) Is under the resident supervision of a physician or registered nurse (R.N.);
- (b) Provides continuous skilled nursing care for 24 hours of every day;
- (c) Requires that the health care of every patient be under the supervision of a physician;
- (d) Provides that a physician be available at all times to furnish necessary medical care in emergencies;
- (e) Maintains clinical records for each patient;
- (f) Has an effective utilization review plan;
- (g) Has a transfer agreement with at least one (1) hospital;
- (h) Is not, other than incidentally, a clinic, a place devoted to care of the aged or a place for treatment of mental disorders or mental retardation;
- (i) Is not a place for custodial care.

"TEMPORARY MECHANICAL EQUIPMENT" means any non-organic device used in conjunction with the recipient's own body organ for the purpose of sustaining a bodily function for which a transplant has been deemed necessary by the attending physician.

"TRANSPLANT SURGERY" means the transfer of body organ(s) from a donor to a recipient.

"USUAL & CUSTOMARY CHARGE" means charges for Medically Necessary services and supplies which would usually be provided for cases the same as or similar to the one being treated. The Usual and Customary charge is limited to the lesser of:

- (a) The fee usually charged by the provider for similar services and supplies; and
- (b) The fee usually charged for the same service or supply by other providers who are in the same area. "Area" means a geographical area as determined by the Claims Administrator to be significant enough to establish a representative base of charge for the treatment. The determination of the "usual and customary" charges by the Claims Administrator shall be based on standard profiles and statistical sampling methods accepted in the benefits industry. Usual and customary shall be based on the 85th percentile and updated on a semi-annual basis. All charges above or beyond the "usual and customary" charges so determined are the financial responsibility of the Covered Person. Upon request, the City will furnish information or assistance to a Covered Person to enable them to contest excessive charges, in accordance with the policy of the Employee Benefits Office in effect at the time of the request.

Covered Medical Expenses shall be the portion, set forth in the Schedule of Benefits, of the usual and customary charges for the following services, supplies, and treatment when medically necessary and when ordered by a licensed physician or surgeon. Medical expenses exceeding usual and customary expenses covered by this plan will be the obligation of the Covered Person.

1. Daily semi-private room charge in a hospital or rehabilitation facility.
2. Services and supplies furnished by a hospital.
3. Treatment by a physician or surgeon.
4. Treatment by an other covered provider not related by blood or marriage.
5. Anesthetic and its administration.
6. "Surgery in mouth or oral cavity" is limited to:
 - (a) removal of non-odontogenic lesions, tumors or cysts;
 - (b) incision and drainage of non-odontogenic cellulitis;
 - (c) surgery on accessory sinuses, salivary glands and ducts and tongue;
 - (d) surgical treatment of fractures and dislocation of the jaw resulting from an accidental injury.
7. Diagnostic radiology, radiation therapy and laboratory examinations.
8. Ambulance charges to or from the nearest medically appropriate hospital by an ambulance service operated in accordance with State law.
9. Medical supplies and equipment as follows:
 - (a) drugs and medicines which can be obtained only by numbered prescription for the specified illness or injury for which the patient is being treated;
 - (b) birth control pills, injections and medication implants are covered for employees and dependent spouses only. No other contraceptive methods or devices are covered;
 - (c) blood and blood plasma;

- (d) charges for drawing and storing autologous blood;
 - (e) prosthetic appliances such as artificial limbs or eyes, not including their replacement except when required due to growth or development of a dependent child. After a covered mastectomy, breast implants or prostheses are also covered. Replacement of breast prosthesis is covered only when original prosthesis was required due to a major catastrophic illness or injury;
 - (f) crutches. The rental (but not to exceed the total cost of purchase) or, at the option of the Claims Administrator, the purchase of durable medical equipment when medically necessary and prescribed by a physician for therapeutic use, including wheelchairs, hospital beds, oxygen and equipment for its administration including IPPB (Intermittent Positive Pressure Breathing);
 - (g) medical supplies such as lancets, autolets, syringes, dextrowash and dextrostix, ostomy supplies, casts, splints, trusses and braces;
 - (h) orthopedic shoes when prescribed by a physician.
10. Dental treatment for fractured jaw or for injury to sound natural teeth including replacement of such teeth within six months after the date of accident, provided that such accident occurs while the insurance is in force as to the covered person.
11. Expenses incurred for maternity care and services shall be covered on the same basis as for any other illness incurred by the covered person or the dependent spouse. There is no coverage for expenses for maternity care and services incurred by a dependent child except for complications of pregnancy which shall be treated as any other illness.

The attending physician shall make the determination as to whether a delivery is complicated.

Under Federal law, group health plans generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The 48-hour period (or 96-hour period if applicable) begins at the time a delivery occurs in the hospital (or in the case of multiple births, at the time of the last delivery) or, if the delivery occurs outside the hospital, at the time a mother and/or newborn are admitted. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable) following the delivery.

If a decision is made to discharge a mother or her newborn child from inpatient care before the expiration of the minimum hours of coverage of inpatient care as provided above, the Plan will provide coverage for timely Post Delivery Care as defined herein. Such care may be provided to the mother and the child by a physician, registered nurse or other appropriate licensed health care provider and may be provided at the mother's home, a health care provider's office, a health care facility or another location determined to be appropriate under rules adopted by the Commissioner of Insurance.

12. Newborn care.
13. Services of a licensed speech therapist are covered when therapy is rendered in accordance with physician's specific instructions as to type and duration when speech was present before the illness and/or injury, and for a child born under the plan with developmental disorder or birth defects.
14. Services of a licensed physical therapist are covered only for those services that require the technical medical proficiency and skills of a licensed physical therapist and which are rendered in accordance with a physician's specific instructions as to type and duration.
15. Acupuncture or hypnosis when performed by a covered provider and in lieu of anesthesia.
16. Psychiatric Treatment. Serious mental illness includes the following; (1) schizophrenia; (2) paranoia and other psychotic disorders; (3) bipolar disorders (mixed, manic, depressive, and hypomanic); (4) major depressive disorders (single episode or recurrent); (5) schizo-affective disorders (bipolar or depressive); (6) pervasive developmental disorders; (7) obsessive-compulsive disorders; and (8) depression in childhood and adolescence. Treatment of the above-listed serious mental illnesses is limited to 45 days of inpatient treatment per calendar year and 60 visits for outpatient treatment, including group and individual outpatient treatment, per calendar year. Coverage for such treatment does not include addiction to a controlled substance or marihuana that is used in violation of law or mental illness resulting from the use of a controlled substance or marihuana in violation of law. The above-listed serious mental illnesses will be covered as any other illness subject to applicable deductibles, coinsurance, limits and exclusions, pre-certification and non-pre-certification penalties. Any diagnosis other than those listed in the sub-paragraph will be subject to the current Plan design in each program.
17. Chemical dependency and substance abuse will be treated as any other illness.
18. Voluntary sterilization is covered.
19. Preventive services:
 - a. One routine pap smear (doctor's procedure charge, lab expenses and office visit) per calendar year for female covered persons;
 - b. One routine mammogram per calendar year for female covered persons age thirty-five (35) and over;
 - (c) One (1) routine physical examination per calendar year for an eligible employee only.
 1. If performed by the employee's own physician, covered services will be limited to a preventative medical examination, blood chemistry profile, thyroid function (TSH), fecal occult blood, urinalysis, electrocardiogram, body fat measurement, health risk appraisal, stress and personality profile, and nutritional analysis, subject to the deductible and coinsurance as stated herein.
 2. If performed at the Occupational Health Clinic, at 401 West Commerce, the Plan will cover a complete blood count, cholesterol and glucose screening; blood pressure check; height and weight evaluation; and a health assessment questionnaire at 100%.

- (d) A physical examination for the detection of prostate cancer and prostate-specific Antigen test used for the detection of prostate cancer for each male enrolled in the Plan who is;
 - 1. at least 50 years of age and asymptomatic; or
 - 2. at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

- 20. (a) Gamma globulin injections and the following immunizations for Covered Dependents from birth through the date the child is six (6) years of age shall be covered: (a) DTP, (b) polio (OPV), (c) MMR, (d) meningitis (HIB); (e) hepatitis B (HBV); (f) TB tine; (g) varicella; and (h) any other immunizations as required by Texas law. After age six (6), the aforementioned immunizations will be covered only if the dependent was covered under this Plan before attaining age six (6). Expenses for all covered immunizations are covered at 100%, deductible waived. Other services provided at the same time as the immunizations, including, but not limited to, office visit charges, shall be subject to the deductible and coinsurance.

(b) Synagis (Palivizumab) administration for the prevention of respiratory syncytial virus (RSV) among high risk infants meeting prescribing criteria set forth by American Academy of Pediatrics (AAP) will be covered at 100%, deductible waived, only if such treatment is determined to be medically necessary and prior authorization obtained on or before administration of the first injection.

- 21. Expenses for Attention Deficit Disorder.

- 22. Occupational Therapy.

- 23. Diabetes. Coverage shall be provided to each Qualified Insured as defined herein for:
 - a. diabetes equipment;
 - b. diabetes supplies; and
 - c. diabetes self-management training programs as defined herein.

A health care practitioner or provider who is licensed, registered, or certified in Texas to provide appropriate health care services must provide diabetes self-management training. Self-management training includes:

- a. training provided to a Qualified Insured after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies;

- b. additional training authorized on the diagnosis of a physician or other health care practitioner of a significant change in the Qualified Insured's symptoms or condition that requires changes in the Qualified Insured's self-management regime; and

- c. periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.

24. Temporomandibular Joint. Medically necessary diagnostic or surgical treatment of conditions affecting the temporomandibular joint (jaw and the craniomandibular joint) resulting from one of the following shall be covered:
- a. an accident;
 - b. a trauma;
 - c. a congenital defect;
 - d. a developmental defect; or
 - e. a pathology.

Such coverage is subject to the same Plan provisions as for any surgical treatment including, but not limited to, the requirements for pre-certification of benefits.

25. Mastectomy. Coverage for inpatient care for a Covered Person is as follows:

- a. 48 hours following a mastectomy; and
- b. 24 hours following a lymph node dissection for the treatment of breast cancer.

For reconstruction of the breast on which a medically necessary mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses and treatment of physical complications for all stages of the mastectomy, including lymphedemas are covered under this Plan.

If the Covered Person and the Covered Person's attending physician determine that a shorter period of inpatient care is appropriate, the Plan is not required to provide the minimum hours of coverage of inpatient care stated above.

26. Treatment for Mental and Nervous Conditions

- a. There is a limit of 30 days on the number of days for hospital confinement (20% coinsurance applies).
- b. There is a limit of 60 days on the number of days for treatment at psychiatric day treatment facility (20% coinsurance applies).
- c. Psychiatric counseling will be paid at 50% of usual and customary.

27. Hospice Care. Hospice care is an alternative to the Hospital Confinement of a terminally ill person. Hospice Benefits are available for Covered Persons with a life expectancy of six (6) months or less provided the attending Physician approves the program. Failure to pre-certify will result in no benefit allowances. Hospice care is subject to the deductibles and co-insurance as provided in the applicable appendix for each class of City employee, retiree, and official.

Eligible Hospice Charges are charges made by a Hospice for:

- a. room and board;
- b. private duty nursing care provided by or under the supervision of a Registered Nurse (R.N.);
- c. part-time or intermittent home health aide services which consist primarily of caring for the patient by employees of the Hospice;
- d. social work performed by a licensed social worker, routinely provided by the Hospice

- agency;
- e. nutritional services, including, special meals, if included in the per diem;
- f. emotional support services routinely provided by the Hospice agency, if included in the per diem;
- g. bereavement counseling sessions for eligible dependents covered under the Plan, if included in the per diem; and
- h. drugs and medication.

28. Organ Transplants. If covered expenses are incurred as a result of a body organ transplant, the Plan will pay the applicable co-insurance percentage of the Covered Expenses, as defined herein, after the deductible is applied, subject to the lifetime maximum benefit and the following conditions:

- a. Benefits are available for body organ transplantation, subject to determination made on an individualized case by case basis in order to establish medical necessity;
- b. Benefits will be provided only when the hospital and physician customarily charge a transplant recipient for such care and services;
- c. When only the transplant recipient is a Covered Person, the benefits of the Plan will be provided for the donor to the extent that such benefits are not provided under any other form of coverage. In no such case under the Plan will any payment of a "personal service" fee be made to any donor. Only the necessary hospital and physician's medical care and services expenses with respect to the donor will be considered for benefits;
- d. When only the donor is a Covered Person, the donor will receive benefits for care and services necessary to the extent such benefits are not provided under any coverage available to the recipient. Benefits will not be provided to any recipient who is not a Covered Person; and
- e. When the recipient and the donor are both Covered Persons, as provided herein, benefits will be provided for both in accordance with their respective Covered Expenses.

If the recipient is the Covered Person and/or pursuant to the conditions set forth above, the following coverage shall be provided:

- a. The use of temporary mechanical equipment, pending the acquisition of "matched" body organ(s);
- b. Transplant surgery of a body organ(s) as defined herein;
- c. Multiple transplant(s) during one (1) operative session;
- d. Replacement(s) or subsequent transplant(s); and
- e. Follow-up expenses for covered services, including immunosuppressant therapy.

If the donor is a Covered Person and pursuant to the conditions set forth above, the following coverage shall be provided:

- a. The acquisition of a body organ(s) from the donor;
- b. The life support of a donor pending the removal of a usable body organ(s); and
- c. Transportation of a body organ(s). However, transportation of a body organ(s) shall not include transportation of a living donor and/or a donor on life support.

Benefit limitations apply to the following conditions and services:

1. Abortions

Abortions will be covered when the attending physician certifies that the mother's life would be endangered if the fetus were carried to term.

2. Cosmetic Procedure

Elective procedure performed solely to improve appearance is not covered. Nor are the complications that may arise from or are the direct result of such procedure covered. A procedure utilized as treatment of neurosis, psychoneurosis, psychopathy, psychosis and other mental, nervous and emotional illnesses is not covered. However, expenses incurred for a cosmetic procedure for the prompt repair or alleviation of damage caused solely by accidental bodily injury, or congenital defects of children, or for the correction of a congenital anomaly in a newborn child, or for the reconstruction of the breast on which a medically necessary mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses and treatment of physical complications for all stages of the mastectomy, including lymphedemas are covered under this Plan.

3. Treatment in Mouth or Oral Cavity

The care and treatment of the teeth, gums or alveolar process or for dentures, appliances or supplies used in such care and treatment is not covered, except for charges incurred as a result of and within six months after an accident suffered while covered hereunder for treatment of injuries to sound, natural teeth, including replacement of such teeth, or for setting of a jaw fractured or dislocated in such accident; provided, however, that this exclusion shall not be applicable to services and supplies rendered to a newborn child which are necessary for treatment or correction of a congenital defect.

4. Maternity for Dependents

Maternity care and services rendered to a dependent child are limited to treatment of Complications of Pregnancy.

5. Mental and Nervous Conditions

Subject to the applicable percentage payable as stated in the Schedule of Benefits, charges for services provided by a physician (M.D., D.O., clinical psychologist, certified social worker or licensed professional counselor) including group therapy, and collateral visits with members of the patients immediate family for the treatment of mental, nervous, emotional, drug or substance abuse illness or disorders of any type are payable as follows:

Covered physician charges provided on an inpatient basis are covered at the applicable percentage rate stated in the Schedule of Benefits.

No coverage is provided for physical or psychological therapy in an in or out patient setting where art, play, music, drama, reading, nutrition, massage, education, home economics or recreational activities is the method of treatment.

Psychological testing, evaluation or assessment is covered at the applicable percentage rate listed in the Schedule of Benefits.

Expenses for treatment in a psychiatric day treatment facility for a mental, nervous or emotional disorder, if the attending physician certifies that such treatment is in lieu of hospitalization, will be covered as if incurred on an inpatient basis. Any benefits so provided shall be determined as if necessary care and treatment in a psychiatric day treatment facility were inpatient care and treatment in a hospital; each full day or treatment in a psychiatric day treatment facility shall be considered equal to one-half day of hospital confinement for purposes of determining benefits and benefit maximums under the Plan.

6. Private Room Limit

When private room accommodations have been used, charges will be reimbursed at the average semi-private room rate in the facility. If a hospital has private rooms available only, then the maximum eligible charge will be based on the usual and customary semi-private room charge in the community.

No coverage is provided under the Plan for services and supplies:

1. For which the patient or employee has no legal obligation to pay, or for which no charge would be made if the employee had no health coverage.
2. Any treatment or service rendered by a Covered Provider related by blood or marriage.
3. Not medically necessary for the diagnosis and treatment of an illness or injury or which exceed the usual and customary charges.
4. For intentionally self-inflicted injury, whether sane or insane.
5. For diseases contracted or injuries sustained as a result of service in any branch of the armed forces.
6. For accidental bodily injury or illness which is covered by Workers' Compensation or an Occupational Medical Policy, or any expenses payable under compromise settlement agreements arising from a Workers' Compensation Claim.
7. For marital, family, vocational and other counseling services, except for nutritional counseling for diabetics.
8. For sex transformation surgery and all expenses in connection with such surgery.
9. For reversal or attempted reversal of sterilization.
10. For services, therapy and counseling for sexual dysfunction or inadequacies or for implants or aids to sexual function except due to a disease or injury which is otherwise covered by this plan.
11. Family planning, infertility treatment and services including but not limited to: artificial insemination and personal therapy for infertility, except in-vitro coverage as allowed in the Schedule of Benefits
12. For a dependent child's pregnancy except for complication as defined by the Plan arising from a dependent child's pregnancy.
13. For smoking cessation seminars, services, devices or medications.
14. For the surgery or treatment of obesity, morbid obesity, dietary control, or for weight reduction.
15. For nutritional supplements, including prescription and over the counter vitamins.

16. For exercise equipment or exercise programs.
17. For orthotics (arch supports, etc.) and other supportive devices for feet that are not prescribed by a physician.
18. For air conditioners, filters, humidifiers, dehumidifiers, and purifiers.
19. For eye exercises, visual training (orthoptics), eyeglasses, including contact lenses, hearing aids, or examinations for the purpose of determining visual acuity or level of hearing.
20. For radial keratotomy surgery and orthokeratology.
21. For medical, dental or surgical treatment including associated diagnostic procedures of orthognathic conditions.
22. For vocational therapy.
23. For preparing medical reports or itemized bills.
24. For travel or accommodations, whether or not recommended by a physician.
25. For charges associated with non-emergency hospital admissions on either a Friday or a Saturday unless a surgical procedure is performed within 24 hours of admission.
26. For special education, counseling or care for learning deficiencies or behavioral problems whether or not associated with a manifest mental disorder or other disturbance.
27. For care in a health resort, rest home, nursing home, residential treatment center, or any institution primarily providing convalescent, or custodial care.
28. For custodial care.
29. For any claims filed more than one (1) year from the month the covered service or supply was provided.
30. For admissions aimed at primarily overcoming the after effects of a specific episode of drug abuse (detoxification), or to keep the patient from access to drugs (maintenance care).
31. For sales tax, transportation, tariffs, immigration fees for international travel, or federal excise taxes are not covered under this plan document.
32. For routine physical examinations for eligible dependents and for eligible employees not covered in Chapter 5, paragraph 19(c).
33. No coverage is provided for services and supplies for routine or preventative immunizations or vaccinations except for gamma globulin injections and child immunizations.
34. Coverage for **Hospice Care** does not include the following charges:

- (a) nutritional services, including special means not included in the per diem;
- (b) emotional support services not routinely provided by the Hospice agency and/or not included in the per diem;
- (c) bereavement counseling sessions for eligible dependents covered under the Plan not included in the per diem;
- (d) funeral arrangements;
- e. pastoral counseling; and
- f. financial or legal counseling.

35. Coverage for Organ Transplant Surgery does not include the following charges:

- a. Experimental treatment for new procedures, and treatments, services or supplies which are still considered experimental or investigational and not "generally accepted" by the medical profession. The judgment whether a procedure, treatment, service or supply is experimental is based upon all of the relevant facts and circumstances, including, but not limited to:
 - 1. Approval by the U.S. Food and Drug Administration, the American Medical Association or the appropriate Medical Specialty Society;
 - 2. Medical and scientific literature;
 - 3. Scientifically demonstrated health benefits;
 - 4. Safety and effectiveness compared to alternatives; and
 - 5. Safety, effectiveness and benefits when used outside of a research setting;
- (b) Any animal organ or mechanical equipment, mechanical device, or mechanical organ(s), except as provided herein;
- (c) Any financial consideration to the donor other than for a covered service or supply which is incurred in the performance of or in relation to transplant surgery; and
- (d) Transportation of a donor, except as provided herein.

DEFINITIONS

The following terms shall mean:

A “pre-existing condition” is a condition (whether physical or mental and regardless of the cause of the condition) for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period prior to an individual’s “enrollment date.” Genetic information will not be treated as a condition in the absence of a diagnosis of a specific condition. Pregnancy will not be treated as a pre-existing condition.

“Enrollment date” means the first day of an individual’s coverage or, if there is a waiting period before an individual’s coverage becomes effective, the first day of the waiting period; therefore, conditions first diagnosed or treated during the waiting period will not be treated as pre-existing conditions. For an individual who enrolls during a special enrollment period (or as a late entrant), the enrollment date is the first day of the individual’s coverage.

“Late entrant” means an individual who enrolls other than during the initial enrollment period or a special enrollment period as provided under the “ELIGIBILITY REQUIREMENTS” of the Plan.

“Creditable coverage” includes prior coverage under another group health plan, group or individual health insurance coverage issued by a state regulated insurer or an HMO, COBRA, Medicaid, Medicare, CHIP (Children’s Health Insurance Program), the Active Military Health Program, CHAMPUS, American Indian Health Care Programs, a State health benefits risk pool, the Federal Employees Health Plan, the Peace Corp Health Program, or a public health plan.

PRE-EXISTING CONDITION EXCLUSION PERIOD

Expenses for treatment of pre-existing conditions will not be covered for 6 months following an individual’s enrollment date. Once this exclusion period has been satisfied, normal benefits will be payable.

The pre-existing condition exclusion period will not apply to pregnancy (regardless of whether the woman had previous coverage) or to a newborn or adopted child under age 18 (or child placed for adoption under age 18) provided the child became covered under the Plan or other creditable coverage within 31 days of birth or adoption (or adoptive placement) and provided they have not incurred a subsequent break in coverage of 63 consecutive days or more.

The Plan’s pre-existing condition exclusion period may be reduced by an equal period of any prior continuous health coverage (creditable coverage) as long as there is no break in coverage of 63 consecutive days or more. Individuals have a right to demonstrate prior health coverage to reduce the Plan’s pre-existing condition exclusion period by providing Certificates of Creditable Coverage.

CHAPTER 9

SUPPLEMENTAL ACCIDENT BENEFITS

This provision provides you and your dependents with supplemental benefits for hospital and medical expenses resulting from an Accidental Injury occurring while you are covered by this Plan.

Covered medical expenses directly related to the accident and incurred within the first ninety (90) calendar days of the date of the accident, are covered at 100% up to a maximum of \$500. Deductible does not apply.

If a Covered Person who is scheduled for inpatient surgery in a hospital, has preoperative testing relating to this surgery performed within ten (10) days prior to the scheduled surgery and the testing is performed at a physician's office, diagnostic laboratory, ambulatory surgery center or on a hospital outpatient basis, the Plan will pay pre-operative testing at 100% provided:

1. The charge for the surgery is a covered expense;
2. The tests would have been covered had the patient been confined as a hospital inpatient;
3. The tests are not repeated when the patient is confined for the surgery;
4. The test results are a part of the patient's medical record;
5. The surgery is performed in a hospital;
6. The service is identified as pre-admission or preoperative testing.

The deductible does not apply.

Certification of ALL admissions to a hospital including admissions for rehabilitation, treatment of mental or nervous condition, drug, alcohol or substance abuse and maternity is required prior to or on the day of admission as an inpatient. Emergency admissions must be verified within forty-eight (48) hours following admissions. Confirmation of the admission or an extension beyond the period originally authorized will be provided by the Utilization Review Nurse to the Covered Person, the hospital and the physician.

Certification of all outpatient surgery, performed in an ambulatory surgery center or hospital outpatient facility, is required prior to or on the day of the surgery. Emergency outpatient surgery must be certified within forty-eight (48) hours following the surgery. Confirmation of the outpatient surgery will be provided by the Utilization Review Nurse to the Covered Person, the outpatient facility and the physician.

The Covered Person is responsible for the certification of hospital admission and outpatient surgery.

For all hospital admissions and outpatients surgeries:

The patient, a family member, the physician or the hospital must call the City of San Antonio's Utilization Review Nurse for:

For regular admissions and outpatient surgery:

Call prior to the scheduled admission or surgery date.

For emergency admissions and outpatient surgery:

Call within forty-eight (48) hours of admission or surgery. The number to call for pre-certification is listed on the back of the Plan identification card provided by the Claims Administrator.

If Pre-Certification Authorization is not obtained the maximum benefit paid for the doctor and hospital will be fifty percent (50%) of the usual and customary charges. The fifty percent (50%) not reimbursed by the Plan will not count toward satisfaction of the Plan year out-of-pocket maximum.

Pursuant to State law, the Plan will not restrict benefits for any hospital length of stay in connection with a mastectomy or lymph node dissection of less than 48 hours following a mastectomy or less than 24 hours following a lymph node dissection or require that a provider obtain authorization from the Plan for prescribing a length or stay within the above periods. Certification is required for a length of stay, which is in excess of the above periods.

Pursuant to State law, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child of less than 48 hours following an uncomplicated vaginal

delivery or less than 96 hours following an uncomplicated cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay within the above periods. Certification is required for a length of stay, which is in excess of the above periods.

PREFERRED PROVIDER NETWORK

The City of San Antonio participates in a Preferred Provider Network of hospitals, physicians and other providers that are contracted to furnish, at negotiated costs, medical care for the City employees and their dependents. The use of a Preferred Provider may result in reduced out of pocket expenses to the Covered Person.

A current listing of the Preferred Provider Network contracting hospitals, physicians and other providers is available in the Employee Benefits Office. A Covered Person may choose any health care provider.

The City reserves the right to terminate or modify the Preferred Provider Network program, or any portion thereof, at any time. In the event the City changes the PPO provider, the City will ensure that the employees will not be substantially affected by a disruption of available in-network providers.

The "In-Network Benefit" level will be paid if a covered person receives services from a Non-Participating Provider only in the following situations:

1. Emergency Services. If you receive Emergency Services from a Non-Participating Provider.
2. Court-Ordered Dependents. If your court-ordered Eligible Dependent lives outside the service area, and no Out-of-Area Participating Providers are reasonably available to treat the Eligible Dependent. Contact the Employee Benefits Office for details.
3. Continuity of Care if Participating Provider Leaves the PPO Network. If your Participating Provider leaves the PPO Network, a covered person may continue to see that Provider and receive PPO Benefits under "special circumstances."
4. "Special circumstance" means a condition such that a covered person's Participating Provider reasonably believes discontinuation of care could cause harm to that person, such as a Disability, an acute condition, a life-threatening illness or a pregnancy that is past the 24th week. If a covered person's Participating Provider makes such a request and special circumstances exist, In-Network Benefits will continue:
 - (a) In the case of a Covered Person who is past the 24th week of pregnancy, through the delivery of the child, immediate postpartum care, and the follow-up checkup within the first six (6) weeks of delivery;
 - (b) In the case of other special circumstances, (e.g. terminally ill), for 90 days;
 - (c) If a Participating Provider, including a facility or a specialist is not available to a covered person within the service area to provide Medically Necessary services covered by the Plan, the Claims Administrator, approves the coverage in advance.

Obtaining Covered Prescriptions In-Network

With this program you can obtain prescriptions from three different sources, depending on your needs.
Retail Pharmacy - Up to a 30-day Supply

The retail network of pharmacies is available for prescriptions you need right away or for a short time only (such as antibiotics). You can obtain up to a 30-day supply of medication from thousands of participating retail network pharmacies nationwide. The retail network for the City of San Antonio (COSA) includes all Walgreen's, HEB, Target, Wal-Mart, Sam's Club, Costco and some independent pharmacies. To locate the nearest participating retail network pharmacy, call WHI's Member Services at 800-207-2568, or access the WHI website at www.walgreenshealth.com. A small number of medications are limited to a 30-day or less supply such as, but not limited to, Accutane or Peg-Intron.

Mail Service Pharmacy

Prescriptions for maintenance medications or chronic long-term health conditions can be ordered through the Walgreen's mail service pharmacy. Ordering through the mail is both a safe and easy way to receive prescriptions and save money.

To order, simply obtain a new prescription from your doctor for a 90-day supply. Then complete a COSA mail registration and order form and send it with your original prescription and appropriate co-insurance payment to the Orlando, FL address indicated on the form. The registration and order form provides important health, allergy and plan ID information and is available by contacting the COSA Benefits Office, or from the COSA Benefits Home Page. Forms are not available through Walgreen's Customer Service.

Walgreen's Advantage90™

When you need prescriptions for chronic or long-term health conditions (such as but not limited to high blood pressure, diabetes, or asthma) you can purchase a three-month supply at any Walgreen's retail pharmacy. The Physician must write the prescription for an 84 – 90 day supply, or the medication will only be filled based on a 30-day supply.

Schedule of Pharmacy Co-insurance

In-Network Benefits Only	TIER 1 Generic	TIER 2 Preferred Brand (Formulary)	TIER 3 Non-Preferred Brand (Non-Formulary)
Up to a 30-Day Supply at Network Participating Retail Pharmacies	0% co-insurance	20% co-insurance	30% co-insurance
Three Month Supply at any Walgreen's Retail Pharmacies	0% co-insurance	10% co-insurance	20% co-insurance
Three Month Supply through the Walgreen's Healthcare Plus Mail Order Facility	0% co-insurance	10% co-insurance	20% co-insurance

Obtaining Covered Prescriptions Out-of-Network

Out-Of-Network Benefits Only	TIER 1 Generic	TIER 2 Preferred Brand (Formulary)	TIER 3 Non-Preferred Brand
All prescriptions filled at out-of-network Pharmacies	20% coinsurance after out of network medical deductible	40% coinsurance after out of network medical deductible	50% coinsurance after out of network medical deductible

Maximum Out-of-Pocket Benefit

Co-insurance paid toward prescription medications under the WHI program are included in the In-Network Pharmacy Out-of-Pocket Maximum under the group health care coverage.

Coinsurance amounts paid toward out-of-network prescriptions do not apply to the out-of-pocket maximum under the group health care coverage.

The amount a member pays for any non-covered drug will not be included in calculating the Annual Out-of-Pocket maximum. The member is responsible for paying 100% of the cost for any non-covered drug and the contracted rates will not be available.

Covered Items

The following items are covered under the prescription program, unless specifically listed in the “Exclusions and Limitations” section below.

- Federal legend drugs (drugs that federal law prohibits dispensing without a prescription)
- Compound prescriptions containing at least one legend ingredient
- Insulin and diabetic supplies such as disposable needles and syringes, blood test strips, and lancets and any other items mandated under Texas Insurance Code
- Topical acne agents through age 23 (over age 23, prior authorization required)
- ADHD/Narcolepsy drugs through age 19 (over age 19, prior authorization required)
- Oral contraceptives for Employee or eligible spouse only
- Only prescriptions which are prescribed for the condition for which they are labeled

Exclusions and Limitations [See Chapter 7]

- Drugs used for cosmetic purposes, including but not limited to certain anti-fungals, hair loss treatments and those used for pigmenting/depigmenting and reducing wrinkles
- Diabetic alcohol swabs
- Fluoride supplements
- Nutritional/Dietary Supplements
- Over-the-counter medications and other over the counter items
- Vitamins
- Miscellaneous medical supplies
- Anti-obesity drugs
- Smoking cessation medications
- Experimental or Investigational drugs or for drugs labeled “Caution – limited by federal law to Investigational use”
- Immunization agents, allergens, serums, blood or blood plasma
- Therapeutic devices or appliances, support garments or other non-medical appliances, except those listed as covered drugs
- Coverage for prescription drug products for an amount which exceeds the supply limit (days supply or quantity limit)
- Prescription drug products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers’ compensation law or other similar laws
- Drugs purchased during time of no coverage

- Drugs for any treatment or condition which is listed under expenses not covered in the medical plan
- Charges to administer or inject any drug
- Prescription drugs that are not Medically Necessary
- Charges for delivering any drugs, except through the mail order benefit. Express or over night delivery is at the member's expense.
- Experimental or Investigational medications
- Prescription drugs purchased from an institutional pharmacy for use while the member is an in-patient in that institution regardless of the level-of-care
- Reimbursement for prescription drugs purchased outside of your prescription drug benefit is subject to review under the Direct Member Reimbursement Process and reimbursement may be limited to contract rate less Co-insurance
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a Hospital, extended care facility, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Off labeled drugs
- Penlac

Formulary Management

A Formulary is a list of medications that have received FDA approval as safe and effective, and have been chosen for inclusion on the Formulary by a committee of Physicians and pharmacists. The Formulary drug list can help the member and Physician to maximize benefits while minimizing overall prescription drug costs to the member and the Plan.

WHI's Pharmacy and Therapeutics (P&T) committee evaluates clinical efficacy and safety of each drug and votes the drug into one of three categories:

- Therapeutically Unique – Clinical effectiveness of the drug is superior to existing drugs with an acceptable safety profile prompting automatic addition to the Formulary
- Therapeutically Equivalent – Clinical effectiveness and safety profile are comparable to existing drugs
- Therapeutically Inferior – Clinical effectiveness of the drug is no greater than existing drugs and the safety profile is less favorable prompting automatic non-Formulary status

Products classified by the P&T as therapeutically equivalent are further evaluated from an economic perspective to determine which clinically appropriate drugs are most cost-effective for clients. The P&T evaluation is based solely on clinical criteria. It is only after the P&T clinical assessment is made that the economics of the drug are considered.

New FDA approved drugs that arrive on the market are automatically available to the members and are initially placed into the third tier (non-Formulary brand) except those excluded under the benefit plan. Based on the P&T decision, the new drug may then be placed in the second tier (Formulary brand). Additions to the Formulary are made on a quarterly basis throughout the year with deletions most often occurring annually.

Three-Tier Co-insurance Level	Type of Medication
Lowest Co-insurance – Generic Tier 1	Medications classified as generic by “First Data Bank”
Middle Co-insurance – Preferred Brand Tier 2	Preferred Brand medications on the Formulary list with no generic available
Highest Co-insurance – Non-Preferred Brand Tier 3	Non-preferred brands (not on Formulary list) or brands with a generic available as classified by “First Data Bank”

The most up-to-date Formulary guide is available on the WHI web site at www.mywhi.com.

Note: Drugs listed on the WHI Formulary may not be covered as they are subject to the City of San Antonio’s specific plan coverages, exclusions, and limitations.

Prior Authorizations [Current Practice]

Certain prescriptions require “clinical prior authorization” or approval from your Plan before they will be covered. WHI, as pharmacy benefit manager, administers the clinical prior authorization process on behalf of the City of San Antonio.

A Clinical Prior Authorization (CPA) can be initiated by you or your Physician by calling 1-877-665-6609. To initiate a clinical prior authorization, the caller should have available the name of the medication, Physician’s name, telephone number (and fax number, if available), member’s ID number, and the Rx group number (274316).

After the initial call is placed, the Clinical Services Representative obtains information and verifies that COSA participates in a CPA program for the particular drug category. The Clinical Services Representative generates a drug specific form and faxes it to the prescribing Physician. Once the fax form is received back into the Clinical Call Center, a pharmacist reviews the information and approves or denies the request based on established protocols. Determinations may take up to 48 hours from WHI’s receipt of the completed form, not including weekends and holidays.

If the prior authorization request is APPROVED, the WHI Clinical Service Representative contacts the person who initiated the request and enters an override into the WHI processing system for a limited period of time. The pharmacy will then process your prescription.

If the prior authorization request is DENIED, the WHI Clinical Call Center pharmacist contacts the person who initiated the request and sends a denial letter explaining the denial reason. This includes denials due to Physician non-response. The letter will include instructions for appealing the denial. The categories/medications that require prior authorization include, but are not limited to:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Narcolepsy
- Anabolic steroids (all forms)
- Anti-Fungals (i.e., Lamisil, Sporanox)

- Botulinum Toxins (Botox)
- Contraceptives (for dependents)
- Crinone 8%

The criteria for the Clinical Prior Authorization programs are based on nationally recognized guidelines; FDA approved indications and accepted standards of practice. Each specific guideline has been reviewed and approved by WHI's Pharmacy and Therapeutics (P&T) Committee for appropriateness.

To confirm whether you need clinical prior authorization and/or to request a CPA, call toll free to WHI's Clinical Member Services at 877-665-6609, Monday through Friday, 8:00 a.m. - 8:00 p.m., Central time.

Please have the information listed below when initiating your request for a clinical prior authorization:

- Name of your Medication
- Physician's Name
- Physician's Phone Number
- Physician's Fax Number, if available
- WHI member ID number (from your card)
- City of San Antonio Group Number: 274316

Age and Quantity Limitations

Some medications are subject to age and quantity limits. Your prescription will be denied at time of purchase if it exceeds these limitations. Limitations are based on criteria developed with guidelines from various national medical agencies and in conjunction with WHI's clinical review process.

Age Limitations

Certain medications having an age limitation include but are not limited to, the following health conditions:

- Topical Acne
- Attention Deficit Hyperactivity Disorder (ADHD)
- Narcolepsy

If your prescription is "denied" due to age limitations, but you and your Physician believe it is Medically Necessary for you to take the medication to treat one of the above conditions, you may request a clinical prior authorization. Refer to the previous section titled "Prior Authorizations" for details.

Quantity Limitations

Certain medications having quantity limitations include but are not limited to, the following health conditions and medications:

- Impotency
- Insomnia
- Migraine

- Butorphanol
- Oral Antiemetics
- Diflucan 150mg

If your prescription is “denied” due to quantity limitations, and you and your Physician believe it is Medically Necessary for you to take a larger quantity of the medication, you may request a clinical prior authorization. Refer to the previous section titled “Prior Authorizations” for details.

Specialty Pharmacy

Walgreen’s Specialty Pharmacy provides convenient, dependable access to medications for people living with complex health conditions. The programs and services focus on injectibles and medication therapies involving strict compliance requirements, special storage/handling/delivery, complex administration methods, and education /monitoring/ ongoing support. Drugs that fall under this category can only be dispensed at a Walgreen’s retail pharmacy or via a home delivery method through the Walgreen’s mail service pharmacy. These drugs are limited to a 30-day supply regardless if dispensed at a retail pharmacy or at mail service. The retail co-insurance will apply for specialty pharmacy medications regardless if the medication is obtained at retail or mail.

Certain classifications of specialty pharmacy medications will require prior authorization or approval before they will be covered by your plan. Drugs include the following, but are not limited to:

- Asthma (Xolair)
- Endometriosis (Lupron)
- Growth Hormone Deficiency (Genotropin, Nutropin)
- Osteoarthritis (Synvisc)
- Osteoporosis (Forteo)
- Parkinson’s Disease (Apokyn)
- Precocious Puberty (Lupron-Ped)
- Prostate Cancer (Lupron, Viadur)

A member may enroll in the Specialty Pharmacy Program by contacting the Walgreen’s Specialty Pharmacy Center at 1-888-782-8443, or a Specialty Care Representative may contact you to facilitate your ongoing prescription needs. Trained Specialty Care pharmacy staff are available 24 hours a day, 7 days a week to assist you.

Direct Member Reimbursement

There may be instances where you need to fill a prescription but are unable to have your claim processed through a WHI pharmacy due to situations such as an emergency situation, or a new member whose enrollment has not been processed. In these instances, you will be required to pay the full retail cost of the covered medication, and then file for reimbursement.

You can receive reimbursement for covered prescriptions you’ve paid for under the Plan by following these steps:

- Pay the pharmacist the full amount of your prescription. Keep your receipt(s).
- Obtain and complete a Direct Member Reimbursement claim form available from the COSA Employee Benefits Office.
- Send your completed form and itemized receipts to the COSA Benefits Office at 506 Dolorosa, Room 124; San Antonio, TX 78204.

The Benefits Office will make a determination, and if approved, will forward your claim(s) to WHI to process your request for reimbursement according to the Plan's guidelines, coverages, and limitations.

Please note that WHI will reimburse you according to the Plan's guidelines.

Drug Utilization Alerts at Time of Purchase

Drug Utilization Review (DUR) is an effective tool in monitoring drug use to assure that it is appropriate, safe, and effective. At the time of purchase, WHI's DUR program monitors claim submissions across all pharmacies and Physicians, compares each claim with the active prescriptions of individual members, and sends "flags" back to the pharmacists should any drug utilization alerts occur. The DUR system adheres to the National Council for Prescription Drug Products (NCPDP) DUR guidelines and monitors every prescription for numerous conditions. Examples of some of the DUR alerts are listed below.

Drug/Drug Interaction

A drug/drug interaction is a potentially harmful result that can occur when a patient is taking two or more drugs at the same time. The possible results of the interaction may include the increase or decrease in drug effectiveness or an increase in the adverse effects of one or both of the drugs.

When these occur, the WHI system advises the dispensing pharmacist that the drug he/she is about to dispense may have a potentially harmful interaction with a drug the patient is currently taking. This allows the pharmacist to use professional judgment to intervene, if necessary, to prevent the patient from being harmed.

Over Utilization

The submission of prescription drug claims across all contracted pharmacies is monitored. When a pharmacy claim request is received, the WHI system reviews each patient's drug profile, searching for a previous prescription for the same drug or its generic equivalent. The system then applies any other parameters that have been defined to reject a claim if the request for the medication is being submitted sooner than the Plan recognizes as appropriate.

Therapeutic Duplication Monitoring

Duplicate therapy monitoring informs the dispensing pharmacist that the newly prescribed drug may duplicate the therapeutic effects of another drug already prescribed for the patient. This duplication can occur even when the two drugs are prescribed for different medical conditions.

When a duplication of therapy is detected, WHI will transmit information back to the dispensing pharmacist, including the name of the drug that is duplicating the therapy, for further evaluation and intervention.

On inpatient hospital bills under \$3,000.00 the Plan will make a cash presentation to any employee who (1) detects a billing overcharge made by a hospital as a result of an inpatient confinement to any covered family member and (2) receives a billing adjustment and (3) the Plan realizes a savings.

Upon discharge from the hospital, simply review the bill. If there is any error, it may be in one of the following area:

A Calculation Error

A charge for service the patient did not receive.

The patient received a service but not in the quantity indicated.

Remember, take the original bill and obtain a corrected bill and present both to the City Claims Administrator for review and determination. The Plan will pay the employee 25% of the savings or maximum of \$500, whichever is less. As an example, if an employee detects an incorrect charge of \$1,200 and this is confirmed, the employee will receive a check for 25% of the savings, or \$300 from the Plan.

The COB provision is designed to correct over coverage which occurs when a person has health coverage for the same expenses under two (2) or more of the plans listed below. Should this type of duplication occur, the benefits under this Plan will be coordinated with those of the other plans so that the total benefits from all plans will not exceed the expenses actually incurred.

If a Covered Person's benefits under another health plan are reduced due to cost containment provisions, such as a second surgical opinion, pre-certification, HMO or preferred provider arrangements, the amount of the reduction shall not be considered as an allowable expense under this Plan.

The benefits provided by the plans listed below are considered in determining duplication of coverage:

1. This Plan;
2. Any other group insurance or prepayment plan, Health Maintenance Organizations (HMOs); Blue Cross/Blue Shield;
3. Any labor-management trustee plan, union welfare plan, employer organization plan or employee benefit organization plan;
4. Any government plan or statute providing benefits for which COB is not prohibited by law.

Order of Benefit Determination

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

1. A plan with no COB provision will determine its benefits before a plan with a COB provision;
2. A plan that covers a person other than as a Dependent will determine its benefits before a plan that covers such person as a Dependent;
3. Any labor-management trustee plan, union welfare plan, employer organization plan or employee benefit organization plan will determine its benefits before this plan;
4. When a claim is made for a dependent child who is covered by more than one (1) plan:
 - (a) the benefits of the plan of the parent whose birthday falls earlier in the year will be determined before the benefits of the plan of the parent whose birthday falls later in that year; but

- (b) if both parents have the same birthday, the benefits of the plan which covered the parent longer will be determined before those of the plan which covered the other parent for a shorter period of time.

This method of determining the order of benefits will be referred to as the "Birthday Rule." The Birthday Rule will be used to determine the order of benefits for dependent children in all cases except those described below.

- (c) if the other plan does not have the Birthday Rule, then the plan which covers the child as a dependent of the male parent will pay its benefits first.
- (d) if the parents are legally separated or divorced, benefits for the child will be determined in this order:
 - (i) first, the plan of the parent with custody of the child will pay its benefits;
 - (ii) then, the plan of the spouse of the parent with custody of the child will pay its benefits; and
 - (iii) 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 determine its benefits before any other plan.

5. A plan that covers a person as:

- (a) a laid off employee; or
- (b) a retired employee; or
- (c) a dependent of such employee;

will determine its benefits after the plan that does not cover such person as:

- (a) a laid off employee; or
- (b) a retired employee; or
- (c) a dependent of such 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.

6. If one of the above rules establishes the order of payment, a plan under which the person has been covered for the longer time will determine its benefits before a plan covering that person for a shorter time.

Two successive plans of the same group will be considered one plan if the person was eligible for coverage under the new plan within twenty-four (24) hours after the old plan terminated. A change in the

amount or scope of benefits, or a change in the carrier, or a change from one type of plan to another (e.g., single employer plan to multiple employer plan) will not constitute the start of a new plan.

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

- (a) each benefit will be reduced proportionately; and
- (b) only the reduced amount will be charged against any benefit limits under the Plan.

The COB provision is applied throughout the calendar year. If there is any reduction of the benefits provided under a specific Benefit Provision of this Plan because of duplicate coverage, similar benefits may be payable later in that year if more Allowable Expenses are incurred under the same Benefit Provision of this Plan because of duplicate coverage, similar benefits may be payable later in that year if more Allowable Expenses are incurred under the same Benefit Provision. "Allowable Expense" means any necessary, usual and customary item of expense at least part of which is covered under at least one of the plans covering the person for who claim is made or service provided, in no event will Allowable Expense 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.

Benefits under a governmental plan will be taken into consideration without expanding the definition of "Allowable Expense" beyond the hospital, medical and surgical benefits as may be provided by such governmental plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

The Plan has the right to release to, or obtain from, any other organization or person any information necessary for the administration of this provision and to pay to any organization any amounts necessary to satisfy the intent of this provision.

If the Plan has paid any amounts in excess of those necessary to satisfy the intent of this provision, it has the right to recover such excess from the person, to or for whom, such payments were made or from an insurance company or organization.

When you claim benefits under the Plan, you must furnish information about other coverage, which may be involved in applying this coordination provision.

A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, the Claims Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Compliance with Cost Containment Health Plan Provisions

If the Covered Person's benefits are reduced by a health plan that has cost containment provisions, such as a second surgical opinion, HMO, pre-certification or preferred provider arrangements, the amount of such reduction shall not be an allowable expense.

PROVISION FOR SUBROGATION AND RIGHT OF RECOVERY

A third party may be liable or legally responsible for expenses incurred by a Covered Person for an illness or a bodily injury.

Benefits may also be payable under the Plan for such expenses. When this happens, the Plan may, at its option:

1. Take over the Covered Person's right to receive payment of the benefits from the third party. The Covered Person will:
 - (a) transfer to the Plan any rights he may have to take legal action against the third party with respect to benefits paid by the Plan which are subject to this provision; and
 - (b) cooperate fully with the Plan in asserting its right to subrogate. This means the Covered Person must supply the Plan with all information and sign and return all documents reasonably necessary to carry out the Plan's right to recover from the third party any benefits paid under the Plan which are subject to this provision.
2. Recover from the Covered Person any benefits paid under the Plan which the Covered Person is entitled to receive from the third party. The Plan will have a first lien upon any recovery, whether by settlement, judgment or otherwise, that the Covered Person received from:
 - (a) the third party; or
 - (b) the third party's insurer or guarantor; or
 - (c) the Covered Person's uninsured motorist insurance.

This lien will be for the amount of benefits paid by the Plan for the treatment of illness or bodily injury for which the third party is liable or legally responsible. If the Covered Person:

- (a) makes any recovery as set forth in this provision; and
- (b) fails to reimburse the Plan fully for any benefits paid under this provision; then he will be personally liable to the Plan to the extent of such recovery up to the amount of the first lien. The Covered Person must cooperate fully with the Plan in asserting its right to recover.

1. Proof of Loss

Written proof of loss must be furnished to the Claims Administrator within one (1) year after the month such loss was incurred. Failure to furnish proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one (1) year from the month care, treatment, service or supply was first provided for the illness or injury.

2. Legal Actions

No action at law or in equity shall be brought to recover on the Plan unless the employee or retiree has exhausted administrative remedies provided in the review and appeal process in Chapter 16.

3. Examination

The Claims Administrator shall have the right and opportunity to have the Covered Person examined whose injury or illness is the basis of a claim when and so often as it may reasonably require during pendency of a claim.

4. Conformity with Federal Statutes

Any provision of this Plan, which on its effective date is in conflict with federal statutes, is hereby amended to conform to the minimum requirements of such federal statutes.

5. Choice of Physician

The Covered Person shall have free choice of any physician, as defined in this Plan, practicing legally. Benefits may vary depending on the physician's participation in the City's Preferred Provider Network.

6. Entire Contract

The Plan Document constitutes the entire contract of coverage between the Plan Sponsor and the Covered Person.

7. Effect of Changes

All changes to the Plan shall become effective as of a date established by the Plan Administrator, except that:

No increase or reduction in benefits shall be effective with respect to covered expenses incurred prior to the date a change was adopted by the Plan Sponsor, regardless of the effective date of the change; and

8. Written Notice

Any written notice required under the Plan shall be deemed received by a Covered Person sent by regular mail, postage prepaid, to the last address of the Covered Person on the records of the Employer.

9. Clerical Errors/Delay

Clerical errors made on the records of the Plan Sponsor, Plan Administrator or Claims Administrator and delays in making entries on records shall not invalidate coverage or cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of the Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of an error or delay, an equitable adjustment of any contributions will be made.

10. Workers' Compensation

The Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

11. Statements

(a) Not Representations

Statements made by or on behalf of any person to obtain coverage under the Plan shall be deemed representations and not warranties.

(b) Misstatements on Enrollment or Claim Form

If any relevant material fact has been misstated by or on behalf of any person to obtain coverage under the Plan, the true fact shall be used to determine whether coverage is in force and the extent, if any, of coverage. Upon the discovery of any misstatement, an equitable adjustment of any benefit payments will be made.

(c) Time Limit for Misstatement

No misstatement made to obtain coverage under the Plan will be used to void the coverage of any person which has been in force for a period of two (2) years or to deny a claim for a loss incurred or disability commencing after the expiration of the two (2) year period. The provisions of this paragraph shall not apply if any misstatement has been made fraudulently.

(d) Use of Statements

No statement made by or on behalf of any person will be used in any context unless a copy of the written instrument containing the statement has been or is furnished to any person or to any person claiming a right to receive benefits with respect to the person.

12. Identification Cards

Identification card(s) will be issued, which indicate coverage by the City of San Antonio Health Benefits Program. Upon request, the Claims Administrator or the City's Employee Benefits Office will verify coverage of Covered Persons. Identification cards will be for identification of Covered Persons only and do not constitute a guarantee of coverage.

13. Protection Against Creditors

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish same shall be void. If the City finds that such an attempt has been made with respect to any payment due or to become due to any covered person, the City in its sole discretion may terminate the interest of such covered person or former covered person in such payment. And in such case the City shall apply the amount of such payment to or for the benefit of such covered person or former covered person, his/her spouse, parent, adult child, guardian or a minor child, brother or sister, or other relative of a dependent of such covered person or former covered person, as the City may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the City, benefit payments may be assigned to health care providers.

1. Claim Filing

- (a) Medical claims (doctor's visits, prescription drugs, exams, hospital, etc.) shall be filed on a claim form available from the Employee Benefits Office or Claims Administrator.
- (b) The claim form shall include medical bills (itemized only) and the explanation of benefit statement (EOB) from other health insurance policies, if any. The bill should contain the following:
 - (i) the official letterhead of the hospital, doctor, clinic, pharmacy, etc.;
 - (ii) type of service;
 - (iii) date of service received;
 - (iv) amount charged;
 - (v) name of patient; and
 - (vi) diagnosis.
- (c) Only one (1) detailed claim form must be completed per person per year, even for different claims and/or diagnoses. Any additional claims throughout the year may be filed on a short claim form available through the Employee Benefits Office. If a claim is for an accidental injury, then a detailed claim form must be completed for each accident occurrence. All items on the front of the detailed claim form must be completed. It is not necessary to complete the back of the form. The blocked section regarding secondary insurance coverage must be completed.
- (d) The original claim form with the attached bills shall be mailed to the City's claims administrator.

2. Limitation of Liability

The Plan Sponsor shall not be obligated to pay any benefits under the Plan for any claim that is not timely filed.

3. Time of Claims Processing

Benefits for incurred medical expenses which are covered under the Plan will be processed immediately upon receipt of proper written proof of loss by the Claims Administrator. Any benefits payable will be made within twenty (20) working days.

Periodic Payment: Payment of accrued periodic payments for continuing losses which are covered under the Plan will be made immediately upon receipt of proper proof of loss by the Claims Administrator and at the applicable time period.

4. Payment of Benefits

All benefits under the Plan are payable to the Covered Employee whose illness or injury or whose covered dependent's illness or injury is the basis of a claim.

In the event of the death or incapacity of a Covered Employee and in the absence of written evidence to the Plan of the qualification of a guardian for his estate, the Plan may, in its sole discretion, make any and all payments to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of the employee.

Benefits for medical expenses covered under the Plan may be assigned by a Covered Employee to the person or institution rendering the services for which the expenses were incurred. No assignment will bind the Plan Sponsor unless it is in writing and unless it has been received by the Claims Administrator prior to the payment of the benefit assigned. The Claims Administrator will not be responsible for determining whether any assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment signed by the Covered Employee and the assignee has been received before the proof of loss is submitted.

5. Discharge of Liability

Any payment made in accordance with the provisions of this section will fully discharge the liability of the Plan Sponsor to the extent of payment.

6. Recovery of Payments

If the following circumstances apply, the Plan Sponsor reserves the right to deduct from any benefits properly payable under the Plan or recover from the Covered Employee or assignee who received the payment:

- (a) the amount of any payment which has been made in error; or
- (b) pursuant to a misstatement contained in a proof of loss; or
- (c) pursuant to a misstatement made to obtain coverage under the Plan within two (2) years after the date coverage commences.

REVIEW PROCESS FOR DISPUTED CLAIMS

The review process for disputed claims shall include the following:

1. The Employee or Retiree may request a review by writing the Claims Administrator and stating the basis for the disputed claim.
2. This request must be made within ninety (90) calendar days after the receipt of the original explanation of benefits.
3. Upon receipt of the request, the claim will be reviewed by the Claims Administrator who will either affirm the original claim determination in writing, pay the disputed claim amount, or request additional information necessary to make a determination.
4. The Claims Administrator's decision will be sent within thirty (30) calendar days to the Employee or Retiree along with supporting documentation setting out the basis on which the decision is made.
5. Either the Employee/Retiree or the Claims Administrator may request a review by Claims Review Committee in accordance with paragraph six (6) below. The Employee/Retiree's request must be made within fifteen (15) calendar days after the Claims Administrator's decision is mailed.
6. A review may be made within fifteen (15) calendar days by a Claims Review Committee upon the request of the Plan Administrator only if new claims information is provided by the Employee or Retiree which was not considered before by the Claims Administrator. The Committee shall consist of the Plan Administrator, a representative of the Claims Administrator who was not directly involved in processing the initial claim, the medical director of the Claims Administrator and the City's Utilization Review Nurse. The decision of the Committee will be made within fifteen (15) calendar days, mailed to the Employee/Retiree and will be deemed final and binding.

APPENDIX A- Specific Provisions Applicable to Fire Active Employees effective June 1, 2007.
(Cadets are covered under the Flex Plan Document as those provisions apply to Non-Uniform City Employees)

SCHEDULE OF BENEFITS

1. Medical Benefits

Deductible

Maximum per individual per calendar year\$250 in-network/\$500 out-of-network
 Maximum per family per calendar year\$500 in-network/ \$1,000 out-of-network
 Coinsurance80% in-network/ 60% out-of-network

Out-of-pocket maximum (does not include deductible)

Maximum per individual per calendar year\$500 in-network/\$1,000 out-of-network
 Maximum per family per calendar year\$1,500 in-network cumulative
 Maximum per family per calendar year.....\$3,000 out-of-network cumulative

No deductible

Supplemental accident benefits 100%
 up to \$500. No deductible

Immunizations for Covered Dependents from birth through the date the child is six (6) years of age (other services provided at the same time as the immunizations, including, but not limited to, office visit charges will be subject to the deductibles and co-insurance)100% in-network/60% out-of-network

Lifetime maximum per individual (medical)..... \$1,500,000

2. Prescription Benefits

Prescription Drug Benefits effective June 1, 2007

In Network Pharmacy* using prescription drug program:

Participant Co-Insurance

Retail 30 day supply (Full Walgreens Network)

Generic	\$0
Brand (preferred)	20%
Brand (non-preferred)	30%

Retail 90 day supply (Advantage 90- Walgreens location only)

Generic	\$0
Brand (preferred)	10%
Brand (non-preferred)	20%

Mail Order 90 day supply

Generic	\$0
Brand (preferred)	10%
Brand (non-preferred)	20%

Out-of-Network Pharmacy or without utilization of prescription drug program

Participant Co-Insurance

Retail 30 day supply

Generic	20% after CitiMed deductible**
Brand (preferred)	40% after CitiMed deductible**
Brand (non-preferred)	50% after CitiMed deductible**

Retail 90 day supply

Generic	20% after CitiMed deductible**
Brand (preferred)	40% after CitiMed deductible**
Brand (non-preferred)	50% after CitiMed deductible**

Mail Order 90-day supply

Generic	20% after CitiMed deductible**
Brand (preferred)	40% after CitiMed deductible**
Brand (non-preferred)	50% after CitiMed deductible**

*Out of Area Benefit – Participants who live over 30 miles from a participating network pharmacy may submit Out of Network Pharmacy charges for reimbursement at a plan coverage and benefit level.

**This deductible is not an additional deductible. Out of network co-insurance does not apply to annual out-of-pocket.

In Network Annual Prescription Co-insurance out of pocket maximum ...\$150 individual/\$300 family, cumulative

The following provisions apply to the Fire and Police Active Employees as stated herein:

1. Review and Appeal Process.

The review and appeal process in Chapter 17 shall not be construed to supersede, and is in addition to, any grievance procedure set forth in the Collective Bargaining Agreements between the City and the San Antonio Police Officers' Association, in regard to Police Officers and Local 624 of the International Association of Fire Fighters, in regard to Fire Fighters.

2. Amendment or Termination of Plan

The City may amend the provisions of this Plan, from time to time, as the need arises in order to assure the fair and equitable administration of Benefits to be provided eligible Employees in compliance with the terms of the respective Collective Bargaining Agreements.

The City may terminate the provisions of the Plan only during negotiations over the terms to be contained in Collective Bargaining Agreements with Local 624 of the International Association of Firefighters in regard to Fire Fighters and the San Antonio Police Officers' Association, in regard to Police Officers, for any period covered by a Collective Bargaining Agreement.

Nothing in the Document or any related Bargaining Agreements between the City and the Bargaining Agents of the Fire Fighters and Police Officers is intended to imply vesting or irrevocable Benefits for current, active Fire Fighters and Police Officers beyond the provisions of the 2005-2009 Collective Bargaining Agreement between the City and Local 624 of the International Association of Firefighters, in regard to Fire Fighters and the provisions of the 2006-2009 Collective Bargaining Agreement between the City and the San Antonio Police Officers' Association, in regard to Police Officers.

Termination, continuance, alteration, or any related activity on the Plan will be determined by the provisions of future Collective Bargaining Agreements between the City and the San Antonio Police Officers' Association, in regard to Police Officers and Local 624 of the International Association of Firefighters, in regard to Fire Fighters.

3. Covered Medical Expenses

Chapter 5, Covered Medical Expenses, item 19, Preventive services effective January 1, 2009 for Uniformed Fire Fighters:

- (a) One routine pap smear (doctor's procedure charge, lab expenses and office visit) per calendar year for female covered persons; will be covered at 100%, deductible waived;
- (b) One routine mammogram per calendar year for female covered persons age thirty-five (35) and over will be covered at 100%, deductible waived.
- (c) One (1) routine physical examination per calendar year for an eligible employee and covered dependent over the age of 2 is covered.

1. The Plan will cover 100% of the cost of the exam by a licensed Physician to a maximum benefit of \$300 per calendar year per Employee and \$300 per year per covered dependent.
 2. If performed at the Occupational Health Clinic, at 401 West Commerce, the Plan will cover a complete blood count, cholesterol and glucose screening; blood pressure check; height and weight evaluation; and a health assessment questionnaire at 100%.
- (d) A physical examination for the detection of prostate cancer and prostate-specific Antigen test used for the detection of prostate cancer will be covered at 100%, deductible waived for each male enrolled in the Plan who is;
1. at least 50 years of age and asymptomatic; or
 2. at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.
- (e) Well baby and children's routine services for covered dependents Birth to age two (2) will be covered at 100% deductible waived.

4. Limitations

The following limitations are included in Chapter 6, Limitations, for the Uniformed Fire Fighters effective June 1, 2007:

Chiropractic Care Services are subject to the Schedule of Benefits deductibles, coinsurance and out of pocket maximums for in-network or out-of-network providers.

Invitro Fertilization coverage is subject to the Schedule of Benefits deductibles, coinsurance and out of pocket maximums for in-network and out-of-network providers.

ATTACHMENT 3
FORMER MASTER CONTRACT DOCUMENT

City of San Antonio

Master Contract Document

for the

City of San Antonio Uniformed Prefund Retirees
Health Benefit Program

San Antonio, Texas
June 1, 2007

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APPENDIX A

Specific Provisions Applicable to Fire and Police Prefund Retirees (Fire and Police Retirees who retired prior to October 1, 1989, are covered under the Flex Plan Document as those provisions apply to Regular Retirees) 55

FORMER MASTER CONTRACT

INTRODUCTION

The purpose of the Employee Health Benefit Program is to provide the City of San Antonio Uniform Employees and Retirees with a family health plan, with coverage and benefits defined herein.

This Master Contract defines and provides for coverage and administration for the benefits common to uniform City employees, and retirees. The variations in coverage applicable to such classes are set forth in specific appendices to this Master Contract, including but not limited to Firefighters and Police Officers. The coverage provisions applicable to a covered person shall collectively be referred to as the Plan, and the provisions of this Master Contract and the applicable appendices for any covered person shall be referred to as the Plan Document.

This Plan Document does not provide for any premium payment or contributions to the cost of coverage. The obligation and amount of such payments are separately determined from the Ordinances of the City Council or any applicable Collective Bargaining Agreements.

This plan is open to uniform City employees and retired uniform City employees.

The benefits provided and defined in this Master Contract are self-funded by the City of San Antonio at the time this document was drafted, but the City of San Antonio is entitled to reinsure any portion of its obligations hereunder, and additionally may contract for any carrier acceptable to the City Council to assume and administer coverage and benefits under this document.

ANY BENEFITS UNDER THE CITY'S INSURANCE OR SELF FUNDED PROGRAMS ARE SUBJECT TO CHANGE AS DETERMINED BY THE CITY COUNCIL IN ANY BUDGET YEAR, OR BY AMENDMENT OR OTHER LAWFUL CHANGE TO THE APPLICABLE BARGAINING AGREEMENTS.

The City of San Antonio may select a claims administrator from time to time, or may elect to administer claims under the plan as an internal function. The City's claim administrator is not an insurer.

GENERAL INFORMATION

NAME OF PLAN: CitiMed

PLAN YEAR: January 1 through December 31.

PLAN SPONSOR: City of San Antonio
P.O. Box 839966
San Antonio, Texas 78283

PLAN ADMINISTRATOR: Employee Benefits Administrator
City of San Antonio

Human Resources Department
P.O. Box 839966
San Antonio, Texas 78283
(210) 207-8705

CLAIMS ADMINISTRATOR:
Fiserv P.O. Box 690450
San Antonio, Texas 78269-0450

PREFERRED PROVIDER ORGANIZATION (PPO): Texas True Choice
NETWORK: P.O. Box 250089
Plano, Texas 75025-0089 (Submit Claims)
Or EDI to: TTCEC
www.texastruechoice.com

PRESCRIPTION NETWORK: Walgreens Health Initiatives
101 North First Avenue, Suite 1900
Phoenix, Arizona 85003
Customer Service (800) 207-2568
RX Group# 514595
www.walgreenshealth.com

EFFECTIVE/TERMINATION DATES: The effective date of this plan for uniform prefund retirees is November 1, 2003. This plan will expire December 31, 2007. The City and the Associations have agreed upon the terms for providing retiree health insurance, including scope of coverage, contributions and authority of the Board of Trustees as currently set forth in House Bill 2751 and Senate Bill 1778 (hereinafter "pending legislation"). The effective date of this Bill, if enacted is October 1, 2007. The health insurance terms will become effective January 1, 2008. In the event the pending legislation does not become enacted into law, the City and the Associations have agreed to adopt the provisions set forth in the pending legislation verbatim as their contractual agreement during the term of this contract and the City and Associations have authorized the Board of Trustees to implement the terms as set out in the Rudd & Wisdom Report, attached hereto as Attachment A.

PLAN AND CLAIMS ADMINISTRATION

Administration and payment of claims under the Plan Documents shall be carried out by the Claims Administrator, under the supervision of the Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan Document is carried out as written. The Plan Administrator shall have full power to administer the Plans and all of their details, and to make all final determinations about coverage on behalf of the City of San Antonio.

The Plan Administrator will make available for examination, to each Covered Person, his heirs, and/or assigns, records that pertain to the Covered Person at a reasonable time during normal business hours as established by the Plan Administrator.

The Plan Administrator's powers shall include, but shall not be limited to, the following:

- (a) To make and enforce reasonable rules and regulations as the Plan Administrator deems necessary or proper for the effective and efficient administration of the Plan Document;
- (b) To interpret the contract, including, but not limited to, all questions of coverage and eligibility. The Plan Administrator's interpretations thereof in good faith shall be final and conclusive on all persons claiming Benefits under the Plan Document, subject only to the Review and Appeal Process; and
- (c) To coordinate with and supervise the Claims Administrator, prepare and handle budgetary and contractual relationships involving the plan, distribute information to Covered Persons under the plan, appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan Document.

ELIGIBILITY REQUIREMENTS**Eligible Employee**

Full-time City employees (authorized full-time equivalent) are eligible to participate in the Plan on the date their employment begins. Coverage begins on the date of hire, or upon taking office and performing work for the City of San Antonio, whichever occurs later.

A new employee who is not actively at work for any reason other than due to medical disability on his scheduled effective date of coverage will not become covered under the Plan until such time as the employee returns to active employment.

Eligible Dependent

An Eligible Dependent is:

(1) The Eligible Employee's spouse. A spouse that is legally separated under a court decree under the laws of another state shall not be an eligible dependent,

(2) All natural children including legally adopted, under legal guardianship of the Covered Employee and who have not yet reached their twentieth birthday, provided the children have never been married and are principally dependent upon the Eligible Employee, as directed by court order, for support and maintenance. Foster children are not Eligible Dependents under this Plan, unless there has been an application for adoption accepted by the Texas Department of Human Services. Stepchildren are Eligible Dependents during the marriage between the Eligible Employee and the natural parent of the child, so long as (a) they permanently reside in the employee's household, and (b) are principally dependent on the employee.

In addition to the above, children will be considered as Eligible Dependents from age twenty (20) through age twenty-three (23), if they are full-time students, have never been married, and are principally dependent upon the Eligible Employee for support and maintenance.

The term "Eligible Dependent" shall not include anyone who is covered as an Eligible Employee. An Eligible Dependent shall not be entitled to any additional benefits or coverage by virtue of the fact that both parents, step parents or guardians are employed by the City.

Eligible Retiree

Any eligible City employee that retires under the rules of the Fire and Police Pension Fund will be eligible for the City's retiree health program.

Retired Employee's Dependents

If you retire and are eligible to receive retirement benefits you may continue your dependents' coverage, subject to the payment of any applicable premiums without lapse. Only Dependents who participate in the Plan at the time of the eligible employee's retirement are eligible. Eligible dependent children shall not include anyone who is covered as an eligible employee under the Plan.

Incapacitated Dependent

An Eligible Dependent child who is physically or mentally incapable of self-support upon attaining the age of twenty (20) years, shall continue to be an Eligible Dependent while remaining incapacitated, unmarried and continuously covered under the Plan. An eligible incapacitated dependent must be solely dependent on the employee, and must be incapacitated by a disability that arose while such dependent was a covered dependent. To continue eligibility under this provision, proof of incapacity must be submitted by the employee at least thirty-one (31) days prior to such child's attainment of age twenty (20).

Effective Date of Coverage

Coverage does not become effective until the Eligible Employee completes the City's enrollment document.

Newborn infants will be covered from the date of birth as long as the employee is covered under this plan and coverage for the newborn child is requested within 31 days of the child's date of birth. If coverage of a newborn is not requested within 31 days of the child's date of birth, then coverage cannot become effective until the next re-enrollment period.

Eligible Dependents who are enrolled after the effective date of this Plan will become covered on the date such dependent is acquired, provided that the covered Employee enrolls such dependent within 31 days of the date the dependent is acquired. If coverage of a dependent is not requested within 31 days of the date the dependent was acquired, the coverage cannot become effective until the next re-enrollment period.

Change of Family Status

If there is a legal change in family status, the employee has thirty-one (31) calendar days to notify the Employee Benefits Office in writing. The notice may be given by personally appearing in the Benefits Office and completing a change of dependent coverage form.

If there is no change in family status or if notice is not given for additional coverage within thirty-one (31) days after the legal change in status, no change can become effective until the next re-enrollment period, which shall be not less than thirty –one (31) days, occurring during the months of October or November, as the Plan Administrator shall determine, or as otherwise established by the City Council.

A legal change in family status includes: divorce; marriage; birth or adoption of a child, including a child living with the adopting parents during the period of probation; change in employment status for the employee's spouse; or ineligibility of a child due to age, or change in student status.

Termination of Coverage for Individuals

The coverage of any Covered Person under the Plan shall terminate on the earliest of the following dates:

1. The date of termination of the Plan;
2. The date employment terminates;

3. The date all coverage or certain benefits are terminated in a particular class by modification of the Plan; and

4. The date an active Eligible Employee is covered under a qualified Health Maintenance Organization (HMO) or any other available alternative health care delivery system for the employee or dependents of the employee.

Termination of Coverage for Dependents

Coverage with respect to the Covered Person's dependents shall terminate under the Plan at the earliest time specified below:

1. Upon termination of employment for the covered employee;
2. On the date dependents cease to be eligible as defined in the Plan.

Termination of Coverage for Failure to Pay Premium

Coverage with respect to any Covered person for which a premium or contribution is required shall terminate 31 days after the due date for such premium, or as soon thereafter as otherwise allowed by law.

Documentation

The Plan Administrator is entitled to require relevant legal documentation to be furnished with any request for coverage or change in status.

CONTINUATION COVERAGE

On April 7, 1986, a federal law was enacted requiring that most employers sponsoring group health plans offer employees, retirees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This law is called the Consolidated Omnibus Budget Reconciliation Act of 1985, better known as COBRA. This notice is intended to inform employees and retirees, in a summary fashion, of rights and obligations under the continuation coverage provisions of COBRA. The employee, retiree and spouse should take the time to read this notice carefully.

"Qualified Beneficiary" means:

- a. you, as a Covered Employee, for termination or reduced hours;
- b. your spouse or your dependent child if he/she was a dependent under the Plan on the day before your Qualifying Event occurred; or
- c. a child who is born to a Covered Employee during a period of COBRA continuation coverage.

"Qualifying Event for a Covered Employee" means a loss of coverage due to:

- a. termination of employment for any reason other than gross misconduct; or
- b. reduction in hours of employment.

"Qualifying Event for a Covered Dependent" means a loss of coverage due to:

- a. a Covered Employee's termination of employment for any reason other than a gross misconduct or reduction in hours of employment;
- b. a Covered Employee's death; a spouse's divorce or legal separation from a Covered Employee;
- c. a Covered Employee's entitlement to Medicare; or
- d. a dependent child's loss of dependent status under the Plan.

"Timely contribution payment" means contribution payment must be made within 30 days of the due date or within such longer period as applies to or under the Plan.

Continuation of Health Coverage. Continuation of health coverage shall be available to you and/or your Covered Dependents upon the occurrence of a Qualifying Event. To continue health coverage, the Plan Administrator must be notified of a Qualifying Event by:

- (a) the Employer, within 30 days of such event, if the Qualifying Event is:
 1. for a Covered Dependent, the Covered Employee's death;
 2. the Covered Employee's termination other than for gross misconduct or reduction in hours;
 3. for a Covered Dependent, the Covered Employee's entitlement to Medicare.

- (b) you or a Qualified Beneficiary, within 60 days of such event, if the Qualifying Event is:
 - 1. for a spouse, divorce, or legal separation from a Covered Employee; or
 - 2. for a dependent child, loss of dependent status under the Plan.

The Plan Administrator must, within 14 days of receiving such notice, notify any Qualified Beneficiary of his/her continuation right. Notice to a Qualified Beneficiary who is your spouse shall be notice to all other Qualified Beneficiaries residing with such spouse when such notice is given.

Upon termination of employment or reduction in hours, to continue health coverage for 29 months, a Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act to be disabled on such date or at any time during the first 60 days of COBRA continuation coverage, must notify the Plan Administrator of such disability within 60 days from the date of determination and before the end of the 18 month period. If a Qualified Beneficiary entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, the non-disabled family members are also entitled to the disability extension.

Qualified Beneficiaries who are disabled under Title II or Title XVI of the Social Security Act must notify the Plan Administrator within 30 days from the date of final determination that they are not longer disabled.

A Qualified Beneficiary must elect Continuation of Health Coverage within 60 days from the later of the date of the Qualifying Event or the date notice was sent by the Plan Administrator.

A newborn child of a Qualified Beneficiary or a child placed with a Qualified Beneficiary for adoption may be added according to the enrollment requirements for dependent coverage under the Eligibility Requirements of the Plan.

Any election by you or your spouse shall be deemed to be an election by any other Qualified Beneficiary, though each Qualified Beneficiary is entitled to an individual election of continuation coverage.

Upon election to continue health coverage, a Qualified Beneficiary must, within 45 days of the date of such election, pay all required contribution to date to the Plan Administrator. All future contribution payments by a Qualified Beneficiary must be made to the Plan Administrator and are due the first of each month with a 30-day grace period.

A Qualified Beneficiary will be notified by the Plan Administrator of the amount of the required contribution payment and the contribution payment options available.

Termination of Coverage. Coverage will end upon the earliest of the following:

- (a) termination or reduction of hours:
 - 1. 18 months from the date of the Qualifying Event; or
 - 2. 29 months from the date of the Qualifying Event if the Qualified Beneficiary is determined under Title II or Title XVI of the Social Security Act to be disabled on such date or at any time during the first 60 days of COBRA continuation coverage and provides notice as required by law (including, COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension).
- (b) the day, after the 18 month continuation period, which begins more than 30 days from the date of a final determination under Title II or Title XVI of the Social Security Act that a Qualified Beneficiary, entitled to 29 months, is no longer disabled (including COBRA

continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension who is no longer disabled).

- c. for a Covered Dependent, 36 months from the date of the Qualifying Event if the Qualifying Event is:
 - 1. the Covered Employee's death;
 - 2. the Covered Employee's entitlement to Medicare;
 - 3. a spouse's divorce or legal separation from a Covered Employee; or
 - 4. a dependent child's loss of dependent status under the Plan.
- d. if any of the Qualifying Events listed in (c) occurs during the 18-month period after the date of the initial Qualifying Event listed in (a), coverage terminates 36 months after the date of the Qualifying Event listed in 1.
- e. the date on which the Employer ceases to provide any group health plan to any employee;
- f. the date on which a Qualified Beneficiary fails to make timely payment of the required contribution;
- g. the date on which a Qualified Beneficiary first becomes (after the date of the election) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary;
- h. the first day of the month in which a Qualified Beneficiary becomes entitled to Medicare; or
- i. the date this Plan terminates.

Continuation of health coverage under this provision shall not duplicate health care coverage continued under any state or federal law.

Any questions about COBRA should be directed to the City's Employee Benefits Office,
506 Dolorosa , Suite 124, San Antonio, Texas 78204, (210) 207-8705.

A. Use and Disclosure of Protected Health Information (PHI)

The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the Plan to determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or review of appropriateness of care or justification of charges;
- utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- reimbursement to the plan.

Health Care Operations include, but are not limited to, the following activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- **rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;**
- underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- business management and general administrative activities of the Plan, including, but not limited to:
 - (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
 - (b) customer service, including the provision of data analysis for management; and
- resolution of internal grievances.

B. The Plan Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary

C. For Purposes of This Section, the City of San Antonio is the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions.

D. With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions

The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the plan document or as required by law;
- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the plan Sponsor with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

E. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, only the following employees may be given access to PHI:

- the staff of the Employee Benefits Division of the Human Resources Department
- the staff of the Finance Department assigned to the Self Insurance Fund and
- the staff of Legal Department assigned to the Employee Benefits Division.

F. Noncompliance Issues

If the persons described in section E do not comply with this plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

"**ACCIDENTAL INJURY**" means a condition caused by an accidental means which results in traumatic damage to the Covered Person's body from an external force that is unexpected at the time, but which occurrence was definite as to time and place. Normal and routine human movements and activities shall not be considered accidents, even though unexpected physiological injury or damage may occur as a result thereof. (Such as bending, stooping or lifting resulting in disc injury; or yawning that damages the temporomandibular joint).

"**ACTIVELY AT WORK**" means the active expenditure of time and energy in the service of the Employer, except that an employee shall be deemed actively at work on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day.

"**ALLOWABLE EXPENSE**" relates to coordination of benefits, under Chapter 13 of this Plan Document. Allowable expenses shall mean any necessary usual, customary and reasonable expenses incurred while eligible for benefits under the Plan, part or all of which would be covered under any of the plans, but not including any expenses contained in the Exclusions chapter.

"**AMBULATORY SURGICAL CENTER**" means a specialized facility which is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures on an outpatient basis and which fully meets one of the following two tests:

- (a) It is licensed as an ambulatory surgical facility in the state in which it is located; or
- (b) Where licensing is not required:
 - 1. it is operated under the full-time supervision of a physician;
 - 2. it permits surgical procedures to be performed only by physicians who are privileged to perform the procedure in at least one local hospital;
 - 3. it requires in all cases, except for those using only local infiltration anesthetics, that a licensed anesthesiologist either administers the anesthetic or supervises an anesthesiologist who administers it and that the anesthesiologist or anesthesiologist remains present throughout the surgical procedure;
 - 4. it provides at least one operating room and at least one post-anesthesia recovery room;
 - 5. it is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services;
 - 6. it has trained personnel and necessary equipment to handle emergencies;
 - 7. it has immediate access to a blood bank or blood supplies;
 - 8. it provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating room and post-anesthesia recovery room; and
 - 9. it maintains an adequate medical record for each patient that contains an admitting diagnosis that includes, except for patients undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays, and operative report and discharge summary.

"ANNUAL OUT OF POCKET" is the sum of the deductible and any co-insurance under the Plan Document. When the annual out of pocket is reached (which can be for an individual or a family) covered expenses incurred during that plan year will be paid at 100%.

Out of Pocket does not include:

- * Charges beyond usual & customary fees;
- * Penalties resulting from non-compliance with pre-certification;
- * Co-insurance for inpatient or outpatient mental & nervous benefits;
- * Charges not covered under the Plan.

"BODY ORGAN" means the following (a) a kidney; (b) a heart; (c) a heart/lung; (d) a liver, (e) a pancreas, when the condition is not treatable by use of insulin therapy; (f) bone marrow; and (g) a cornea.

"CALENDAR YEAR" a period of 12 consecutive months beginning with January 1 through December 31 of the same year. For new employees and dependents, the calendar year is the effective date of their coverage through December 31 of the same year.

"CITY" means the City of San Antonio.

"CLAIMS ADMINISTRATOR" means the Third Party Administrator or any City employee or office designated to process claims under the Plan Document.

"COINSURANCE" is the Covered Person's obligation to pay a percentage of the costs of care in accordance with the terms and provisions of this Plan document. For example, if this plan provides for payment of 80% of eligible medical expense, the remaining 20% is the employee's obligation, and is referred to as "coinsurance."

"COPAYMENT" is the covered person's obligation to pay a fixed dollar amount for the services rendered, e.g., \$10 for prescription medications.

"COMPLICATIONS OF PREGNANCY" means:

- (a) conditions requiring hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity; or
- (b) non-elective caesarean section; ectopic pregnancy which is terminated; or spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

"Complications of pregnancy" does not mean: false labor; occasional spotting; physician prescribed rest during pregnancy; morning sickness; hyperemesis gravidarum; preeclampsia; or similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

"COSMETIC PROCEDURES" mean any surgical procedure or any portion of a surgical procedure performed primarily to improve physical appearance and does not promote the proper function of the body or treat any illness or injury.

"COVERED PERSON" means an eligible Employee, retiree, official or eligible Dependent covered under this Plan.

"COVERED PROVIDER" means an ambulatory surgical center, a home health care agency, a licensed hospice care center, a hospital, a physician, a surgeon, a psychiatric day treatment facility, a rehabilitation facility and a skilled nursing facility.

"CUSTODIAL CARE" means that type of care or service, wherever furnished and by whatever name called, which is designated primarily to assist a covered person, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in or out of bed, and supervision over medication which can normally be self-administered.

"DEDUCTIBLE" means the amount of Covered Medical Expenses a Covered Person must incur and pay each calendar year before benefits are payable under the Plan.

"FAMILY DEDUCTIBLE LIMIT" means that, once the sum of the family deductible has been satisfied by the cumulative Covered Medical Expenses of the eligible employee and one (1) or more of his eligible dependents in a Calendar Year, no further deductible need be satisfied in that Calendar Year for any other eligible member of the family.

For example:

Employee	\$ 85.00	
Spouse	200.00	Satisfied the Individual Deductible
Child	90.00	
Child 2	<u>50.00</u>	
Total submitted	\$ 425.00	
Family Deductible Accumulation	<u>- 400.00</u>	
	\$ 25.00	reimbursed at coinsurance level

Where a City employee, by virtue of his relationship to another City employee, would be considered an eligible dependent but for his employment with the City, the higher of the two (2) family deductibles of these two (2) City employees need only be satisfied.

"DENTIST" means a currently licensed dentist practicing within the scope of the license or any physician furnishing dental services which the physician is licensed to perform.

"DIABETES EQUIPMENT" means the following:

- a. blood glucose monitors, including monitors designed to be used by blind individuals;
- b. insulin pumps and associated appurtenances;
- c. insulin infusion devices; and
- d. podiatric appliances for the prevention of complications associated with diabetes.

"DIABETES SUPPLIES" means the following:

- a. test strips for blood glucose monitors;
- b. visual reading and urine test strips;
- c. lancets and lancet devices;

- d. insulin and insulin analogs;
- e. injection aids; syringes;
- f. prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and
- g. glucagon emergency kits.

"**DONOR**" means a person who undergoes a surgical operation for the purpose of donating a body organ(s) for transplant surgery.

"**DURABLE MEDICAL EQUIPMENT**" means equipment prescribed by the attending physician which meets each of the following: a) medically necessary; b) is not primarily or customarily used for non-medical purposes; c) is designated for prolonged use; and d) serves a specific therapeutic purpose in the treatment of any injury or illness.

"**EFFECTIVE DATE**", when applied to an individual's coverage under the Plan, means the first day of the individual's coverage. The individual's effective date may or may not be the same as the individual's enrollment date (as "enrollment date" is defined by the Plan).

"**ELIGIBLE EXPENSE**" is any expense, which is eligible for payment, in whole or in part under this plan document.

"**EMPLOYEE**" means a person who is directly employed by the City of San Antonio and is regularly scheduled for a full shift or schedule in like manner as other similarly situated workers in the department or division. "Employee" shall also include employees on Worker's Compensation, Disability, or Non-Paid status.

"**EMPLOYER**" means the City of San Antonio.

"**FIRE FIGHTER**" means any full time, permanent, paid Employee who:

- (a) Is employed by the City's Fire Department;
- (b) Has been hired in substantial compliance with Chapter 143 of the Local Government Code;
- (c) Has successfully completed the Fire Academy; and
- (d) Has received his or her certificate from the Fire Chief.

"**FULL TIME STUDENT**" means a participant's dependent child who is enrolled in and regularly attending an accredited college, university or institution on a full time basis as determined by the institution attended by the student. Evidence of the child's status as a full time student satisfactory to the claims administrator must be furnished by the covered person in the event of a claim or enrollment. A person ceases to be a full time student at the end of the month during which the person graduates or otherwise ceases to be enrolled and in attendance at the institution on a full time basis. A person continues to be a full time student during periods of vacation established by the institution, unless the person does not continue as a full time student immediately following the period of vacation.

"**HOME HEALTH CARE AGENCY**" means an agency or organization which meets all of the following requirements:

- (1) It is licensed and primarily engaged in providing skilled nursing care and other therapeutic services;

- (2) It has policies established by a professional group associated with the agency or organization and includes at least one physician and one registered graduate nurse (R.N.) who provide full time supervision of such services;
- (3) It maintains complete medical records on each individual;
- (4) It has a full time administrator.

"HOSPICE" means an agency which:

- a. is primarily engaged in providing counseling, medical services or room and board to terminally ill persons;
- b. has professional service policies established by a group associated with it. This group must include one (1) Physician, one (1) Registered Nurse (RN) and one (1) social service coordinator;
- c. has full-time supervision by a Physician;
- d. has a full-time Administrator;
- e. provides services 24 hours a day, seven (7) days a week;
- f. maintains a complete medical record of each patient; and
- g. is licensed in accordance with state law.

"HOSPITAL" means only an institution constituted and operated pursuant to any applicable law, engaged in providing, on an inpatient basis at the patient's expense, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick individuals by or under the supervision of a licensed physician or surgeon and continuously providing 24-hour-a-day services by registered nurses. The term "hospital" shall not include any institution or part thereof which is other than incidentally a place for rest, a residential treatment center, or a nursing home or convalescent hospital.

"INTENSIVE CARE UNIT OR CARDIAC CARE UNIT" means a clearly designated service area which is maintained within a hospital and which meets all of the following tests:

- (a) It is solely for the treatment of patients who require special medical attention because of their critical condition;
- (b) It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the hospital;
- (c) It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area; and
- (d) It provides at least one professional registered nurse who continuously and constantly attends to the patient confined in such area on a twenty-four (24) hour a day basis; or
- (e) An alternate hospital that is approved by the Plan Administrator, as long as the cost of care does not exceed the cost of care at a hospital that substantially meets subparagraphs (a) through (d) above, in accordance with one or more of the following criteria:
 - 1. to facilitate provision of medical services by a particular physician;
 - 2. the covered person's physician certifies in writing to the Plan Administrator before services are rendered that the hospital is equipped to provide needed intensive or cardiac care;

3. proximity of the covered person's immediate family members;
4. the medical condition of the covered person indicates that it would be inadvisable to transfer to another hospital.

"**LIFETIME MAXIMUM**" is the cumulative maximum amount payable during the lifetime of the covered person, during periods of eligibility, as set forth in the Schedule of Benefits.

"**MASTER CONTRACT**" means and refers to this Plan Document, which sets forth the provisions of universal applicability to the City's various health benefit plans.

"**MEDICALLY NECESSARY**" means any care, treatment, service or supply provided for the diagnosis and treatment of a specific illness, injury or condition which meets all of the following.

- (a) The care and treatment is appropriate given the symptoms, and is consistent with the diagnosis, if any. "Appropriate" means that the type, level, and length of service and the setting are needed to provide safe and adequate care and treatment;
- (b) It is rendered in accordance with generally accepted medical practice and professionally recognized standards in the United States medical community;
- (c) It is not treatment that is generally regarded as experimental, educational or unproven; and
- (d) It is specifically allowed by the licensing statutes that apply to the provider that renders the service.

With respect to confinement in a hospital "medically necessary" further means that the medical condition requires confinement and that safe and effective treatment cannot be provided as an outpatient.

The Claims Administrator may require satisfactory proof in writing, that any type of treatment, service or supply received is Medically Necessary. The Claims Administrator may also specifically require the prescribing physician or consulting board or committee of any facility to provide a written analysis of the necessity and acceptability of the methods, process or procedure under this paragraph, taking into account the criteria set forth above. The fact that a physician may prescribe, order, recommend or approve care, treatment, service or supply does not, in itself, make them Medically Necessary.

Medical necessity specifically does not include any:

- (a) Repeated test which would not be necessary if initially done correctly, or is not necessary at current intervals;
- (b) Care, treatment, service or supply which is for the psychological support, education or vocational training of the Covered Person;

Criteria used in determining that a procedure is experimental includes:

- (a) Whether there is an appropriate rationale for the treatment;
- (b) Whether there is evidence that the treatment is effective;
- (c) Whether there is evidence that the treatment is harmful;

- (d) Whether the benefits justify the immediate and delayed risks of treatment;
- (e) Whether the treatment has been endorsed or approved by the appropriate medical authorities, such as the FDA, the AMA or other medical specialty societies or specialists or whether the treatment is covered by Medicare or other public programs;
- (f) Whether the device or treatment is the subject of ongoing investigation or research;
- (g) Whether the treatment is legal;
- (h) Whether controlled medical trials have been carried out that demonstrate the treatment's efficacy.

"**NEWBORN CARE**" charges for the routine care of a newborn child, while hospital confined, are covered by the Plan on the same basis as an illness of such newborn child. Such charges will be considered separate from the mother's charges and subject to the deductible and the applicable benefit percentage payable as shown in the Schedule of Benefits. All such newborn coverage shall include circumcision. Well baby care is covered for three days after birth, before an individual dependent deductible is applicable to the newborn.

"**OTHER COVERAGE**" means any other contract or policy under which the Covered Person is enrolled, such as:

- * Group or blanket insurance;
- * Group practice, group Blue Cross, group Blue Shield, individual practice offered on a group basis, or other group prepayment coverage;
- * Labor management trustee plans, union welfare plans, employee organization plans, or employee benefit organization plans;
- * Government programs, such as Medicare, or coverage required or provided by statute;
- * Any group coverage of a child sponsored by, or provided through, any educational institution;
- * Group arrangements for members of associations or individuals.

"**OTHER COVERED PROVIDER**" means a certified social worker (CSW) licensed professional counselor (LPC), licensed occupational therapist (LOT), certified nurse midwife, licensed speech therapist, licensed physical therapist, registered nurse, licensed vocational nurse, or licensed practical nurse.

"**PHYSICIAN OR SURGEON**" means any professional practitioner who holds a lawful license authorizing the person to practice medicine or surgery in the locale in which the service is rendered, limited to a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Podiatric Medicine (D.P.M.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Chiropractic (D.C.), a Clinical Psychologist (Ph.D), who has met the standards of the National Register of Health Service Providers in Psychology.

"**PLAN**" whenever used herein without qualification means this Plan Document.

"**PLAN ADMINISTRATOR**" means the City of San Antonio's designated Employee Benefits Administrator.

"PLAN DOCUMENT" means this Master Contract and any Addendum, which collectively provide and define coverage for particular employees and dependents.

"PLAN SPONSOR" means the City of San Antonio.

"PLAN SUMMARY" is the information provided to City employees concerning coverage and benefits to assist in understanding and using available benefits. **THE PLAN SUMMARY DOES NOT DEFINE COVERAGE, WHICH IS THE SOLE PURPOSE OF THE MASTER CONTRACT. ANY STATEMENT ABOUT COVERAGE IN THE SUMMARY IS A GENERAL INTERPRETATION ONLY, AND IS NOT MADE FOR SPECIFIC APPLICATION TO ANY COVERED PERSON, ILLNESS, OR EXPENSE.**

"POLICE OFFICER" means any full time, permanent, paid employee who:

- (a) Is employed by the City's Police Department;
- (b) Has been hired in substantial compliance with Chapter 143 of the Local Government Code;
- (c) Has successfully completed the Police Academy; and
- (d) Has received his or her certificate from the Police Chief.

"POST DELIVERY CARE" means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. Post Delivery Care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests.

"PRINCIPALLY DEPENDENT" shall have the meaning defined in Sections 151 and 152 of the Internal Revenue Code and the regulations thereunder.

"PSYCHIATRIC DAY TREATMENT FACILITY" means an institution which meets all of the following requirements:

- (a) It is a mental health facility which: provides treatment for individuals suffering from acute mental, nervous or emotional disorders, in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program; and is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.
- (b) It is accredited by the Program for Psychiatric Facilities or its successor, or the Joint Commission on Accreditation of Hospital; and
- (c) Its patients are treated for not more than eight (8) hours in any twenty-four (24) hour period.

"QUALIFIED INSURED" means an individual eligible for coverage under the Plan who has been diagnosed with:

- a. insulin dependent or non-insulin dependent diabetes;
- b. elevated blood glucose levels induced by pregnancy; or

- c. another medical condition associated with elevated blood glucose levels.

"RECIPIENT" means an insured person who undergoes a surgical operation to receive a body organ transplant.

"REHABILITATION FACILITY" means a facility that provides services of acute rehabilitation. All services are provided under the direction of a physician with a specialty in rehabilitation and physical medicine. The facility is staffed around the clock by registered nurses and it does not provide services of a custodial nature. The facility must be Medicare certified, licensed by the State Department of Health as a "special hospital" and accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is also accredited by the Commission on Accreditation of Rehabilitation Facilities.

"SKILLED NURSING FACILITY" means a legally operated institution, or a distinct part of an institution, primarily engaged in providing skilled nursing care to patients recovering from injury or illness and which:

- (a) Is under the resident supervision of a physician or registered nurse (R.N.);
- (b) Provides continuous skilled nursing care for 24 hours of every day;
- (c) Requires that the health care of every patient be under the supervision of a physician;
- (d) Provides that a physician be available at all times to furnish necessary medical care in emergencies;
- (e) Maintains clinical records for each patient;
- (f) Has an effective utilization review plan;
- (g) Has a transfer agreement with at least one (1) hospital;
- (h) Is not, other than incidentally, a clinic, a place devoted to care of the aged or a place for treatment of mental disorders or mental retardation;
- (i) Is not a place for custodial care.

"TEMPORARY MECHANICAL EQUIPMENT" means any non-organic device used in conjunction with the recipient's own body organ for the purpose of sustaining a bodily function for which a transplant has been deemed necessary by the attending physician.

"TRANSPLANT SURGERY" means the transfer of body organ(s) from a donor to a recipient.

"USUAL & CUSTOMARY CHARGE" means charges for Medically Necessary services and supplies which would usually be provided for cases the same as or similar to the one being treated. The Usual and Customary charge is limited to the lesser of:

- (a) The fee usually charged by the provider for similar services and supplies; and
- (b) The fee usually charged for the same service or supply by other providers who are in the same area. "Area" means a geographical area as determined by the Claims Administrator to be significant enough to establish a representative base of charge for the treatment. The determination of the "usual and customary" charges by the Claims Administrator shall be based on standard profiles and statistical sampling methods accepted in the

benefits industry. Usual and customary shall be based on the 85th percentile and updated on a semi-annual basis. All charges above or beyond the "usual and customary" charges so determined are the financial responsibility of the Covered Person. Upon request, the City will furnish information or assistance to a Covered Person to enable them to contest excessive charges, in accordance with the policy of the Employee Benefits Office in effect at the time of the request.

CHAPTER 5

COVERED MEDICAL EXPENSES

Covered Medical Expenses shall be the portion, set forth in the Schedule of Benefits, of the usual and customary charges for the following services, supplies, and treatment when medically necessary and when ordered by a licensed physician or surgeon. Medical expenses exceeding usual and customary expenses covered by this plan will be the obligation of the Covered Person.

1. Daily semi-private room charge in a hospital or rehabilitation facility.
2. Services and supplies furnished by a hospital.
3. Treatment by a physician or surgeon.
4. Treatment by an other covered provider not related by blood or marriage.
5. Anesthetic and its administration.
6. "Surgery in mouth or oral cavity" is limited to:
 - (a) removal of non-odontogenic lesions, tumors or cysts;
 - (b) incision and drainage of non-odontogenic cellulitis;
 - (c) surgery on accessory sinuses, salivary glands and ducts and tongue;
 - (d) surgical treatment of fractures and dislocation of the jaw resulting from an accidental injury.
7. Diagnostic radiology, radiation therapy and laboratory examinations.
8. Ambulance charges to or from the nearest medically appropriate hospital by an ambulance service operated in accordance with State law.
9. Medical supplies and equipment as follows:
 - (a) drugs and medicines which can be obtained only by numbered prescription for the specified illness or injury for which the patient is being treated;
 - (b) birth control pills, injections and medication implants are covered for employees and dependent spouses only. No other contraceptive methods or devices are covered;
 - (c) blood and blood plasma;
 - (d) charges for drawing and storing autologous blood;

- (e) prosthetic appliances such as artificial limbs or eyes, not including their replacement except when required due to growth or development of a dependent child. After a covered mastectomy, breast implants or prostheses are also covered. Replacement of breast prosthesis is covered only when original prosthesis was required due to a major catastrophic illness or injury;
 - (f) crutches. The rental (but not to exceed the total cost of purchase) or, at the option of the Claims Administrator, the purchase of durable medical equipment when medically necessary and prescribed by a physician for therapeutic use, including wheelchairs, hospital beds, oxygen and equipment for its administration including IPPB (Intermittent Positive Pressure Breathing);
 - (g) medical supplies such as lancets, autolets, syringes, dextrowash and dextrostix, ostomy supplies, casts, splints, trusses and braces;
 - (h) orthopedic shoes when prescribed by a physician.
10. Dental treatment for fractured jaw or for injury to sound natural teeth including replacement of such teeth within six months after the date of accident, provided that such accident occurs while the insurance is in force as to the covered person.
12. Expenses incurred for maternity care and services shall be covered on the same basis as for any other illness incurred by the covered person or the dependent spouse. There is no coverage for expenses for maternity care and services incurred by a dependent child except for complications of pregnancy which shall be treated as any other illness.

The attending physician shall make the determination as to whether a delivery is complicated.

Under Federal law, group health plans generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The 48-hour period (or 96-hour period if applicable) begins at the time a delivery occurs in the hospital (or in the case of multiple births, at the time of the last delivery) or, if the delivery occurs outside the hospital, at the time a mother and/or newborn are admitted. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable) following the delivery.

If a decision is made to discharge a mother or her newborn child from inpatient care before the expiration of the minimum hours of coverage of inpatient care as provided above, the Plan will provide coverage for timely Post Delivery Care as defined herein. Such care may be provided to the mother and the child by a physician, registered nurse or other appropriate licensed health care provider and may be provided at the mother's home, a health care provider's office, a health care facility or another location determined to be appropriate under rules adopted by the Commissioner of Insurance.

12. Newborn care.
13. Services of a licensed speech therapist are covered only when there has been a partial or total loss of functional speech due to illness or injury, when normal speech was present before the illness or injury, and when therapy is rendered in accordance with a physician's specific instructions as to type and duration.
14. Services of a licensed physical therapist are covered only for those services that require the technical medical proficiency and skills of a licensed physical therapist and which are rendered

in accordance with a physician's specific instructions as to type and duration.

15. Acupuncture or hypnosis when performed by a covered provider and in lieu of anesthesia.
16. Psychiatric Treatment. Serious mental illness includes the following; (1) schizophrenia; (2) paranoia and other psychotic disorders; (3) bipolar disorders (mixed, manic, depressive, and hypomanic); (4) major depressive disorders (single episode or recurrent); (5) schizo-affective disorders (bipolar or depressive); (6) pervasive developmental disorders; (7) obsessive-compulsive disorders; and (8) depression in childhood and adolescence. Treatment of the above-listed serious mental illnesses is limited to 45 days of inpatient treatment per calendar year and 60 visits for outpatient treatment, including group and individual outpatient treatment, per calendar year. Coverage for such treatment does not include addiction to a controlled substance or marihuana that is used in violation of law or mental illness resulting from the use of a controlled substance or marihuana in violation of law. The above-listed serious mental illnesses will be covered as any other illness subject to applicable deductibles, coinsurance, limits and exclusions, pre-certification and non-pre-certification penalties. Any diagnosis other than those listed in the sub-paragraph will be subject to the current Plan design in each program.
17. Chemical dependency and substance abuse will be treated as any other illness.
18. Voluntary sterilization is covered.
19. Preventive services:
 - (a) One routine pap smear (doctor's procedure charge, lab expenses and office visit) per calendar year for female covered persons;
 - (b) One routine mammogram per calendar year for female covered persons age thirty-five (35) and over;
 - (c) One (1) routine physical examination per calendar year for an eligible employee only
 1. If performed by the employee's own physician, covered services will be limited to a preventative medical examination, blood chemistry profile, thyroid function (TSH), fecal occult blood, urinalysis, electrocardiogram, body fat measurement, health risk appraisal, stress and personality profile, and nutritional analysis, subject to the deductible and coinsurance as stated herein.
 2. If performed at the Occupational Health Clinic, at 401 West Commerce, the Plan will cover a complete blood count, cholesterol and glucose screening; blood pressure check; height and weight evaluation; and a health assessment questionnaire at 100%.
 - (d) A physical examination for the detection of prostate cancer and prostate-specific Antigen test used for the detection of prostate cancer for each male enrolled in the Plan who is;
 1. at least 50 years of age and asymptomatic; or
 2. at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.
20. (a.) Gamma globulin injections and the following immunizations for Covered Dependents from birth through the date the child is six (6) years of age shall be covered: (a) DTP, (b) polio (OPV), (c) MMR, (d) meningitis (HIB); (e) hepatitis B (HBV); (f) TB tine; (g) varicella; and (h) any other immunizations as required by Texas law. After age six (6), the aforementioned

immunizations will be covered only if the dependent was covered under this Plan before attaining age six (6). Expenses for all covered immunizations are covered at 100%, deductible waived. Other services provided at the same time as the immunizations, including, but not limited to, office visit charges, shall be subject to the deductible and coinsurance.

(b.) Synagis (Palivizumab) administration for the prevention of respiratory syncytial virus (RSV) among high risk infants meeting prescribing criteria set forth by American Academy of Pediatrics (AAP) will be covered at 100%, deductible waived, only if such treatment is determined to be medically necessary and prior authorization obtained on or before administration of the first injection.

21. Expenses for Attention Deficit Disorder.
22. Occupational Therapy.
23. Diabetes. Coverage shall be provided to each Qualified Insured as defined herein for:
 - (a) diabetes equipment;
 - (b) diabetes supplies; and
 - (c) diabetes self-management training programs as defined herein.

A health care practitioner or provider who is licensed, registered, or certified in Texas to provide appropriate health care services must provide diabetes self-management training. Self-management training includes:

- (a) training provided to a Qualified Insured after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies;
 - (b) additional training authorized on the diagnosis of a physician or other health care practitioner of a significant change in the Qualified Insured's symptoms or condition that requires changes in the Qualified Insured's self-management regime; and
 - (c) periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.
24. Temporomandibular Joint. Medically necessary diagnostic or surgical treatment of conditions affecting the temporomandibular joint (jaw and the craniomandibular joint) resulting from one of the following shall be covered:
 - (a) an accident;
 - (b) a trauma;
 - (c) a congenital defect;
 - (d) a developmental defect; or
 - (e) a pathology.

Such coverage is subject to the same Plan provisions as for any surgical treatment including, but not limited to, the requirements for pre-certification of benefits.

25. Mastectomy. Coverage for inpatient care for a Covered Person is as follows:
 - (a) 48 hours following a mastectomy; and

- (b) 24 hours following a lymph node dissection for the treatment of breast cancer.

For reconstruction of the breast on which a medically necessary mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses and treatment of physical complications for all stages of the mastectomy, including lymphedemas are covered under this Plan.

If the Covered Person and the Covered Person's attending physician determine that a shorter period of inpatient care is appropriate, the Plan is not required to provide the minimum hours of coverage of inpatient care stated above.

26. Treatment for Mental and Nervous Conditions

- (a) There is a limit of 30 days on the number of days for hospital confinement (20% coinsurance applies).
- (b) There is a limit of 60 days on the number of days for treatment at psychiatric day treatment facility (20% coinsurance applies).
- (c) psychiatric counseling will be paid at 50% of usual and customary.

27. Hospice Care. Hospice care is an alternative to the Hospital Confinement of a terminally ill person. Hospice Benefits are available for Covered Persons with a life expectancy of six (6) months or less provided the attending Physician approves the program. Failure to pre-certify will result in no benefit allowances. Hospice care is subject to the deductibles and co-insurance as provided in the applicable appendix for each class of City employee, retiree, and official.

Eligible Hospice Charges are charges made by a Hospice for:

- (a) room and board;
- (b) private duty nursing care provided by or under the supervision of a Registered Nurse (R.N.);
- (c) part-time or intermittent home health aide services which consist primarily of caring for the patient by employees of the Hospice;
- (d) social work performed by a licensed social worker, routinely provided by the Hospice agency;
- (e) nutritional services, including, special meals, if included in the per diem;
- (f) emotional support services routinely provided by the Hospice agency, if included in the per diem;
- (g) bereavement counseling sessions for eligible dependents covered under the Plan, if included in the per diem; and
- (h) drugs and medication.

28. Organ Transplants. If covered expenses are incurred as a result of a body organ transplant, the Plan will pay the applicable co-insurance percentage of the Covered Expenses, as defined herein, after the deductible is applied, subject to the lifetime maximum benefit and the following conditions:

- (a) Benefits are available for body organ transplantation, subject to determination made on an individualized case by case basis in order to establish medical necessity;
- (b) Benefits will be provided only when the hospital and physician customarily charge a transplant recipient for such care and services;
- (c) When only the transplant recipient is a Covered Person, the benefits of the Plan will be provided for the donor to the extent that such benefits are not provided under any other form of coverage. In no such case under the Plan will any payment of a "personal

- service" fee be made to any donor. Only the necessary hospital and physician's medical care and services expenses with respect to the donor will be considered for benefits;
- (d) When only the donor is a Covered Person, the donor will receive benefits for care and services necessary to the extent such benefits are not provided under any coverage available to the recipient. Benefits will not be provided to any recipient who is not a Covered Person; and
 - (e) When the recipient and the donor are both Covered Persons, as provided herein, benefits will be provided for both in accordance with their respective Covered Expenses.

If the recipient is the Covered Person and/or pursuant to the conditions set forth above, the following coverage shall be provided:

- (a) The use of temporary mechanical equipment, pending the acquisition of "matched" body organ(s);
- (b) Transplant surgery of a body organ(s) as defined herein;
- (c) Multiple transplant(s) during one (1) operative session;
- (d) Replacement(s) or subsequent transplant(s); and
- (e) Follow-up expenses for covered services, including immunosuppressant therapy.

If the donor is a Covered Person and pursuant to the conditions set forth above, the following coverage shall be provided:

- (a) The acquisition of a body organ(s) from the donor;
- (b) The life support of a donor pending the removal of a usable body organ(s); and
- (c) Transportation of a body organ(s). However, transportation of a body organ(s) shall not include transportation of a living donor and/or a donor on life support.

CHAPTER 6

LIMITATIONS

Benefit limitations apply to the following conditions and services:

1. Abortions

Abortions will be covered when the attending physician certifies that the mother's life would be endangered if the fetus were carried to term.

2. Cosmetic Procedure

Elective procedure performed solely to improve appearance is not covered. Nor are the complications that may arise from or are the direct result of such procedure covered. A procedure utilized as treatment of neurosis, psychoneurosis, psychopathy, psychosis and other mental, nervous and emotional illnesses is not covered. However, expenses incurred for a cosmetic procedure for the prompt repair or alleviation of damage caused solely by accidental bodily injury, or congenital defects of children, or for the correction of a congenital anomaly in a newborn child, or for the reconstruction of the breast on which a medically necessary mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses and treatment of physical complications for all stages of the mastectomy, including lymphedemas are covered under this Plan.

3. Treatment in Mouth or Oral Cavity

The care and treatment of the teeth, gums or alveolar process or for dentures, appliances or supplies used in such care and treatment is not covered, except for charges incurred as a result of and within six months after an accident suffered while covered hereunder for treatment of injuries to sound, natural teeth, including replacement of such teeth, or for setting of a jaw fractured or dislocated in such accident; provided, however, that this exclusion shall not be applicable to services and supplies rendered to a newborn child which are necessary for treatment or correction of a congenital defect.

4. Maternity for Dependents

Maternity care and services rendered to a dependent child are limited to treatment of Complications of Pregnancy.

5. Mental and Nervous Conditions

Subject to the applicable percentage payable as stated in the Schedule of Benefits, charges for services provided by a physician (M.D., D.O., clinical psychologist, certified social worker or licensed professional counselor) including group therapy, and collateral visits with members of the patients immediate family for the treatment of mental, nervous, emotional, drug or substance abuse illness or disorders of any type are payable as follows:

Covered physician charges provided on an inpatient basis are covered at the applicable percentage rate stated in the Schedule of Benefits.

No coverage is provided for physical or psychological therapy in an in or out patient setting where art, play, music, drama, reading, nutrition, massage, education, home economics or recreational activities is the method of treatment.

Psychological testing, evaluation or assessment is covered at the applicable percentage rate listed in the Schedule of Benefits.

Expenses for treatment in a psychiatric day treatment facility for a mental, nervous or emotional disorder, if the attending physician certifies that such treatment is in lieu of hospitalization, will be covered as if incurred on an inpatient basis. Any benefits so provided shall be determined as if necessary care and treatment in a psychiatric day treatment facility were inpatient care and treatment in a hospital; each full day or treatment in a psychiatric day treatment facility shall be considered equal to one-half day of hospital confinement for purposes of determining benefits and benefit maximums under the Plan.

6. Private Room Limit

When private room accommodations have been used, charges will be reimbursed at the average semi-private room rate in the facility. If a hospital has private rooms available only, then the maximum eligible charge will be based on the usual and customary semi-private room charge in the community.

No coverage is provided under the Plan for services and supplies:

1. For which the patient or employee has no legal obligation to pay, or for which no charge would be made if the employee had no health coverage.
2. Any treatment or service rendered by a Covered Provider related by blood or marriage.
3. Not medically necessary for the diagnosis and treatment of an illness or injury or which exceed the usual and customary charges.
4. For intentionally self-inflicted injury, whether sane or insane.
5. For diseases contracted or injuries sustained as a result of service in any branch of the armed forces.
6. For accidental bodily injury or illness which is covered by Workers' Compensation or an Occupational Medical Policy, or any expenses payable under compromise settlement agreements arising from a Workers' Compensation Claim.
7. For marital, family, vocational and other counseling services, except for nutritional counseling for diabetics.
8. For sex transformation surgery and all expenses in connection with such surgery.
9. For reversal or attempted reversal of sterilization.
10. For services, therapy and counseling for sexual dysfunction or inadequacies or for implants or aids to sexual function except due to a disease or injury which is otherwise covered by this plan.
11. Family planning, infertility treatment and services including but not limited to: artificial insemination and personal therapy for infertility.
12. For a dependent child's pregnancy except for complication as defined by the Plan arising from a dependent child's pregnancy.
13. For smoking cessation seminars, services, devices or medications.
14. For the surgery or treatment of obesity, morbid obesity, dietary control, or for weight reduction.
15. For nutritional supplements, including prescription and over the counter vitamins.
16. For exercise equipment or exercise programs.

17. For orthotics (arch supports, etc.) and other supportive devices for feet that are not prescribed by a physician.
18. For air conditioners, filters, humidifiers, dehumidifiers, and purifiers.
19. For eye exercises, visual training (orthoptics), eyeglasses, including contact lenses, hearing aids, or examinations for the purpose of determining visual acuity or level of hearing.
20. For radial keratotomy surgery and orthokeratology.
21. For medical, dental or surgical treatment including associated diagnostic procedures of orthognathic conditions.
22. For vocational therapy.
23. For preparing medical reports or itemized bills.
24. For travel or accommodations, whether or not recommended by a physician.
25. For charges associated with non-emergency hospital admissions on either a Friday or a Saturday unless a surgical procedure is performed within 24 hours of admission.
26. For special education, counseling or care for learning deficiencies or behavioral problems whether or not associated with a manifest mental disorder or other disturbance.
27. For care in a health resort, rest home, nursing home, residential treatment center, or any institution primarily providing convalescent, or custodial care.
28. For custodial care.
29. For any claims filed more than one (1) year from the month the covered service or supply was provided.
30. For admissions aimed at primarily overcoming the after effects of a specific episode of drug abuse (detoxification), or to keep the patient from access to drugs (maintenance care).
31. For sales tax, transportation, tariffs, immigration fees for international travel, or federal excise taxes are not covered under this plan document.
32. For routine physical examinations for eligible dependents and for eligible employees not covered in Chapter 5, paragraph 19(c).
33. No coverage is provided for services and supplies for routine or preventative immunizations or vaccinations except for gamma globulin injections and child immunizations.
34. Coverage for Hospice Care does not include the following charges:
 - (a) nutritional services, including special means not included in the per diem;
 - (b) emotional support services not routinely provided by the Hospice agency and/or not included in the per diem;
 - (c) bereavement counseling sessions for eligible dependents covered under the Plan not included in the per diem;
 - (d) funeral arrangements;

- (e) pastoral counseling; and
- (f) financial or legal counseling.

35. Coverage for Organ Transplant Surgery does not include the following charges:

- (a) Experimental treatment for new procedures, and treatments, services or supplies which are still considered experimental or investigational and not "generally accepted" by the medical profession. The judgment whether a procedure, treatment, service or supply is experimental is based upon all of the relevant facts and circumstances, including, but not limited to:
 - 1. Approval by the U.S. Food and Drug Administration, the American Medical Association or the appropriate Medical Specialty Society;
 - 2. Medical and scientific literature;
 - 3. Scientifically demonstrated health benefits;
 - 4. Safety and effectiveness compared to alternatives; and
 - 5. Safety, effectiveness and benefits when used outside of a research setting;
- (b) Any animal organ or mechanical equipment, mechanical device, or mechanical organ(s), except as provided herein;
- (c) Any financial consideration to the donor other than for a covered service or supply which is incurred in the performance of or in relation to transplant surgery; and
- (d) Transportation of a donor, except as provided herein.

DEFINITIONS

The following terms shall mean:

A “pre-existing condition” is a condition (whether physical or mental and regardless of the cause of the condition) for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period prior to an individual’s “enrollment date.” Genetic information will not be treated as a condition in the absence of a diagnosis of a specific condition. Pregnancy will not be treated as a pre-existing condition.

“Enrollment date” means the first day of an individual’s coverage or, if there is a waiting period before an individual’s coverage becomes effective, the first day of the waiting period; therefore, conditions first diagnosed or treated during the waiting period will not be treated as pre-existing conditions. For an individual who enrolls during a special enrollment period (or as a late entrant), the enrollment date is the first day of the individual’s coverage.

“Late entrant” means an individual who enrolls other than during the initial enrollment period or a special enrollment period as provided under the “ELIGIBILITY REQUIREMENTS” of the Plan.

“Creditable coverage” includes prior coverage under another group health plan, group or individual health insurance coverage issued by a state regulated insurer or an HMO, COBRA, Medicaid, Medicare, CHIP (Children’s Health Insurance Program), the Active Military Health Program, CHAMPUS, American Indian Health Care Programs, a State health benefits risk pool, the Federal Employees Health Plan, the Peace Corp Health Program, or a public health plan.

PRE-EXISTING CONDITION EXCLUSION PERIOD

Expenses for treatment of pre-existing conditions will **not** be covered for 6 months following an individual’s enrollment date. Once this exclusion period has been satisfied, normal benefits will be payable.

The pre-existing condition exclusion period will not apply to pregnancy (regardless of whether the woman had previous coverage) or to a newborn or adopted child under age 18 (or child placed for adoption under age 18) provided the child became covered under the Plan or other creditable coverage within 31 days of birth or adoption (or adoptive placement) and provided they have not incurred a subsequent break in coverage of 63 consecutive days or more.

The Plan’s pre-existing condition exclusion period may be reduced by an equal period of any prior continuous health coverage (creditable coverage) as long as there is no break in coverage of 63 consecutive days or more. Individuals have a right to demonstrate prior health coverage to reduce the Plan’s pre-existing condition exclusion period by providing Certificates of Creditable Coverage.

CHAPTER 9

SUPPLEMENTAL ACCIDENT BENEFITS

This provision provides you and your dependents with supplemental benefits for hospital and medical expenses resulting from an Accidental Injury occurring while you are covered by this Plan.

Covered medical expenses directly related to the accident and incurred within the first ninety (90) calendar days of the date of the accident, are covered at 100% up to a maximum of \$500. Deductible does not apply.

CHAPTER 10

PRE-ADMISSION TESTING

If a Covered Person who is scheduled for inpatient surgery in a hospital, has preoperative testing relating to this surgery performed within ten (10) days prior to the scheduled surgery and the testing is performed at a physician's office, diagnostic laboratory, ambulatory surgery center or on a hospital outpatient basis, the Plan will pay pre-operative testing at 100% provided:

1. The charge for the surgery is a covered expense;
2. The tests would have been covered had the patient been confined as a hospital inpatient;
3. The tests are not repeated when the patient is confined for the surgery;
4. The test results are a part of the patient's medical record;
5. The surgery is performed in a hospital;
6. The service is identified as pre-admission or preoperative testing.

The deductible does not apply.

Certification of ALL admissions to a hospital including admissions for rehabilitation, treatment of mental or nervous condition, drug, alcohol or substance abuse and maternity is required prior to or on the day of admission as an inpatient. Emergency admissions must be verified within forty-eight (48) hours following admissions. Confirmation of the admission or an extension beyond the period originally authorized will be provided by the Utilization Review Nurse to the Covered Person, the hospital and the physician.

Certification of all outpatient surgery, performed in an ambulatory surgery center or hospital outpatient facility, is required prior to or on the day of the surgery. Emergency outpatient surgery must be certified within forty-eight (48) hours following the surgery. Confirmation of the outpatient surgery will be provided by the Utilization Review Nurse to the Covered Person, the outpatient facility and the physician.

The Covered Person is responsible for the certification of hospital admission and outpatient surgery.

For all hospital admissions and outpatients surgeries:

The patient, a family member, the physician or the hospital must call the City of San Antonio's Utilization Review Nurse for:

For regular admissions and outpatient surgery:

Call prior to the scheduled admission or surgery date.

For emergency admissions and outpatient surgery:

Call within forty-eight (48) hours of admission or surgery. The number to call for pre-certification is listed on the back of the Plan identification card provided by the Claims Administrator.

If Pre-Certification Authorization is not obtained the maximum benefit paid for the doctor and hospital will be fifty percent (50%) of the usual and customary charges. The fifty percent (50%) not reimbursed by the Plan will not count toward satisfaction of the Plan year out-of-pocket maximum.

Pursuant to State law, the Plan will not restrict benefits for any hospital length of stay in connection with a mastectomy or lymph node dissection of less than 48 hours following a mastectomy or less than 24 hours following a lymph node dissection or require that a provider obtain authorization from the Plan for prescribing a length or stay within the above periods. Certification is required for a length of stay, which is in excess of the above periods.

Pursuant to State law, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child of less than 48 hours following an uncomplicated vaginal delivery or less than 96 hours following an uncomplicated cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay within the above periods. Certification is required for a length of stay, which is in excess of the above periods.

Preferred Provider Network

The City of San Antonio participates in a Preferred Provider Network of hospitals, physicians and other providers that are contracted to furnish, at negotiated costs, medical care for the City employees and their dependents. The use of a Preferred Provider may result in reduced out of pocket expenses to the Covered Person.

A current listing of the Preferred Provider Network contracting hospitals, physicians and other providers is available in the Employee Benefits Office. A Covered Person may choose any health care provider.

The City reserves the right to terminate or modify the Preferred Provider Network program, or any portion thereof, at any time.

On inpatient hospital bills under \$3,000.00 the Plan will make a cash presentation to any employee who (1) detects a billing overcharge made by a hospital as a result of an inpatient confinement to any covered family member and (2) receives a billing adjustment and (3) the Plan realizes a savings.

Upon discharge from the hospital, simply review the bill. If there is any error, it may be in one of the following area:

A Calculation Error

A charge for service the patient did not receive.

The patient received a service but not in the quantity indicated.

Remember, take the original bill and obtain a corrected bill and present both to the City Claims Administrator for review and determination. The Plan will pay the employee 25% of the savings or maximum of \$500, whichever is less. As an example, if an employee detects an incorrect charge of \$1,200 and this is confirmed, the employee will receive a check for 25% of the savings, or \$300 from the Plan.

The COB provision is designed to correct over coverage which occurs when a person has health coverage for the same expenses under two (2) or more of the plans listed below. Should this type of duplication occur, the benefits under this Plan will be coordinated with those of the other plans so that the total benefits from all plans will not exceed the expenses actually incurred.

If a Covered Person's benefits under another health plan are reduced due to cost containment provisions, such as a second surgical opinion, pre-certification, HMO or preferred provider arrangements, the amount of the reduction shall not be considered as an allowable expense under this Plan.

The benefits provided by the plans listed below are considered in determining duplication of coverage:

1. This Plan;
2. Any other group insurance or prepayment plan, Health Maintenance Organizations (HMOs); Blue Cross/Blue Shield;
3. Any labor-management trustee plan, union welfare plan, employer organization plan or employee benefit organization plan;
4. Any government plan or statute providing benefits for which COB is not prohibited by law.

Order of Benefit Determination

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

1. A plan with no COB provision will determine its benefits before a plan with a COB provision;
2. A plan that covers a person other than as a Dependent will determine its benefits before a plan that covers such person as a Dependent;
3. Any labor-management trustee plan, union welfare plan, employer organization plan or employee benefit organization plan will determine its benefits before this plan;
4. When a claim is made for a dependent child who is covered by more than one (1) plan:
 - (a) the benefits of the plan of the parent whose birthday falls earlier in the year will be determined before the benefits of the plan of the parent whose birthday falls later in that year; but

- (b) if both parents have the same birthday, the benefits of the plan which covered the parent longer will be determined before those of the plan which covered the other parent for a shorter period of time.

This method of determining the order of benefits will be referred to as the "Birthday Rule." The Birthday Rule will be used to determine the order of benefits for dependent children in all cases except those described below.

- (c) if the other plan does not have the Birthday Rule, then the plan which covers the child as a dependent of the male parent will pay its benefits first.
- (d) if the parents are legally separated or divorced, benefits for the child will be determined in this order:
 - (i) first, the plan of the parent with custody of the child will pay its benefits;
 - (ii) then, the plan of the spouse of the parent with custody of the child will pay its benefits; and
 - (iii) 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 determine its benefits before any other plan.

5. A plan that covers a person as:

- (a) a laid off employee; or
- (b) a retired employee; or
- (c) a dependent of such employee;

will determine its benefits after the plan that does not cover such person as:

- (a) a laid off employee; or
- (b) a retired employee; or
- (c) a dependent of such 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.

6. If one of the above rules establishes the order of payment, a plan under which the person has been covered for the longer time will determine its benefits before a plan covering that person for a shorter time.

Two successive plans of the same group will be considered one plan if the person was eligible for coverage under the new plan within twenty-four (24) hours after the old plan terminated. A change in the amount or scope of benefits, or a change in the carrier, or a change from one type of plan to another (e.g., single employer plan to multiple employer plan) will not constitute the start of a new plan.

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

- (a) each benefit will be reduced proportionately; and
- (b) only the reduced amount will be charged against any benefit limits under the Plan.

The COB provision is applied throughout the calendar year. If there is any reduction of the benefits provided under a specific Benefit Provision of this Plan because of duplicate coverage, similar benefits may be payable later in that year if more Allowable Expenses are incurred under the same Benefit Provision of this Plan because of duplicate coverage, similar benefits may be payable later in that year if more Allowable Expenses are incurred under the same Benefit Provision. "Allowable Expense" means any necessary, usual and customary item of expense at least part of which is covered under at least one of the plans covering the person for who claim is made or service provided, in no event will Allowable Expense 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.

Benefits under a governmental plan will be taken into consideration without expanding the definition of "Allowable Expense" beyond the hospital, medical and surgical benefits as may be provided by such governmental plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

The Plan has the right to release to, or obtain from, any other organization or person any information necessary for the administration of this provision and to pay to any organization any amounts necessary to satisfy the intent of this provision.

If the Plan has paid any amounts in excess of those necessary to satisfy the intent of this provision, it has the right to recover such excess from the person, to or for whom, such payments were made or from an insurance company or organization.

When you claim benefits under the Plan, you must furnish information about other coverage, which may be involved in applying this coordination provision.

A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, the Claims Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Medicare

This Plan covers most of the same kinds of expenses as Medicare, which has two parts (Part A, hospital insurance, and Part B, medical insurance). Mutually provided benefits are coordinated under the double coverage provision.

This Plan will pay 80% after Medicare has paid as primary (which requires that the Covered Person is entitled to or has elected parts A and B of Medicare coverage) and after the deductible under this Plan has been met.

Generally, whether Medicare is the primary payor of benefits is determined under Federal law and regulations. Certain retirees will have coverage supplemental to Medicare benefits, as provided in the

Appendix applicable to those retirees. For information on this subject, you may consult the Employee Benefits Office or your Social Security Office.

If a Covered Person has other primary medical insurance other than Medicare, benefits will be paid at 80% of usual and customary charges under this plan, after the deductible is paid. Once the employee or retiree is eligible for Medicare such person is required to apply for and maintain Medicare benefits. Once Medicare is effective, the health plan would coordinate, as secondary coverage to Medicare whereby retirees would meet the health plan's deductible before expenses are covered at 80%, to the extent permitted by federal law and regulations.

Once the retiree or spouse is individually eligible for Medicare, such person is required to apply for and maintain Medicare benefits. Once Medicare is effective, this health plan provides coverage supplemental to Medicare. The covered person must meet this plan's deductible before expenses are covered at 80%.

Compliance with Cost Containment Health Plan Provisions

If the Covered Person's benefits are reduced by a health plan that has cost containment provisions, such as a second surgical opinion, HMO, pre-certification or preferred provider arrangements, the amount of such reduction shall not be an allowable expense.

PROVISION FOR SUBROGATION AND RIGHT OF RECOVERY

A third party may be liable or legally responsible for expenses incurred by a Covered Person for an illness or a bodily injury.

Benefits may also be payable under the Plan for such expenses. When this happens, the Plan may, at its option:

1. Take over the Covered Person's right to receive payment of the benefits from the third party. The Covered Person will:
 - (a) transfer to the Plan any rights he may have to take legal action against the third party with respect to benefits paid by the Plan which are subject to this provision; and
 - (b) cooperate fully with the Plan in asserting its right to subrogate. This means the Covered Person must supply the Plan with all information and sign and return all documents reasonably necessary to carry out the Plan's right to recover from the third party any benefits paid under the Plan which are subject to this provision.
2. Recover from the Covered Person any benefits paid under the Plan which the Covered Person is entitled to receive from the third party. The Plan will have a first lien upon any recovery, whether by settlement, judgment or otherwise, that the Covered Person received from:
 - (a) the third party; or
 - (b) the third party's insurer or guarantor; or
 - (c) the Covered Person's uninsured motorist insurance.

This lien will be for the amount of benefits paid by the Plan for the treatment of illness or bodily injury for which the third party is liable or legally responsible. If the Covered Person:

- (a) makes any recovery as set forth in this provision; and
- (b) fails to reimburse the Plan fully for any benefits paid under this provision; then he will be personally liable to the Plan to the extent of such recovery up to the amount of the first lien. The Covered Person must cooperate fully with the Plan in asserting its right to recover.

1. Proof of Loss

Written proof of loss must be furnished to the Claims Administrator within one (1) year after the month such loss was incurred. Failure to furnish proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one (1) year from the month care, treatment, service or supply was first provided for the illness or injury.

2. Legal Actions

No action at law or in equity shall be brought to recover on the Plan unless the employee or retiree has exhausted administrative remedies provided in the review and appeal process in Chapter 16.

3. Examination

The Claims Administrator shall have the right and opportunity to have the Covered Person examined whose injury or illness is the basis of a claim when and so often as it may reasonably require during pendency of a claim.

4. Conformity with Federal Statutes

Any provision of this Plan, which on its effective date is in conflict with federal statutes, is hereby amended to conform to the minimum requirements of such federal statutes.

5. Choice of Physician

The Covered Person shall have free choice of any physician, as defined in this Plan, practicing legally. Benefits may vary depending on the physician's participation in the City's Preferred Provider Network.

6. Entire Contract

The Plan Document constitutes the entire contract of coverage between the Plan Sponsor and the Covered Person.

7. Effect of Changes

All changes to the Plan shall become effective as of a date established by the Plan Administrator, except that:

No increase or reduction in benefits shall be effective with respect to covered expenses incurred prior to the date a change was adopted by the Plan Sponsor, regardless of the effective date of the change; and

8. Written Notice

Any written notice required under the Plan shall be deemed received by a Covered Person sent by regular mail, postage prepaid, to the last address of the Covered Person on the records of the Employer.

9. Clerical Errors/Delay

Clerical errors made on the records of the Plan Sponsor, Plan Administrator or Claims Administrator and delays in making entries on records shall not invalidate covered or cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of the Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of an error or delay, an equitable adjustment of any contributions will be made.

10. Workers' Compensation

The Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

11. Statements

(a) Not Representations

Statements made by or on behalf of any person to obtain coverage under the Plan shall be deemed representations and not warranties.

(b) Misstatements on Enrollment or Claim Form

If any relevant material fact has been misstated by or on behalf of any person to obtain coverage under the Plan, the true fact shall be used to determine whether coverage is in force and the extent, if any, of coverage. Upon the discovery of any misstatement, an equitable adjustment of any benefit payments will be made.

(c) Time Limit for Misstatement

No misstatement made to obtain coverage under the Plan will be used to void the coverage of any person which has been in force for a period of two (2) years or to deny a claim for a loss incurred or disability commencing after the expiration of the two (2) year period. The provisions of this paragraph shall not apply if any misstatement has been made fraudulently.

(d) Use of Statements

No statement made by or on behalf of any person will be used in any context unless a copy of the written instrument containing the statement has been or is furnished to any person or to any person claiming a right to receive benefits with respect to the person.

12. Identification Cards

Identification card(s) will be issued, which indicate coverage by the City of San Antonio Health Benefits Program. Upon request, the Claims Administrator or the City's Employee Benefits Office will verify coverage of Covered Persons. Identification cards will be for identification of Covered Persons only and do not constitute a guarantee of coverage.

13. Protection Against Creditors

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish same shall be void. If the City finds that such an attempt has been made with respect to any payment due or to become due to any covered person, the City in its sole discretion may terminate the interest of such covered person or former covered person in such payment. And in such case the City shall apply the amount of such payment to or for the benefit of such covered person or former covered person, his/her spouse, parent, adult child, guardian or a minor child, brother or sister, or other relative of a dependent of such covered person or former covered person, as the City may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the City, benefit payments may be assigned to health care providers.

1. Claim Filing

- (a) Medical claims (doctor's visits, prescription drugs, exams, hospital, etc.) shall be filed on a claim form available from the Employee Benefits Office or Claims Administrator.
- (b) The claim form shall include medical bills (itemized only) and the explanation of benefit statement (EOB) from other health insurance policies, if any. The bill should contain the following:
 - (i) the official letterhead of the hospital, doctor, clinic, pharmacy, etc.;
 - (ii) type of service;
 - (iii) date of service received;
 - (iv) amount charged;
 - (v) name of patient; and
 - (vi) diagnosis.
- (c) Only one (1) detailed claim form must be completed per person per year, even for different claims and/or diagnoses. Any additional claims throughout the year may be filed on a short claim form available through the Employee Benefits Office. If a claim is for an accidental injury, then a detailed claim form must be completed for each accident occurrence. All items on the front of the detailed claim form must be completed. It is not necessary to complete the back of the form. The blocked section regarding secondary insurance coverage must be completed.
- (d) The original claim form with the attached bills shall be mailed to the City's claims administrator.

2. Limitation of Liability

The Plan Sponsor shall not be obligated to pay any benefits under the Plan for any claim that is not timely filed.

3. Time of Claims Processing

Benefits for incurred medical expenses which are covered under the Plan will be processed immediately upon receipt of proper written proof of loss by the Claims Administrator. Any benefits payable will be made within twenty (20) working days.

Periodic Payment: Payment of accrued periodic payments for continuing losses which are covered under the Plan will be made immediately upon receipt of proper proof of loss by the Claims Administrator and at the applicable time period.

4. Payment of Benefits

All benefits under the Plan are payable to the Covered Employee whose illness or injury or whose covered dependent's illness or injury is the basis of a claim.

In the event of the death or incapacity of a Covered Employee and in the absence of written evidence to the Plan of the qualification of a guardian for his estate, the Plan may, in its sole discretion, make any and all payments to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of the employee.

Benefits for medical expenses covered under the Plan may be assigned by a Covered Employee to the person or institution rendering the services for which the expenses were incurred. No assignment will bind the Plan Sponsor unless it is in writing and unless it has been received by the Claims Administrator prior to the payment of the benefit assigned. The Claims Administrator will not be responsible for determining whether any assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment signed by the Covered Employee and the assignee has been received before the proof of loss is submitted.

5. Discharge of Liability

Any payment made in accordance with the provisions of this section will fully discharge the liability of the Plan Sponsor to the extent of payment.

6. Recovery of Payments

If the following circumstances apply, the Plan Sponsor reserves the right to deduct from any benefits properly payable under the Plan or recover from the Covered Employee or assignee who received the payment:

- (a) the amount of any payment which has been made in error; or
- (b) pursuant to a misstatement contained in a proof of loss; or
- (c) pursuant to a misstatement made to obtain coverage under the Plan within two (2) years after the date coverage commences.

REVIEW PROCESS FOR DISPUTED CLAIMS

The review process for disputed claims shall include the following:

1. The Employee or Retiree may request a review by writing the Claims Administrator and stating the basis for the disputed claim.
2. This request must be made within ninety (90) calendar days after the receipt of the original explanation of benefits.
3. Upon receipt of the request, the claim will be reviewed by the Claims Administrator who will either affirm the original claim determination in writing, pay the disputed claim amount, or request additional information necessary to make a determination.
4. The Claims Administrator's decision will be sent within thirty (30) calendar days to the Employee or Retiree along with supporting documentation setting out the basis on which the decision is made.
5. Either the Employee/Retiree or the Claims Administrator may request a review by Claims Review Committee in accordance with paragraph six (6) below. The Employee/Retiree's request must be made within fifteen (15) calendar days after the Claims Administrator's decision is mailed.
6. A review may be made within fifteen (15) calendar days by a Claims Review Committee upon the request of the Plan Administrator only if new claims information is provided by the Employee or Retiree which was not considered before by the Claims Administrator. The Committee shall consist of the Plan Administrator, a representative of the Claims Administrator who was not directly involved in processing the initial claim, the medical director of the Claims Administrator and the City's Utilization Review Nurse. The decision of the Committee will be made within fifteen (15) calendar days, mailed to the Employee/Retiree and will be deemed final and binding.

APPENDIX A-

Specific Provisions Applicable to Fire and Police Prefund Retirees. (Fire and Police Retirees who retired prior to October 1, 1989, are covered under the Flex Plan Document as those provisions apply to Regular Retirees). This plan will expire December 31, 2007. The City and the Associations have agreed upon the terms for providing retiree health insurance, including scope of coverage, contributions and authority of the Board of Trustees as currently set forth in House Bill 2751 and Senate Bill 1778 (hereinafter “pending legislation”). The effective date of this Bill, if enacted is October 1, 2007. The health insurance terms will become effective January 1, 2008. In the event the pending legislation does not become enacted into law, the City and the Associations have agreed to adopt the provisions set forth in the pending legislation verbatim as their contractual agreement during the term of this contract and the City and Associations have authorized the Board of Trustees to implement the terms as set out in the Rudd & Wisdom Report, attached hereto as Attachment A.

SCHEDULE OF BENEFITS

THE BENEFITS SET FORTH IN THIS SCHEDULE ARE THE TOTAL BENEFITS PAYABLE BY MEDICARE, PARTS A AND B, AS SUPPLEMENTED BY THE PROVISIONS OF THIS PLAN FOR THE RETIREES. IF YOU ARE A RETIRED POLICE OFFICER OR FIREFIGHTER COVERED BY THIS SCHEDULE, AND YOU ARE ELIGIBLE FOR MEDICARE, THE BENEFITS AND SERVICES PROVIDED BY MEDICARE WILL BE PAID BEFORE THE BENEFITS DESCRIBED IN THIS APPENDIX AND THE MASTER CONTRACT ARE PAID. THIS WILL ALSO APPLY TO YOUR HUSBAND OR WIFE WHO IS ELIGIBLE FOR MEDICARE.

Deductible

Maximum per individual per calendar year	\$200
Maximum per family per calendar year	\$400
Coinsurance	80%

No deductible

Supplemental accident benefits	100%
up to \$500. No deductible.	
Immunizations for Covered Dependents from birth through the date the child is six (6) years of age (other services provided at the same time as the immunizations, including, but not limited to, office visit charges will be subject to the deductibles and co-insurance.....	100%

Prescription Drug Benefits effective November 19, 2003 or upon signing of this agreement, whichever is later

In Network Pharmacy* using prescription drug program:

Participant Co-payment		
Retail 30 day supply		
Generic		\$0
Brand without Generic		20%
Brand with Generic		20%
Retail 90 day supply		
Generic		\$0
Brand without Generic		20%
Brand with Generic		20%
Mail Order 90 day supply		
Generic		\$0
Brand without Generic		20%
Brand with Generic		20%

In Network co-payment applies to deductible and annual out-of-pocket.

Out of Network Pharmacy or without utilization of prescription drug program:

Participant Co-Payment		
Retail 30 day supply		
Generic	20% after CitiMed deductible**	
Brand without Generic	40% after CitiMed deductible**	
Brand with Generic	50% after CitiMed deductible**	
Retail 90 day supply		
Generic	20% after CitiMed deductible**	
Brand without Generic	40% after CitiMed deductible**	
Brand with Generic	50% after CitiMed deductible**	
Mail Order 90-day supply		
Generic	20% after CitiMed deductible**	
Brand without Generic	40% after CitiMed deductible**	
Brand with Generic	50% after CitiMed deductible**	

*Out of Area Benefit – Participants who live over 30 miles from a participating network pharmacy may submit Out of Network Pharmacy charges for reimbursement at a plan coverage and benefit level.

**This deductible is not an additional deductible. Out of network co-payment does not apply to annual out of pocket.

Out of pocket (including deductible)

Maximum per individual per calendar year	\$700
Maximum per family per calendar year	\$1,900
Lifetime maximum per individual (medical)	\$1,500,000

PROVISIONS APPLICABLE TO ALL RETIREES

RETIREES AND SPOUSES SHALL BE ENTITLED TO BASIC COVERAGE UNDER THE CITY'S MASTER PLAN DOCUMENT FROM THE DATE OF RETIREMENT UNTIL THE DATE OF ELIGIBILITY FOR MEDICARE. UPON REACHING THE AGE AND ESTABLISHED CRITERIA FOR MEDICARE ELIGIBILITY, BENEFITS UNDER THIS PLAN AS PRIMARY COVERAGE SHALL NO LONGER BE APPLICABLE, AND THIS COVERAGE SHALL CONVERT TO SUPPLEMENTAL COVERAGE ONLY, IN ACCORDANCE WITH THE PROVISIONS SET FORTH HEREINAFTER.

A RETIREE'S SPOUSE WILL BE COVERED IF ELECTED AT THE TIME OF THE EMPLOYEE'S RETIREMENT, SUBJECT TO THE PAYMENT OF ANY REQUIRED PREMIUM. IF THE RETIREE DIES, THEN A PREVIOUSLY COVERED SPOUSE SHALL BE ELIGIBLE FOR CONTINUED COVERAGE, SUBJECT TO THE PAYMENT OF ANY REQUIRED PREMIUM.

A SURVIVING SPOUSE WHO OBTAINS COVERAGE UNDER THIS PLAN SHALL BE ELIGIBLE FOR CONTINUED COVERAGE UNTIL RE-MARRIAGE OR DEATH, SUBJECT TO PAYMENT OF ANY APPLICABLE PREMIUM.

ONLY PREVIOUSLY COVERED DEPENDENTS ELECTED ON THE RETIREE ENROLLMENT FORM FOR THE RETIREMENT PLAN AT THE TIME OF THE EMPLOYEE'S RETIREMENT ARE ELIGIBLE FOR COVERAGE.

ELIGIBLE DEPENDENT SHALL NOT INCLUDE ANYONE WHO IS COVERED AS AN ELIGIBLE EMPLOYEE UNDER THE CITY'S BENEFIT PROGRAMS. IF AND WHEN SUCH DEPENDENT TERMINATES EMPLOYMENT AND LOSES EMPLOYEE COVERAGE UNDER THE CITY'S PLANS, THE RETIREE MAY ELECT TO COVER ANY SUCH ELIGIBLE DEPENDENT UNDER THE RETIREE PLAN.

ONCE THE COVERED PERSON IS ELIGIBLE FOR MEDICARE, THE COVERED PERSON IS REQUIRED TO APPLY FOR, PURCHASE AND MAINTAIN MEDICARE BENEFITS. THE PLAN ADMINISTRATOR MAY APPROVE ANY ALTERNATE HEALTH CARE COVERAGE PROVIDED BY THE ELIGIBLE SPOUSE OF A RETIRED OR DECEASED POLICE OFFICER, IN LIEU OF MEDICARE COVERAGE, TO COMPLY WITH THIS REQUIREMENT. AFTER THE DATE OF MEDICARE ELIGIBILITY, RETIREES SHALL BE ENTITLED TO SUPPLEMENTAL BENEFITS ONLY. THIS PLAN WILL SUPPLEMENT AVAILABLE MEDICARE COVERAGE AND BENEFITS AS DEFINED IN THIS ADDENDUM AND THE SCHEDULE OF BENEFITS FOR RETIREES, NOT TO EXCEED THE BENEFITS OTHERWISE APPLICABLE UNDER THE SAN ANTONIO MASTER CONTRACT DOCUMENT.

THE SURVIVING SPOUSE, UPON THE DEATH OF THE COVERED EMPLOYEE A FIRE FIGHTER OR POLICE OFFICER WHO MEETS ALL THE PRESCRIBED PROVISIONS FOR RETIREMENT ELIGIBILITY AFTER SEPTEMBER 30, 1989, AS DEFINED IN THE FIRE FIGHTER AND POLICE OFFICER PENSION PLAN DOCUMENT, BUT WHO DIES PRIOR TO ACTUAL RETIREMENT, BECOMES ELIGIBLE TO PARTICIPATE IN THE BENEFITS OF THIS PLAN, UPON PAYMENT OF ANY REQUIRED PREMIUM, IF THE FOLLOWING CRITERIA ARE MET:

- 1) THE DECEASED FIRE FIGHTER OR POLICE OFFICER MUST HAVE MET, AT THE TIME OF HIS OR HER DEATH, ALL OF THE PRESCRIBED PROVISIONS FOR MINIMUM RETIREMENT ELIGIBILITY IN EXISTENCE AFTER SEPTEMBER 30, 1989, AS DEFINED IN THE FIRE FIGHTER AND POLICE OFFICER PENSION PLAN;

2) A SURVIVING SPOUSE WHO IS COVERED UNDER ANOTHER HEALTH PLAN SHALL BE COVERED AS A DEPENDENT FOR PURPOSES OF COORDINATION OF BENEFITS UNDER THIS PLAN;

3) SURVIVING SPOUSE IS DEFINED AS A SPOUSE WHO HAS BEEN CONTINUOUSLY MARRIED TO THE DECEASED FIRE FIGHTER OR POLICE OFFICER AT LEAST ONE (1) YEAR PRIOR TO THE DEATH OF SAID FIRE FIGHTER OR POLICE OFFICER, AND REMAINED MARRIED TO THE SAID PERSON UNTIL THE TIME OF DEATH;

4) A SURVIVING SPOUSE HEREUNDER SHALL BE ELIGIBLE FOR CONTINUED COVERAGE UNTIL RE-MARRIAGE OR DEATH, PROVIDED THAT THERE IS NO LAPSE OF COVERAGE FOR NON-PAYMENT OF APPLICABLE PREMIUMS;

5) A SURVIVING SPOUSE HEREUNDER HAS NO RIGHT TO ELECT ANY DEPENDENT COVERAGE.

UPON RETIREMENT, A FIRE FIGHTER OR POLICE OFFICER MAY ELECT TO CONTINUE COVERAGE FOR ANY OTHER PREVIOUSLY COVERED ELIGIBLE DEPENDENT (OTHER THAN SPOUSE AT ONE HUNDRED PERCENT (100%) OF THE ACTUAL CLAIMS COST FOR THE RETIREE DEPENDENT MEDICAL BENEFITS ACCOUNT FOR THE PRIOR YEAR, ADJUSTED AS DETERMINED BY THE CITY'S ACTUARY, WHOSE DETERMINATION SHALL BE FINAL. THIS COST, ANALOGOUS TO A PREMIUM PAYMENT, SHALL BE ESTIMATED ANNUALLY AND PAID BY PAYROLL DEDUCTION OR IN CASH, PAID MONTHLY.

A FIREFIGHTER RETIREE WHO IS REEMPLOYED BY THE CITY AND IS THERE BY FURNISHED BENEFITS UNDER THE CURRENT EMPLOYEE PLAN, TEMPORARILY SUSPENDS STATUS IN THE RETIREE PLAN, WILL BE ALLOWED TO RE-ENROLL IN THE RETIREE PLAN WHEN HE TERMINATES SUCH CITY EMPLOYMENT. ALL SERVICE TIME WITH THE CITY WILL BE COMBINED TO DETERMINE THE TOTAL NUMBER OF SERVICE YEARS TOWARD PREMIUMS IF APPLICABLE TO THE EMPLOYEE/RETIREE. (THIS PROVISION CURRENTLY APPLIES ONLY TO THOSE CITY EMPLOYEES RETIRED BEFORE OCT. 1, 1989.)

EFFECTIVE NOVEMBER 19, 2003 OR UPON SIGNING OF THIS AGREEMENT, WHICHEVER IS LATER, RETIRED POLICE OFFICERS COVERED UNDER THIS AGREEMENT SHALL BE GRANTED THE OPTION OF ENTERING INTO OR EXITING FROM THE FLEXIBLE BENEFITS PROGRAM AS PROVIDED FOR BY THE CITY TO SUBSTITUTE FOR THE BASIC PROGRAM AS OUTLINED IN SECTION 2 ABOVE. SAID OPTION MUST BE EXERCISED BY THE RETIRED POLICE OFFICER DURING THE CITY'S RE-ENROLLMENT PERIOD BETWEEN THE DATES OF OCTOBER 1 AND DECEMBER 31 OF EACH CALENDAR YEAR. OFFICERS WHO RETIRE FROM THE SAN ANTONIO POLICE DEPARTMENT AND WHO BECOME EMPLOYED BY THE CITY AS A FULL TIME PERMANENT CIVILIAN EMPLOYEE SHALL HAVE THE OPTION OF ENROLLING IN THE CIVILIAN FLEXIBLE BENEFITS PROGRAM PROVIDED BY THE CITY AS PRIMARY COVERAGE AT WHICH TIME MEDICAL BENEFITS PROVIDED UNDER THE MASTER CONTRACT DOCUMENT SHALL CONVERT TO SECONDARY COVERAGE IN ACCORDANCE WITH THE PROVISIONS SET FORTH IN THE MASTER CONTRACT DOCUMENT. A RETIRED POLICE OFFICER MAY CHOOSE NOT TO ENROLL IN THE CIVILIAN FLEXIBLE BENEFITS PROGRAM IN WHICH CASE THE MEDICAL BENEFITS PROVIDED UNDER THE MASTER CONTRACT DOCUMENT SHALL BE PRIMARY.

ATTACHMENT A

Rudd and Wisdom, Inc.

CONSULTING ACTUARIES

Mitchell L. Bilbe, F.S.A.
Evan L. Dial, A.S.A.
Philip S. Dial, F.S.A.
Charles V. Faerber, F.S.A., A.C.A.S.
Mark R. Fenlaw, F.S.A.
Carl L. Frammolino, F.S.A.
Christopher S. Johnson, F.S.A.
Joe C. Lopez, F.S.A.

9500 Arboretum Blvd., Suite 200
Austin, Texas 78759
Post Office Box 204209
Austin, Texas 78720-4209
Phone: (512) 346-1590
Fax: (512) 345-7437
E-mail: mfenlaw@ruddwisdom.com
rmay@ruddwisdom.com

Robert M. May, F.S.A.
J. Christopher McCaul, F.S.A.
Edward A. Mire, F.S.A.
Rebecca B. Morris, A.S.A.
Amanda L. Murphy, F.S.A.
Michael J. Muth, F.S.A.
Ronald W. Tobleman, F.S.A.
David G. Wilkes, F.S.A.

March 2, 2007

Board of Trustees
Fire and Police Retiree Health
Care Fund, San Antonio
300 Convent Street, Suite 2475
San Antonio, Texas 78205

Re: Revised Actuarial Analysis of Potential Legislation

Dear Board Members:

At your request, we have prepared a revised actuarial analysis of various potential changes to the retiree health benefits for the current and future retired fire and police covered by the Fire and Police Retiree Health Care Fund, San Antonio (Fund). This report replaces two prior ones dated February 20, 2007 and February 28, 2007. The potential changes included in this analysis are based on the draft of potential legislation to amend Article 6243q, Vernon's Texas Civil Statutes, the state law governing the Fund, which has been given to the Legislature, and on the resolution you adopted at your February 20, 2007 meeting regarding the Board's commitment to the additional authority that the Board would be responsible for if the potential legislation were to become law. We based this analysis on our October 1, 2006 actuarial valuation of the Fund and on the actuarial methods and assumptions used in that valuation, except for the revised assumptions described in this report. The results of the analysis are summarized in the attached Exhibits 1A and 1B and are described more fully in the rest of this report.

Summary of Fund's Current Actuarial Condition

Our February 19, 2007 report of the October 1, 2006 actuarial valuation of the Fund revealed that the expected contributions are not adequate to provide the normal cost contributions of 10.92% of covered payroll and to amortize the unfunded actuarial accrued liability (UAAL) of \$505 million over an acceptable period of time. In fact, the UAAL will never be amortized with the current financing arrangement and the current benefits. Therefore, the current financing arrangement is inadequate. Without any changes, we projected that the assets in the Fund would be depleted in fiscal year 2026-2027, and benefits after that date would have to be reduced by more than one half and would be provided on a pay-as-you-go basis from future contributions.

Scope of the Analysis

The potential changes included in our analysis are described below. The changes in Items 1, 2, 3, and 5 would be enacted if the potential legislation were to become law. The changes in Item 4 have been under serious consideration by the Board in anticipation of the additional authority in the potential legislation “to administer the Fund and the retiree health plan... for the greatest benefit of all members.” [new Section 3.01(f)]. The order of the potential changes reflects the order in which they are presented in this report.

1. The benefit provisions for Prefund 1 retirees and spouses would become the same as those for the Prefund 2 retirees and spouses, including each of the potential changes included in this analysis.
2. In addition to the changes in Item 1, the maximum deductible per person in a calendar year would increase initially by \$300 (from \$200 to \$500) beginning January 1, 2008, the maximum out-of-pocket payments per person in a calendar year would increase initially by \$800 (from \$700 to \$1,500) beginning January 1, 2008, and the maximum deductible and the maximum out-of-pocket payments would each increase annually according to changes in the total medical care consumer price index beginning January 1, 2013, but not to exceed 8% in any one year.
3. In addition to the changes in Items 1 and 2, the maximum out-of-pocket payments per person in a calendar year would increase by an additional \$100 per year for the four years beginning January 1, 2009.
4. In addition to the changes in Items 1, 2, and 3, in-network incentives for health care services similar to those in the retiree benefits program for general employees would be added. This would increase the retiree’s cost of using out-of-network providers in order to provide an incentive to use the discounted services of the network providers and to provide a reduction in claims paid by the Fund if out-of-network providers continue to be used.
5. In addition to the changes in Items 1, 2, 3, and 4, contributions would be required of future retirees who retire with less than 30 years of service equal to what they would have contributed as employees if they had continued employment for 30 years.

Exhibit 2 shows the details of the in-network incentives for health care services that were considered in Item 4 above. Exhibit 3 discloses the changes in actuarial assumptions that were made in determining the effects of each of the potential changes. Exhibit 4 displays the resolution the Board adopted at their February 20, 2007 meeting regarding the Board’s commitment to and ideas for carrying out the additional authority the Board would have for administering the Fund and the retiree health plan if the potential legislation were to become law.

The potential legislation not only includes the changes above in Items 1, 2, 3, and 5 but also includes proposed city contributions of 9.4% of covered payroll and proposed contributions by the fire/police beginning at 2.0% of average pay of the combined fire and police departments October 1, 2007 and increasing annually to 2.7%, 3.4%, 4.1% and then to an ultimate rate of 4.7% October 1, 2011. If the state law is amended in 2007 to include the reductions in benefits and increases in contributions described above, then the actuarial condition of the Fund would be significantly improved.

Further contingent changes (additional increases in contributions and additional reductions in benefits) are expected to be necessary to achieve the financing objective of paying for the normal cost of benefits and amortizing the UAAL in 30 years. These changes would begin to become effective after ten years in 2017 if the amortization period is still above 30 years according to the potential legislation. At that time both the city and the fire/police contribution rates would be increased by up to 10% each year until the Fund has an amortization period of 30 years or less. In addition, there would be benefit reductions

resulting from companion increases of up to 10% each year in the maximum deductibles and in the maximum out-of-pocket payments.

During the 10-year period 2007-2017 the Board and the Board's actuaries will monitor how the actual experience compares to the actuarially assumed experience, and the Board will consider making further reductions in benefits that are necessary to achieve the objective of having a 30-year amortization period. However, if this objective is not achieved by the actuarial valuation as of October 1, 2016, then the package of increases in contributions of up to 10% annually and reductions in benefits would go into effect beginning October 1, 2017 for the contribution rates and January 1, 2018 for the benefits and would continue as long as necessary until meeting the 30-year amortization period objective would require no further increases in contributions and reductions in benefits. In making annual actuarial valuations the actuary will determine the expected contingent future increases that are required prospectively to have a 30-year amortization period based on the then current actuarial condition of the Fund.

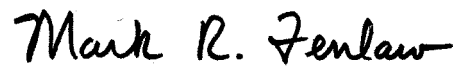
Effect of Potential Changes

The benefit reductions are shown in Exhibit 1A, along with the resulting hypothetical contribution rate beginning October 1, 2006 required to pay the normal cost of reduced benefits and to amortize the reduced UAAL in 30 years. We based our analysis on a 30-year amortization period in order to be consistent with the required contribution rate shown in the actuarial valuation and with the maximum amortization period allowed by GASB Statements 43 and 45.

The reduced actuarially required contribution rate resulting from the benefit reductions and contribution increases for certain retirees is 16.31%, which is more than the ultimate increased contribution rate of 14.1% (9.4% by the city and 4.7% by the fire/police) included as part of the proposed legislation. We assumed the city rate of 9.4% would begin October 1, 2007 and that the fire/police rate would begin at 2.0% effective October 1, 2007 and would increase annually to 2.7%, 3.4%, 4.1%, and 4.7% effective October 1, 2008, 2009, 2010, and 2011, respectively. We have determined that the package of additional contribution rate increases necessary to have an amortization period of 30 years will be 10% after 10 years on October 1, 2017, 10% after 11 years on October 11, 2018, and 1.2% after 12 years on October 1, 2019. This schedule of required contribution rates and increased contribution rates after 10 years required for an amortization period of 30 years as of October 1, 2006 is shown in Exhibit 1B.

Please call if you have any questions.

Sincerely,



Mark R. Fenlaw, F.S.A.



Robert M. May, F.S.A.

MRF;RMM:bb

Enclosures

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Exhibit 1A

Fire and Police Retiree Health Care Fund, San Antonio

Hypothetical Required Contribution Rate with Potential Changes Necessary for 30-Year Amortization of UAAL

	<u>Hypothetical Required Rate¹</u>	<u>Change in Rate</u>
Required contribution rate before potential changes	23.92%	–
Potential changes and their required contribution rate		
1. Prefund 1 benefits changed to be the same as Prefund 2 benefits	23.84	(0.08)%
2. Deductible increased initially by \$300, maximum out of pocket increased initially by \$800, both increased annually by medical care CPI beginning in 1/1/2013 in addition to changes in Item 1	18.87	(4.97)
3. Maximum out of pocket increased by \$100 per year over 4 years beginning 1/1/2009 in addition to changes in Items 1 and 2	17.98	(0.89)
4. In-network incentives for health care services added in addition to changes in Items 1, 2, and 3	16.60	(1.38)
5. Contributions for a limited time by future retirees with less than 30 years of service in addition to changes in Items 1, 2, 3, and 4	16.31	(0.29)

¹ Based on the October 1, 2006 actuarial valuation of the Fund, replacing existing financing with a hypothetical required contribution rate effective on the valuation date to pay normal cost and amortize the unfunded actuarial accrued liability in 30 years.

This exhibit is part of a report dated March 2, 2007.

Exhibit 1B

Fire and Police Retiree Health Care Fund, San Antonio

Schedule of Actuarially Required Contribution Rates to Pay for Plan with Potential Changes Described in Exhibit 1A**

Year	Rates Effective October 1	Contribution Rates		
		City	Fire/Police	Total
1	2007	9.40%	2.00%	11.40%
2	2008	9.40	2.70	12.10
3	2009	9.40	3.40	12.80
4	2010	9.40	4.10	13.50
5	2011	9.40	4.70	14.10
6	2012	9.40	4.70	14.10
7	2013	9.40	4.70	14.10
8	2014	9.40	4.70	14.10
9	2015	9.40	4.70	14.10
10	2016	9.40	4.70	14.10
11	2017*	10.34	5.17	15.51
12	2018*	11.37	5.69	17.06
13	2019*	11.51	5.76	17.27
14	2020	11.51	5.76	17.27
15 and later	2021 and later	11.51	5.76	17.27

* There would also be companion decreases in benefits on January 1, 2018, 2019, and 2020. These decreases are due to the same percentage increases in maximum deductibles and in maximum out-of-pocket payments as in the contribution rates (10% after 10 years, 10% after 11 years, and 1.2% after 12 years).

** Further increases in contributions and decreases in benefits may be required October 1, 2019 or later if the Board's actuary determines these changes are required to continue to achieve the 30-year UAAL amortization period objective.

This exhibit is part of a report dated March 2, 2007.

Exhibit 2

Fire and Police Retiree Health Care Fund, San Antonio

**In-Network Incentives for Health Care Services
Considered for Item 4**

<u>Potential Changes</u>	<u>Prefund 2 Plan In-Network</u>	<u>Prefund 2 Plan Out-of-Network</u>
Years 2008-2012		
<ul style="list-style-type: none"> • annual deductible (individual/family) 2008-2012 	\$500/\$1,000	\$1,000/\$2,000
<ul style="list-style-type: none"> • coinsurance <ul style="list-style-type: none"> paid by Fund paid by retiree out of pocket 	80% 20%	60% 40%
<ul style="list-style-type: none"> • out-of-pocket maximum (individual) 		
2008	\$1,500	\$3,000
2009	1,600	3,200
2010	1,700	3,400
2011	1,800	3,600
2012	1,900	3,800
Subsequent years		
<ul style="list-style-type: none"> • annual deductible (individual/family) 	indexed	double in-network amount
<ul style="list-style-type: none"> • coinsurance <ul style="list-style-type: none"> paid by Fund paid by retiree out of pocket 	80% 20%	60% 40%
<ul style="list-style-type: none"> • out-of-pocket maximum (individual) 	indexed	double in-network amount

This exhibit is part of a report dated March 2, 2007.

Exhibit 3

Fire and Police Retiree Health Care Fund, San Antonio

Changes in Actuarial Assumptions for the Actuarial Analysis of Potential Legislation

Potential Changes	Changes in Actuarial Assumptions from Those Used in the October 1, 2006 Actuarial Valuation
1. Prefund 1 benefits changed to be the same as Prefund 2 benefits	<input type="checkbox"/> Assume the same initial annual claims costs for Prefund 1 as are assumed for Prefund 2
2. Increase initial deductible by \$300 and initial maximum out of pocket by \$800, each increased annually by medical care CPI beginning January 1, 2013, in addition to the changes in Item 1	<input type="checkbox"/> Initial annual claims costs reduced <ul style="list-style-type: none">• 7.3% for ages before 65• 13.3% for ages 65 and above <input type="checkbox"/> Claims costs increase assumption (trend) reduced by 0.5% per year beginning with fiscal year beginning October 1, 2012 to reflect effect of annual increases based on medical care CPI
3. Maximum out of pocket increased by \$100 per year over four years in addition to changes in Items 1 and 2	<input type="checkbox"/> Initial annual claims costs reduced by additional percents <ul style="list-style-type: none">• 2.2% for ages before 65 (9.5% total)• 4.3% for ages 65 and above (17.6% total) <input type="checkbox"/> Same trend assumption as for Item 2
4. In-network incentives for health care services added in addition to the changes in Items 1, 2, and 3	<input type="checkbox"/> Initial annual claims costs reduced by additional 5.0% <ul style="list-style-type: none">• 14.5% total for ages before 65• 22.6% total for ages 65 and above <input type="checkbox"/> Same trend assumption as for Item 2
5. Contributions for future retirees with under 30 years in addition to the changes in Items 1, 2, 3, and 4	<input type="checkbox"/> Same initial annual claims costs as for Item 4 <input type="checkbox"/> Same trend assumption as for Item 2 <input type="checkbox"/> Assume average pay in fiscal year 2006-2007 will be \$57,451 <input type="checkbox"/> Assume contribution in each fiscal year is 4.7% of average pay <input type="checkbox"/> Assume average pay increases 4.0% per year

This exhibit is part of a report dated March 2, 2007.

Exhibit 4

Fire and Police Retiree Health Care Fund, San Antonio

Resolution Adopted by Board of Trustees on February 20, 2007

Mr. Burney requested Board consideration of the following Board resolution:

“If legislative amendments are approved by the Legislature and signed by the Governor, the Board of the Health Fund will be vested with the authority to design a retiree health care benefit plan that addresses the needs of retirees while recognizing the fiscal target of amortizing the unfunded actuarial liability of the Health Fund to under thirty (30) years. The Board is committed to drafting a new Schedule of Benefits and Plan that considers all options for achieving these goals of retiree health care and fiscal responsibility, starting with the current benefits provided under the collective bargaining agreements as modified by such legislation. All plan design changes and options will be considered, including, but not limited to, those options priced in recent actuarial studies by the Health Fund such as in-network incentives and out-of-network penalties, wellness plans, and prescription drug programs. The Board will solicit assistance from outside sources to prepare such plan, including engaging professionals to assist in drafting a plan and encouraging the active participation of all affected parties, including retirees, COSA, and unions.”

“The final plan will be adopted by the Board prior to the beginning of the calendar year 2008 to provide adequate notice to members of its content. The final decision as to plan design and content is within the Board’s discretion.”

Upon motion by Trustee Martinez and second by Trustee Clancy, the resolution unanimously passed.

This exhibit is part of a report dated March 2, 2007.