

Hallandale Beach RFP # FY 2012-2013-012

Attachment A

Group Medical Benefit Summaries

Please note that the current medical plans include embedded dental and vision coverage. The riders specifying the benefits are included in this section



Schedule of Benefits
Large Group HMO
Focused Deductible Open Access Plan – FDOA2020 Option 7

<i>Referrals are not required for Covered Services**</i>	Member Responsibility
Annual Deductible (per calendar year) <i>Hospital Deductible*</i> <i>Pharmacy Deductible</i>	\$500 \$0
Copayment Maximum (per calendar year) Individual Family	\$2,000 \$6,000
Maximum Lifetime Benefit Pharmacy Maximum (per calendar year)	Unlimited Unlimited
Benefit Provisions	Member Responsibility
Primary Care Physician (PCP) office visits	\$20 copay
Specialist office visits <i>(office visits include lab tests, x-rays, hearing & vision screening, and outpatient surgery)</i>	\$40 copay
Inpatient Hospital / Physician Services*	Member Responsibility
Inpatient Hospital Facility Services <i>(facility services, includes physician services, semi private room and board, general nursing care, intensive care & specialty care units, x-rays, diagnostic test/labs, operating & recovery rooms, and prescription medications dispensed while confined)</i> <ul style="list-style-type: none"> • Rehabilitative Services Limitation: 30 days per calendar year	\$100 copay per day for the first 1-5 days per admission
Inpatient Neonatal Intensive Care Unit (NICU) (admission and subsequent inpatient care)	\$100 copay per day for the first 1-5 days per admission
Outpatient Medical Services	Member Responsibility
Adult Preventive Care <i>(includes annual physical exams, annual well-woman exams, Pap smears, prostate cancer screening, colon cancer screening, eye exams, health education and counseling and immunizations, elective sterilization for women)</i>	No copay
Child Preventive Care <i>(includes well child and well baby exams and immunizations)</i>	No copay
Routine Mammography <i>(based on established guidelines)</i>	No copay
Allergy Injections	Included in office visit
Maternity Prenatal / Postnatal Care <ul style="list-style-type: none"> • in a Physician's office • in a Sub-Specialty office 	One-time \$40 copay \$40 copay
Outpatient Diagnostic Services <ul style="list-style-type: none"> • at a Hospital* • at an Ambulatory Surgical Center • at an Outpatient Diagnostic Center • in a Physician's office 	\$80 copay \$40 copay \$40 copay No additional copay
Outpatient Surgery <i>(includes physician and facility services)</i> <ul style="list-style-type: none"> • at a Hospital* • at an Ambulatory Surgical Center • at an Outpatient Diagnostic Center • in a Physician's office 	\$250 copay \$125 copay \$40 copay No additional copay
Outpatient Endoscopic Procedures (colonoscopy, endoscopy, sigmoidoscopy) <ul style="list-style-type: none"> • at a Hospital* • at an Ambulatory Surgical Center • at an Outpatient Diagnostic Center • in a Physician's office 	\$250 copay \$125 copay \$125 copay No additional copay
Outpatient Physical, Speech and Occupational Therapy Limitation: 60 visits per calendar year, combined all therapies <ul style="list-style-type: none"> • at a Hospital* • at a Freestanding Facility 	\$40 copay \$40 copay
Outpatient Cardiac and Respiratory Therapy <ul style="list-style-type: none"> • at a Hospital* • at a Freestanding Facility 	\$40 copay \$40 copay



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Outpatient Radiation and Chemotherapy <ul style="list-style-type: none"> • at a Hospital* • at a Freestanding Facility 	\$40 copay \$40 copay
Outpatient Dialysis Treatment <ul style="list-style-type: none"> • at a Hospital* • at a Freestanding Facility 	\$40 copay per treatment \$40 copay per treatment
Non-Surgical Spine and Back Services Limitation: 20 visits per calendar year	Same as office visit
Second Medical and Surgical Opinion <ul style="list-style-type: none"> • by Participating Physician • by Non-Participating Physician 	Same as office visit 40% of Allowed Amount
Emergency and Urgent Care Services <ul style="list-style-type: none"> • in hospital emergency room (waived if admitted) • urgent care facility • Ambulance service to hospital 	\$200 copay
	\$20 copay
	No copay
Family Planning <ul style="list-style-type: none"> • Voluntary counseling • Infertility diagnosis • Infertility treatment • Elective abortion • Intrauterine Devices (IUD) (<i>device, insertion, removal</i>) 	\$40 copay
	\$40 copay
	Not covered
	Not covered
	No copay
Elective sterilization <ul style="list-style-type: none"> • at a Hospital* • at a Freestanding Facility 	\$250 copay \$250 copay
Mental Health, Alcohol & Substance Abuse Services	Member Responsibility
Mental Health Care <ul style="list-style-type: none"> • Inpatient Treatment* • Outpatient Treatment 	Same as Inpatient Hospital Services
	\$40 copay
Alcohol and Substance Abuse Care <ul style="list-style-type: none"> • Inpatient detoxification* • Inpatient rehabilitation treatment* • Outpatient rehabilitation treatment 	\$200 copay per day
	Same as Inpatient Hospital Services
	\$40 copay
Other Covered Services	Member Responsibility
Home Health Care Limitation: 60 visits per calendar year	No copay
Hospice Care Limitation: 210 days maximum lifetime benefit	No copay
Skilled Nursing Facility Care Limitation: 30 days per calendar year	\$50 copay per day for the first 1-5 days per admission
Insulin Diabetic supplies (<i>includes glucose monitors, test strips, lancets, etc.</i>)	Applicable copay per prescription Applicable copay per month
Durable Medical Equipment	No copay
External orthotics, prosthetics and breast prosthetics	No copay
Hearing Aids (<i>other than cochlear implants</i>)	Not covered
Circumcision <ul style="list-style-type: none"> • in a Hospital prior to postnatal discharge • in a Physician's office • in a Hospital after postnatal discharge 	No additional copay Same as office visit Same as outpatient surgery copay
Services Provided by Rider or Endorsement	Member Responsibility
Prescription drugs:	Refer to Prescription Drug Rider
Dental Care	Refer to Dental Schedule of Benefits
Vision Care (following an operation for cataract or other diseases of the eye) Limitation: initial prescription lenses (eye glasses or contact lenses) <ul style="list-style-type: none"> • Frame and plastic single vision lenses • Frame and plastic bifocal lenses (FT 25-35 or Executive lenses) • Frame and plastic trifocal lenses (FT 25-35 or Executive lenses) • Contact lenses 	\$29 copay \$49 copay \$59 copay \$69 copay



Schedule of Benefits
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*All services performed at a hospital (inpatient or outpatient) are subject to the Hospital Deductible.

** PCP referrals are not required to obtain Covered Services however] Certain Covered Services require Prior Authorization and approval by Coventry's Medical Management Program. Please refer to the Certificate of Coverage for further details on Prior Authorization requirements.

Out-of-Pocket Maximums include copayment amounts. Deductibles do not apply to Out-of-Pocket Maximums.

Services must be rendered within the Coventry network. Coventry participating physicians and providers have contracted with Coventry to provide care to our members.

This Schedule of Benefits is not a complete summary or explanation of the Covered Services. Please review the Certificate of Coverage for an exact description of the Covered Services, limitations and exclusions and other terms and conditions of coverage.



Schedule of Benefits
 Focused Deductible Open Access
 City of Hallandale Beach

Referrals are not required for Covered Services

Copayment Maximum (Individual / Family) (per calendar year) <i>(Copayments, for Mental Health, Substance Abuse Services and Prescription drugs do not apply toward the Copayment Maximum.)</i>	\$4,000 / \$10,000
Maximum Lifetime Benefit	Unlimited
Annual Hospital Deductible (per calendar year): applies to all inpatient services and outpatient services at hospital	\$250
Benefit Provisions	Member Responsibility
Primary Care Physician (PCP) office visits	\$10 copay
Specialist office visits <i>(office visits include lab tests, x-rays, hearing & vision screening and outpatient surgery)</i>	\$40 copay
Hospital admission	After Hospital Deductible: \$100/ day for the first 5 days
Prescription Drugs: 30-day supply at participating pharmacy (includes contraceptives)	Tier 1A - \$3; MO: 1 copay Tier 1B - \$20 MO: 1 copay Tier 2 - \$40; MO: 2 copays Tier 3 - \$60; MO: 3 copays
Mail Order (MO) 90-day supply	
Inpatient Hospital / Physician Services	Member Responsibility
Inpatient Hospital Facility Services <i>(includes pre-admission testing, room and board, diagnostic tests, x-rays, operating & recovery room, intensive & special care units, general nursing care, anesthesia, prescribed drugs, radiation therapy & chemotherapy, surgeon services, anesthesiologist services, specialist consultation, physician visits, human organ transplants, maternity care; neonatal intensive care unit)</i>	After Hospital Deductible: \$100/ day for the first 5 days
Rehabilitative Services Limitation: 30 days per calendar year	After Hospital Deductible: No additional copay
Neonatal Intensive Care Unit (NICU) (admission and subsequent inpatient care)	After Hospital Deductible: \$100/ day for the first 5 days
Outpatient Medical Services	Member Responsibility
Adult Preventive Care <i>(includes annual physical exams, annual well-woman exams, Pap smears, prostate cancer screening, colon cancer screening, eye exams, health education and counseling and immunizations)</i>	No copay
Child Preventive Care <i>(includes well child and well baby exams and immunizations)</i>	No copay
Routine Mammography <i>(based on established guidelines)</i>	No copay
Maternity Prenatal / Postnatal Care <ul style="list-style-type: none"> • in a Physician's office • in a Sub-Specialty office 	One-time \$40 copay \$40 copay
Outpatient diagnostic services including x-ray and lab <ul style="list-style-type: none"> • at Hospital • at an Outpatient Diagnostic Center 	After Hospital Deductible: \$10 copay \$10 copay
Outpatient Surgery (including physician and facility services) <ul style="list-style-type: none"> • at Hospital • at Ambulatory Surgical Center 	After Hospital Deductible: \$100 copay \$50 copay
Non-Preventive Outpatient Endoscopic Procedures (Colonoscopy, Endoscopy, Sigmoidoscopy) <ul style="list-style-type: none"> • at Hospital • at Ambulatory Surgical Center 	After Hospital Deductible: \$100 copay \$50 copay
Outpatient Physical, Speech and Occupational Therapy Limitation: 60 visits per calendar year, combined all therapies <ul style="list-style-type: none"> • at Hospital • at Freestanding Facility 	After Hospital Deductible: \$10 copay \$10 copay
Outpatient Cardiac and Respiratory Therapy <ul style="list-style-type: none"> • at Hospital • at Freestanding Facility 	After Hospital Deductible: \$25 copay \$25 copay
Outpatient Radiation and Chemotherapy <ul style="list-style-type: none"> • at Hospital • at Freestanding Facility 	After Hospital Deductible: \$25 copay \$25 copay
Non-Surgical Spine and Back Services Limitation: 20 visits per calendar year	\$10 PCP copay; \$40 Specialist copay



Schedule of Benefits
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 City of Hallandale Beach

Second Medical and Surgical Opinion <ul style="list-style-type: none"> Participating Provider Non-Participating Provider 	\$30 copay 40% of Allowed Amount
Emergency and Urgent Care <ul style="list-style-type: none"> in hospital emergency room (waived if admitted) urgent care facility Ambulance service to hospital 	\$200 copay
	\$10 copay
	No copay
Family Planning <ul style="list-style-type: none"> Voluntary counseling Infertility services Infertility treatment Elective abortion Elective sterilization Intrauterine Devices (IUD) (<i>device, insertion, removal</i>) 	\$30 copay
	Not covered
	Not covered
	Not covered
	Copay depending on place of service \$30 copay
Mental Health, Alcohol & Substance Abuse Services	Member Responsibility
Mental Health Care <ul style="list-style-type: none"> Inpatient Treatment Outpatient Treatment 	After Hospital Deductible: No copay
	\$10 copay
Alcohol and Substance Abuse Care <ul style="list-style-type: none"> Inpatient detoxification and rehabilitation treatment Outpatient rehabilitation treatment 	After Hospital Deductible: No copay
	\$10 copay
Other Covered Services	Member Responsibility
Home Health Care Limitation: 60 visits per calendar year	No copay
Hospice Care Limitation: 210 days maximum lifetime benefit	No copay
Skilled Nursing Facility Care Limitation: 100 days per calendar year	No copay
Dialysis treatment (outpatient) <ul style="list-style-type: none"> at Hospital at Freestanding Facility 	After Hospital Deductible: \$25 copay \$25 copay
	Applicable copay per prescription Applicable copay per month
Durable Medical Equipment	No copay
External orthotics, prosthetics and breast prosthetics	No copay
Hearing Aids (<i>other than cochlear implants</i>)	Not covered
Circumcision <ul style="list-style-type: none"> in a Hospital prior to postnatal discharge in a Physician's office in a Hospital after postnatal discharge 	No additional copay Same as office visit Same as outpatient surgery
	\$40 copay
	\$40 copay
Services Provided by Rider or Endorsement	Member Responsibility
Dental Care	Refer to Dental Schedule of Benefits
Vision Care – at a participating Optometrist <ul style="list-style-type: none"> Refractive eye exams Eye glasses 	\$15 copay
	Discounts available at participating provider

*If you or your physician requests a brand name medication when a generic is available, you must pay 100% of the difference in price between the generic and brand name medication, plus the applicable brand copayment. Prescription drug copays do not apply toward the annual copayment maximum.

PCP referrals are not required to obtain Covered Services, however **certain Covered Services require Prior Authorization**. Please refer to the Certificate of Coverage for further details on Prior Authorization requirements. Services must be rendered within the Coventry network. Coventry participating physicians and providers have contracted with Coventry to provide care to our members.

This is a Schedule of Benefits only. Please refer to the Certificate of Coverage for complete details on the plan.



Schedule of Benefits
Large Group PPO
City of Hallandale Beach

Value \$2000 Plan - \$20/\$40/\$60

	In-Network	Out-of-Network
Deductible (Individual / Family) (per calendar year) <i>(amount a Member must pay before Coventry will make any payment toward certain Covered Services.)</i>	\$2,000 / \$4,000	\$3,000 / \$6,000
Coinsurance <i>(the sharing of expenses for Covered Services between Coventry and the Member)</i>	20% after deductible	40% after deductible
Out-of-Pocket Maximum (Individual / Family) (per calendar year) <i>(maximum amount of Deductible and Coinsurance a Member will pay; prescription drugs do not apply toward the maximum)</i>	\$4,000 / \$10,000	\$7,000 / \$18,000
Lifetime Maximum Individual Benefit	Unlimited	
Benefit Provisions	Member Responsibility	
Primary Care Physician (PCP) office visits	\$25 copay	40% after deductible
Specialist office visits <i>(office visits include lab tests, x-rays, hearing & vision screening and outpatient surgery)</i>	\$45 copay	40% after deductible
Hospital admission	20% after deductible	40% after deductible
Prescription Drugs: 30-day supply*	\$20/\$40/\$60	\$20/\$40/\$60
Inpatient Hospital / Physician Services	Member Responsibility	
Inpatient Hospital Facility Services <i>(includes pre-admission testing, room and board, diagnostic tests, x-rays, operating & recovery room, intensive & special care units, general nursing care, anesthesia, prescribed drugs, radiation therapy & chemotherapy, surgeon services, anesthesiologist services, specialist consultation, physician visits, human organ transplants, maternity care)</i>	20% after deductible	40% after deductible
Rehabilitative Services Limitation: 30 days per calendar year	20% after deductible	40% after deductible
Outpatient Medical Services	Member Responsibility	
Adult Preventive Care <i>(includes annual physical exams, annual well-woman exams, Pap smears, prostate cancer screening, colon cancer screening, eye exams, health education and counseling and immunizations)</i>	Covered in full – No deductible	40% after deductible
Child Preventive Care <i>(includes well child and well baby exams, immunizations and vision and hearing screenings)</i>	Covered in full – No deductible	40% after deductible
Routine Mammography <i>(based on established guidelines)</i>	Covered at 100% – No deductible	Covered at 100% – No deductible
Maternity Prenatal / Postnatal Care <ul style="list-style-type: none"> in a Physician's office in a Sub-Specialty office 	One-time office visit copay \$45 copay	40% after deductible 40% after deductible
Outpatient Diagnostic Services	20% after deductible	40% after deductible
Outpatient Surgery <i>(includes physician and facility services)</i>	20% after deductible	40% after deductible
Outpatient Physical, Speech and Occupational Therapy Limitation: 60 visits per calendar year, combined all therapies	20% after deductible	40% after deductible
Outpatient Cardiac and Respiratory Therapy	20% after deductible	40% after deductible
Outpatient Radiation and Chemotherapy	20% after deductible	40% after deductible
Outpatient Dialysis Treatment	20% after deductible	40% after deductible
Non-surgical Spine and Back Treatment Limitation: 20 visits per calendar year	Same as office visit	40% after deductible
Second Medical and Surgical Opinion	Same as office visit	40% after deductible
Emergency and Urgent Care <ul style="list-style-type: none"> in hospital emergency room (waived if admitted) in urgent care facility Ambulance service to hospital 	\$200 copay \$50 copay 20% after deductible	\$200 copay 40% after deductible 40% after deductible



Schedule of Benefits
Large Group PPO
City of Hallandale Beach

Family Planning <ul style="list-style-type: none"> • Voluntary counseling • Infertility diagnosis Limitation: sperm count, endometrial biopsy, hysterosalpingography (HSG) and diagnostic laparoscopy • Elective sterilization • Intrauterine Devices (IUD) (<i>device, insertion, removal</i>) 	\$45 copay	40% after deductible
	\$45 copay	40% after deductible
	\$100 copay	40% after deductible
	\$45 copay	40% after deductible
Mental Health, Alcohol & Substance Abuse Services	Member Responsibility	
Mental Health Care <ul style="list-style-type: none"> • Inpatient Treatment • Outpatient Treatment 	20% after deductible	40% after deductible
	\$45 copay	40% after deductible
Alcohol and Substance Abuse Care <ul style="list-style-type: none"> • Inpatient detoxification • Inpatient rehabilitation treatment • Outpatient rehabilitation treatment 	20% after deductible	40% after deductible
	20% after deductible	40% after deductible
	\$45 copay	40% after deductible
Other Covered Services	Member Responsibility	
Home Health Care Limitation: 60 visits per calendar year	20% after deductible	40% after deductible
Hospice Care Limitation: Unlimited	20% after deductible	40% after deductible
Skilled Nursing Facility Care Limitation: 30 days per calendar year	20% after deductible	40% after deductible
Insulin Diabetic supplies (<i>includes glucose monitors, test strips, lancets, etc.</i>)	Applicable copay per prescription Applicable copay per month	40% after deductible 40% after deductible
Durable Medical Equipment	20% after deductible	40% after deductible
External orthotics, prosthetics and breast prosthetics	20% after deductible	40% after deductible
Circumcision <ul style="list-style-type: none"> • in a Hospital prior to postnatal discharge • in a Physician's office • in a Hospital after postnatal discharge 	20% after deductible	40% after deductible
	Same as office visit	40% after deductible
	20% after deductible	40% after deductible
Services Provided by Rider or Endorsement	Member Responsibility	
Prescription drugs: 30-day supply (<i>includes contraceptives</i>)* Mail Order (MO): 90-day supply at participating pharmacy	Tier 1 - \$20; MO: 1 copay Tier 2 - \$40; MO: 2 copays Tier 3 - \$60; MO: 3 copays	Tier 1 - \$20 Tier 2 - \$40 Tier 3 - \$60

*If a brand name medication is requested when a generic is available, you must pay 100% of the difference in price between the generic and brand name medication, plus the applicable brand copayment.

Certain Covered Services require Prior Authorization. If you do not obtain authorization for services which require a Prior Authorization, the benefit otherwise payable by Coventry is reduced by 20%. This additional out-of-pocket amount will not be used to satisfy Deductible, Coinsurance or Out-of-Pocket Maximum requirements. Please refer to the Certificate of Insurance for further details on Prior Authorization requirements.

All Out-of-Network services are subject to the Out-of-Network Deductible and applicable Coinsurance. In addition to the applicable Deductible and Coinsurance, Members who receive services from Non-Participating Providers shall be responsible for the difference between the Non-Participating Provider's bill and the Out-of-Network Rate.

COVENTRY HEALTH CARE OF FLORIDA, INC.

**PRESCRIPTION DRUG RIDER
CITY OF HALLANDALE BEACH**

The Covered Services outlined in this Prescription Rider are in addition to the Covered Services of the Certificate of Insurance under which you and any eligible dependents are enrolled.

Prescription Drugs (includes contraceptives)	In-Network
Tier 1A (Tier One A)	\$3 Copayment; MO: \$3 Copayment
Tier 1B (Tier One B)	\$20 Copayment; MO: \$20 Copayment
Tier 2 (Tier Two)	\$40 Copayment; MO: \$80 Copayment
Tier 3 (Tier Three)	\$60 Copayment; MO: \$180 Copayment
Tier 4 (Tier Four)	Not Applicable
Mail Order (MO): (90-day supply)	

Definitions

Any capitalized terms used in the Prescription Rider and not otherwise defined herein shall have the meaning set forth in the Certificate of Insurance. The following definitions apply only to this Rider:

- A. Brand Name Drug:** a drug that is approved by the Food and Drug Administration ("FDA") and protected by the trademark registration of the pharmaceutical company that produces it. Brand Name Drugs can be designated as a Tier 1B, Tier 2, Tier 3 or Tier 4.
- B. Drug Formulary:** a list of items that may be dispensed by Participating Pharmacies to Members. This list consists mainly of prescription drugs but also includes some non-prescription drugs. This list is prepared by Coventry and periodically reviewed and modified.
- C. Generic Drug:** a drug that has been approved by the FDA as therapeutically equivalent to a brand-name drug. Generic Drugs can be designated as a Tier 1, Tier 2, Tier 3, or Tier 4.
- D. Mail Order Pharmacy:** the Participating Pharmacy contracted by Us to provide Maintenance Medications through the mail, when applicable.
- E. Maintenance Medication:** a Prescription Drug that is prescribed for long-term or chronic conditions, such as high blood pressure or diabetes, and designated by Us as a Maintenance Medication.
- F. Non-Formulary Drug:** a Prescription Drug not listed in the Drug Formulary and not otherwise excluded from coverage.
- G. Non-Participating Pharmacy:** any registered licensed pharmacy with which we have not directly or indirectly contracted to dispense Prescription drugs to Members.
- H. Participating Pharmacy:** a registered, licensed pharmacy with which we have directly or indirectly contracted to dispense Prescription Drugs to Members.
- I. Prescription Drug:** a drug which has been approved for use by the FDA and which by law is required to bear the legend "Caution - Federal Law prohibits dispensing without prescription"; A Prescription Drug that is not approved by the FDA for treatment of cancer may be covered if the drug has been recognized by one of the following medical references as treatment for the type of cancer for which the drug has been prescribed: the American Medical Drug Evaluations, the American Hospital Formulary Service Drug Information, the United States Pharmacopoeia Drug Information or, when recommended by two peer reviewed articles in a major professional journal.
- J. Prior Authorization:** a determination by Us or Our designee that a prescription order or refill otherwise covered under this Rider has been reviewed and, based upon the information provided, the prescription order or refill satisfies Our requirements for Covered Services.

K. Self-Administered Injectable Drugs: injectable prescription drugs that are commonly and customarily administered by the Member except that the following self-administered injections are not considered Self-Administered Injectable Drugs for purposes of coverage under this Rider: injectable diabetes agents (including but not limited to insulin and glucagons), bee sting kits, injectable migraine agents (including but not limited to Imitrex), and injectable contraceptives.

L. Self-Administered Injectable Drug Copayment/Coinsurance: the amount that will be charged to you by the Specialty Pharmacy to dispense or refill any prescription order or refill for a Self-Administered Injectable Drug. You shall be required to pay the applicable Tier Copayment or Coinsurance, per each Prescription Order or refill directly to the Specialty Pharmacy at the time of service as set forth in the Schedule of Benefits.

M. Specialty Medications: the group of self-administered drugs defined by Us that are typically high-cost drugs and include but are not limited to oral, topical, inhaled, and injected routes of administration. Characteristics of Specialty Medications are drugs that:

- are used to treat rare or complex diseases;
- require close clinical monitoring and management;
- frequently require special handling;
- may have limited access or distribution.

N. Specialty Pharmacy: a pharmacy that directly or indirectly has a contract with Us and is designated as such for certain prescription orders or refills.

O. Tier 1A or Tier One A

A select list of tier 1 drugs determined by Us to be available for a reduced Copayment. These drugs are noted on the Tier 1A Formulary drug list.

P. Tier 1B or Tier One B

The remaining group of medications on Our Formulary that includes:

- Generic Prescription Drugs that we have designated as Tier One;
- The select brand name Prescription Drugs that we have designated as Tier One; and
- Non-Prescription Drugs that we have designated as Tier One.

Q. Tier 2 or Tier Two

The group of medications on Our Formulary that includes:

- Brand Name Prescription Drugs that we have designated as Tier Two;
- Brand Name contraceptives that we have designated as Tier Two;
- Brand Name Prescription Drugs that have a narrow therapeutic index (those for which the dose must be monitored through laboratory tests) that we have designated as Tier Two;
- Brands that have newly introduced generics that we have designated as Tier Two; and
- Drugs designated as “DESI drugs” by the U.S. Food and Drug Administration (“FDA”) that we have designated as Tier Two. (“DESI drugs” are being reviewed for their effectiveness by the FDA because they were approved solely on the basis of their safety prior to 1962.)

R. Tier 3 or Tier Three

The group of medications that includes:

- Prescription Drugs that are not otherwise excluded under your group contract and are not designated as Tier One A, Tier One B; or
- Tier Two, including Brand Name and Generic Prescription Drugs that are not on Our Drug Formulary.

S. Tier 4 or Tier Four

The group of medications on Our Drug Formulary that includes Self-Administered Injectable Drugs. Examples include but are not limited to the following: multiple sclerosis agents, growth hormones, colony stimulating factors, erythropoiesis stimulating agents, chronic medications for hepatitis C, and heparin products.

T. Value Formulary Drugs or Tier 0

The group of medications on the formulary addendum, Value Formulary Tier 0 Drugs, that are available for a limited period of time at no copayment to members who meet the plan criteria specified in the formulary addendum.

Provisions and Benefits

A. The item prescribed must be filled at a pharmacy or via Our Participating Mail Order Pharmacy.

B. Unless otherwise noted in your Schedule of Benefits, Generic Drugs will always be substituted when a Generic Prescription Drug is available. To receive a Brand Name Prescription Drug when a Generic Prescription Drug is available, you or your physician must specifically request and we must approve the Brand Name Drug. If a brand medication is requested when a generic is available, you must pay 100% of the difference in price between the generic and brand name medication, plus the applicable brand Copayment or Coinsurance.

C. General Quantity Limits:

The quantity of a Prescription Drug dispensed by a pharmacy for each prescription order or refill is limited to the lesser of:

- the amount prescribed in the prescription order or refill; or
- the amount determined by Us to be Medically Necessary; or
- the amount determined by Us to be a 30-day supply.

D. Member Responsibility

The Member pays the Participating Pharmacy for a 30-day supply of Prescription Drugs (includes contraceptives).

E. Self-Administered Injectable Drugs

Self-Administered Injectable Drugs are Covered Services under this rider in the amounts described below when they are:

- ordered by a physician for use by a Member;
- not limited or excluded elsewhere in this rider;
- obtained from a Specialty Pharmacy;
- Prior Authorized, except when we determine the situation to be urgent or when Prior Authorization is not required; and
- listed on Our Drug Formulary unless your Schedule of Benefits specifies that Non-Formulary Drugs are covered.

The Member pays the Participating Pharmacy the applicable Copayment for up to a 30-day supply of all Self-Administered Injectable Drugs.

F. Mail Order Pharmacy – (Participating Pharmacy only)

The Member is allowed to utilize the participating mail order pharmacy for Coventry approved maintenance medications.

G. Insulin and Diabetic Supplies

The Member pays the pharmacy:

- Insulin: one applicable Copayment or Coinsurance per prescription for a 30-day supply (or less).
- Diabetic supplies: one applicable Copayment or Coinsurance per month for a 30-day supply (or less) of needles, syringes, lancets and strips, and other diabetic supplies.

H. Travel Supply

The Member is eligible to receive up to a 90-day supply of a Maintenance Medication for a travel supply at the applicable Copayment or Coinsurance and approved by Coventry.

I. Prior Authorization

Regardless of where a prescription order or refill is filled, Covered Services under this rider may be subject to Prior Authorization. The following Prior Authorization provisions apply.

Some drugs require Prior Authorization in order for them to be Covered Services. These include but are not limited to medications that may require special medical tests before use, or that are not recommended as a first-line treatment, or that have a potential for misuse or abuse. Drugs requiring Prior Authorization are identified in the Formulary with “PA” next to the name of the drug. Before you can fill a prescription order or refill for a drug requiring Prior Authorization, the prescribing physician must call Us.

J. Specialty Medications

Specialty Medications are Covered Services under this Rider in the amounts described below when they are:

- ordered by a prescribing physician for use by a Member;
- not limited or excluded elsewhere in this rider;
- obtained from a Specialty Pharmacy;
- prior authorized, except when we determine the situation to be urgent or when Prior Authorization is not required according to your Schedule of Benefits; and
- listed on Our Drug Formulary unless your Schedule of Benefits specifies that Non-Formulary Drugs are covered.

K. Value Formulary (“Tier 0”) copay waiver program

Value Formulary or Tier 0 Drugs are offered at no Copayment on a temporary basis to qualified Members.

Qualified Members are those that meet the plan criteria applicable to each Tier 0 Drug, as designated by Us to promote effective and efficient drug therapy. Members who are on or have recently received certain Prescription Drugs, or who receive a new prescription order for **certain Prescription Drugs, as designated by Us**, may qualify for Tier 0 benefit coverage.

Tier 0 drugs and their plan criteria are listed in the formulary addendum, Value Formulary Tier 0 Drugs, found on Our website at www.chcflorida.com. Members can also call Customer Service at the telephone number on the back of their ID card to get a current listing of the Value Formulary Tier 0 Drugs. **The Value Formulary Tier 0 Drugs formulary addendum may change from time to time without prior notice.**

To be eligible for coverage at the Tier 0 level, Members must meet the plan criteria specified on the Value Formulary Tier 0 formulary addendum. When drugs are temporarily added to Tier 0, Members that appear to meet the plan criteria (as such information is available in Our claims records) will be notified by Us that they qualify for a Tier 0 Drug.

Please note, just because a Member fills a prescription order or refill for a Tier 0 Drug, does not qualify him/her for the Tier 0 Copayment. Only Members that meet plan criteria will receive the selected drug at the Tier 0 Copayment. There may be instances where a drug is on Tier 0 and on Tier 1 or Tier 2. If a Member does not satisfy the Tier 0 criteria, the drug shall be subject to a Tier 1 or Tier 2 Copayment, as applicable. Refer to the current formulary addendum, Value Formulary Tier 0 Drugs, for plan criteria.]

Exclusions and Limitations

- A.** Prescriptions filled at a Non-Participating Pharmacy or a non-participating mail order service. We reserve the right to limit the location at which a Member can fill a covered prescription order or refill to a pharmacy that is mutually agreeable to both Us and the Member. Such limitation may be enforced in the event that We identify an unusual pattern of claims for Covered Services.
- B.** Some medications are subject to quantity limits.
- C.** Experimental or Investigational drugs not approved by the FDA, drugs with no approved FDA indications.

- D.** Any prescription which the pharmacist, in the exercise of his/her professional judgment, decides should not be filled. In such a case, the pharmacist will call the practitioner who wrote the prescription to determine the appropriate course of action.
- E.** Drugs for the treatment of obesity, including over the counter diet pills and aids.
- F.** Dietary supplements, including medical food.
- G.** Vitamins and minerals, both over-the-counter and legend, except legend pre-natal vitamins for pregnant or nursing females, liquid or chewable legend pediatric vitamins for children under age 13, and potassium supplements to prevent/treat low potassium and legend vitamins that are medically necessary for the treatment of renal disease, hypoparathyroidism or other covered conditions with prior approval by Us unless recommended by the United States Preventive Services Task Force (USPSTF).
- H.** Drugs for the treatment of infertility.
- I.** Drugs for the treatment of sexual dysfunction (eg. Viagra®, Caverjet®, Muse®, etc.)
- J.** Biologicals and injectable drugs that must be administered by a health care professional are excluded from the pharmacy benefit, but may be covered as part of the medical benefit, except bee sting kits, injectable diabetes agents (including but not limited to insulin and glucagon), injectable migraine agents (including but not limited to Imitrex), injectable contraceptives and Self-Administered Injectables as approved by Us.
- K.** Pharmaceuticals whose primary use is for cosmetic purposes or athletic performance enhancement, including but not limited to anabolic steroids, tretinoin for aging skin, and minoxidil lotion.
- L.** Smoking cessation products unless recommended by the United States Preventive Services Task Force (USPSTF).
- M.** Methadone maintenance medications used for drug detoxification.
- N.** Refill prescriptions resulting from lost, stolen or destroyed medication(s).
- O.** Devices and appliances that do not have the National Drug Code (NDC).

We reserve the right to include only one manufacturer's product on Our Drug Formulary when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers. The product that is listed on Our Drug Formulary will be covered at the applicable Copayment or Coinsurance. The product or products not listed on Our Drug Formulary will be excluded from coverage.

We reserve the right to include only one dosage or form of a drug on Our Drug Formulary when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms (for example but not limitation, dissolvable tablets, capsules, etc.) from the same or different manufacturers. The product in the dosage or form that is listed on Our Drug Formulary will be covered at the applicable Copayment or Coinsurance. The product or products in other forms or dosages that are not listed on Our Drug Formulary will be excluded from coverage.

All the terms, conditions, limitations and exclusions of the Certificate of Insurance apply to the benefits provided by this Rider.

Coventry Health Care of Florida, Inc.



Richard Weiss
Chief Financial Officer

Coventry Health Care of Florida, Inc.
VISION CARE RIDER

This Rider provides the benefits described below:

I. EYE EXAMINATIONS	COPAYMENT
Comprehensive, Routine Eye Examination, including refraction for eyeglasses, once per calendar year by a participating optometrist	\$15
II. PRESCRIPTION EYEGLASSES	COPAYMENT
One pair each calendar year from the Coventry Standard Collection at a participating provider:	
<ul style="list-style-type: none"> • Frame and Plastic Single Vision Lenses • Frame and Plastic Bifocal Lenses (FT 25 - 35 or Executive Lenses) • Frame and Plastic Trifocal Lenses (FT 25 - 35 or Executive Lenses) 	\$29 \$49 \$59
The following lens options are available:	
<ul style="list-style-type: none"> • Progressive No Line Bifocals and Trifocals • Lenticular • High Index Plastic • Polycarbonate • Glass • Photo Chromatic • Tints • UV Coating • Scratch Coating • Transitions • Polarized • Anti-Reflective Coating 	\$95 \$95 \$50 \$30 \$10 \$20 \$10 \$12 \$15 \$70 \$45 \$36
III. CONTACT LENSES	COPAYMENT
Contact Lens Examination, to include fitting for regular daily wear, extended wear, and disposable lenses, 3 months of follow-up care, and starter kit *	\$69
<ul style="list-style-type: none"> • Daily Wear • Daily Wear Replacement Lenses • Extended Wear • Extended Wear Replacement Lenses • Disposable Lenses (6 packages – 1- week or 2-week wear) • Frequent Replacement Lenses (6 packages – 1- week or 2-week wear) • Daily Disposable Lenses (30 packages – 1-day wear) 	\$35 per pair \$20 per lens \$39 per pair \$25 per lens \$19 per package \$29 per package \$23.50 per package

Items not listed above may be available from the participating provider at other copayments or discounts. Copayments above may not apply to non-standard or special orders.

* Contact Lens Examination is available only after member has received a comprehensive eye examination and refraction from a participating optometrist

All the terms, conditions, limitations and exclusions of your Certificate of Coverage apply to the benefits provided by this Rider.

Coventry Health Care of Florida, Inc.



Richard Weiss
Chief Financial Officer

Exclusions and Limitations

- Any oral evaluation is limited to one (1) time in any six (6) consecutive month period at no charge. All subsequent oral evaluations will be at a 25% discount off the doctor's usual and customary fee without a frequency limitation.
- Bitewing X-rays (2-4 films) are limited to one set in any twelve (12) consecutive month period.
- The dental prophylaxis procedure is limited to one in any six (6) consecutive month period. Any additional procedures will follow the D1110 or D1120 copayment as listed in the Schedule of Benefits.
- Fluoride treatment is limited to one (1) in any twelve (12) consecutive month period for children under the age of 16.
- Sealants are limited to one (1) time per tooth in any three (3) consecutive year period. This is only allowed for unrestored permanent molar teeth for children under the age of 16.
- Space maintainers and all adjustments are limited to children under the age of 16.
- Harmful habit appliances are limited to one (1) time per person under the age of 16.
- Services performed by a dentist or dental specialist, not contracted with Solstice without prior approval.
- Any dental services or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the member's dental health or experimental in nature, as determined by the participating Solstice dentist.
- Orthographic surgery or procedures and appliances for the treatment of myofunctional, myoskeletal or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits.
- General anesthesia or IV sedation.
- Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions, or medications.
- Treatment of malignancies, cysts, or neoplasms.
- Dental implants and related services.
- Dental procedures initiated prior to the member's eligibility under this benefit plan or started after the member's termination from the plan.
- Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member including but not limited to physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.
- New dentures include one (1) relines within the first six (6) months.
- Replacement of crowns, fixed bridges or dentures is limited to once every five (5) years.
- When crown and/or bridgework exceed six (6) consecutive units, there will be an additional charge of \$30.00 per unit.
- Member copayments for endodontic procedures do not include the cost of the final restoration.
- D9972 Excludes bleaching material for home use.
- Copies of X-rays can be obtained for \$2 per periapical film up to a maximum of \$30. Panoramic X-rays can be obtained for \$15.
- A broken appointment fee up to \$20 may be charged by the dental office if 24 hour prior notice is not given.

Coverage Provisions

- This member Schedule of Benefits applies when listed dental services are performed by a participating general dentist, unless otherwise authorized by Solstice Benefits. Copayments are the amount you must pay at the time dental services are rendered.
- Procedures not listed on the Schedule of Benefits that are performed by a participating general dentist will be charged at the participating general dentist's usual and customary fee less 25%.
- An emergency is a dental condition which requires immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. Please contact your network dentist if you have an emergency in the service area. If you have an emergency while you are out of the service area and a network dentist is not available, pay for the services rendered and submit the receipt to Solstice. Emergency treatment is available for palliative treatment for the abatement of pain for up to \$100 per occurrence outside the service area (Florida).
- The participating general dentist you see may not perform all procedures listed. The Copayments shown apply to participating general dentists who do perform these services. Therefore, you are encouraged to secure availability of the scheduled services with a participating general dentist.
- Should the services of a specialist (Oral Surgeon, Endodontist, Orthodontist, Prosthodontist, Periodontist, or Pediatric Dentist) be necessary, you may go directly to a participating specialist with no referral and receive a 25% reduction off the provider's usual and customary fees.

Solstice is responsible for all administrative functions of the program.

If you have an inquiry or a question, submit it in writing: Solstice Benefits, Inc.
P.O. Box 19199
Plantation, FL 33318
Fax 1-954-370-1701

Or contact Member Services at 1-800-848-3480,
Monday through Friday, 8:00 a.m. to 6:00 p.m.



Solstice Benefits, Inc.



Administered by

Solstice Benefits, Inc.

Plus Plan Three Schedule of Benefits

Plus Plan Three Highlights:

- Two free cleanings (D1110 once every 6 months)
- Topical application of fluoride at a general dentist for children at no charge

Using Your Dental Plan

The information in this Schedule of Benefits outlines the utilization of your membership and will help you to better understand how to make the best use of your program.

Member Services

If you have any questions or concerns about the dental plan, our Member Services representatives are just a toll-free phone call away. They can provide information on dental offices in your area; explain dental services and their payments, second opinion or consultation; act as your liaison with your dental office; or explain your benefits. To contact Member Services from any location, call 1-800-848-3480.

Choice of Network Dentist

Solstice Benefits, Inc. contracts with established dentists in the community to provide quality care to our members. When you need care, you must go to a dentist that is contracted with Solstice Benefits, Inc. except in an emergency. Dentists undergo a thorough review process. Each privately owned office is operated by a licensed general dentist and a staff of professional auxiliaries.

To locate your nearest dentist, you have several options to assist you:

- Contact Member Services at 1-800-848-3480.
- Request and/or review our printed network dentist directory.
- Visit us at www.chcflorida.com and utilize our network dentist search feature to make your choice.

Schedule of Benefits

Code	Description	Copayments
APPOINTMENTS		
D0120	Periodic oral evaluation, established patient	\$0
D0140	Limited oral evaluation - problem focused	\$0
D0150	Comprehensive oral evaluation - new or established patient	\$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	\$0
D0170	Re-evaluation - limited, problem focused (established patient, not post-operative visit)	\$15
D0180	Comprehensive periodontal evaluation - new or established patient	\$20
D9110	Palliative (emergency) treatment of dental pain - minor procedure	\$10
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	\$10
D9440	Office visit - after regularly scheduled hours	\$25
RADIOGRAPHY/DIAGNOSTIC DENTISTRY		
D0210	*X-Ray - intraoral - complete series (including bitewings)	\$15
D0220	X-Ray - intraoral - periapical first film	\$4
D0230	X-Ray - intraoral - periapical each additional film	\$2
D0240	X-Ray - intraoral - occlusal film	\$5
D0250	X-Ray - extraoral - first film	\$5
D0260	X-Ray - extraoral - each additional film	\$5
D0270	*X-Ray - bitewing - single film	\$2
D0272	*X-Ray - bitewing - two films	\$4
D0274	*X-Ray - bitewing - four films	\$5
D0277	*Vertical bitewings - 7 to 8 films	\$35
D0290	Posterior-anterior or lateral skull and facial bone survey film	\$175
D0310	Sialography	\$175
D0320	Temporalmandibular joint arthrogram, including injection	\$275
D0322	Tomographic survey	\$222
D0330	Panoramic film	\$25
D0340	Cephalometric film	\$50
D0350	Oral/facial photographic images	\$45
D0415	Collection of microorganisms for culture and sensitivity	\$71
D0416	Viral Culture	\$250
D0421	Genetic test for susceptibility to oral diseases	\$118
D0425	Caries susceptibility tests	\$22
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	\$56

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Code	Description	Copayments
RADIOGRAPHY/DIAGNOSTIC DENTISTRY CONT'D		
D0460	Pulp vitality tests	\$0
D0470	Diagnostic casts	\$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	\$134
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	\$182
PREVENTIVE DENTISTRY		
D1110	Prophylaxis - adult (once every 6 months)	\$0
D1110	Additional routine Prophylaxis - adult	\$20
D1120	Prophylaxis - children under the age of 16 (once every 6 months)	\$0
D1120	Additional routine Prophylaxis - children under age 16	\$20
D1203	Topical application of fluoride - children under age 16	\$0
D1204	Topical application of fluoride - adult	\$5
D1310	Nutritional counseling for control of dental disease	\$8
D1320	Tobacco counseling for the control & prevention of oral disease	\$6
D1330	Oral hygiene instructions	\$0
D1351	Sealant - per tooth - children under the age of 16	\$15
D1510	Space maintainer - fixed - unilateral - children under the age of 16	\$50
D1515	Space maintainer - fixed - bilateral - children under the age of 16	\$50
D1520	Space maintainer - removable - unilateral - children under the age of 16	\$90
D1525	Space maintainer - removable - bilateral - children under the age of 16	\$90
D1550	Re-cementation of space maintainer	\$10
RESTORATIVE DENTISTRY		
D2140	Amalgam - 1 surface, primary or permanent	\$10
D2150	Amalgam - 2 surfaces, primary or permanent	\$15
D2160	Amalgam - 3 surfaces, primary or permanent	\$20
D2161	Amalgam - 4 or more surfaces, primary or permanent	\$25

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Code	Description	Copayments
RESTORATIVE DENTISTRY CONT'D		
D2330	Resin-based composite - 1 surface, anterior	\$35
D2331	Resin-based composite - 2 surfaces, anterior	\$40
D2332	Resin-based composite - 3 surfaces, anterior	\$50
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle (anterior)	\$90
D2390	Resin-based composite crown, anterior	\$135
D2391	Resin-based composite - 1 surface, posterior	\$55
D2392	Resin-based composite - 2 surfaces, posterior	\$80
D2393	Resin-based composite - 3 surfaces, posterior	\$100
D2394	Resin-based composite - 4 or more surfaces, posterior	\$100
D2410	Gold foil - 1 surface	\$350
D2420	Gold foil - 2 surfaces	\$550
D2430	Gold foil - 3 surfaces	\$600
D2510	Inlay - metallic - 1 surface	\$105
D2520	Inlay - metallic - 2 surfaces	\$115
D2530	Inlay - metallic - 3 or more surfaces	\$145
D2542	Onlay - metallic - 2 surfaces	\$325
D2543	Onlay - metallic - 3 surfaces	\$330
D2544	Onlay - metallic - 4 or more surfaces	\$355
D2610	*Inlay - porcelain/ceramic - 1 surface	\$325
D2620	*Inlay - porcelain/ceramic - 2 surfaces	\$350
D2630	*Inlay - porcelain/ceramic - 3 or more surfaces	\$370
D2642	*Onlay - porcelain/ceramic - 2 surfaces	\$395
D2643	*Onlay - porcelain/ceramic - 3 surfaces	\$415
D2644	*Onlay - porcelain/ceramic - 4 or more surfaces	\$445
D2650	Inlay - resin-based composite - 1 surface	\$205
D2651	Inlay - resin-based composite - 2 surfaces	\$250
D2652	Inlay - resin-based composite - 3 or more surfaces	\$275
D2662	Onlay - resin-based composite - 2 surfaces	\$250
D2663	Onlay - resin-based composite - 3 surfaces	\$275
D2664	Onlay - resin-based composite - 4 or more surfaces	\$290
D2710	Crown - resin-based composite (indirect)	\$200
D2712	Crown - 3/4 resin-based composite (indirect)	\$210
D2720	*Crown - resin with high noble metal	\$470
D2721	*Crown - resin with predominantly base metal	\$420
D2722	*Crown - resin with noble metal	\$450
D2740	*Crown - porcelain/ceramic substrate	\$270
D2750	*Crown - porcelain fused to high noble metal	\$280
D2751	*Crown - porcelain fused to predominantly base metal	\$210
D2752	*Crown - porcelain fused to noble metal	\$240
D2780	*Crown - 3/4 cast high noble metal	\$280
D2781	*Crown - 3/4 cast predominantly base metal	\$280

Schedule of Benefits

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1.800.848.3480

Code	Description	Copayments
RESTORATIVE DENTISTRY CONT'D		
D2782	*Crown - 3/4 cast noble metal	\$280
D2783	*Crown - 3/4 porcelain/ceramic	\$280
D2790	*Crown - full cast high noble metal	\$280
D2791	*Crown - full cast predominantly base metal	\$280
D2792	*Crown - full cast noble metal	\$280
D2799	Provisional crown	\$130
D2910	Recement inlay, onlay, or partial coverage restoration	\$0
D2915	Recement cast or prefabricated post and core	\$25
D2920	Recement crown	\$15
D2930	Prefabricated stainless steel crown - primary tooth	\$45
D2931	Prefabricated stainless steel crown - permanent tooth	\$95
D2932	Prefabricated resin crown	\$105
D2933	Prefabricated stainless steel crown with resin window	\$150
D2934	Prefabricated esthetic coated stainless steel crown -	\$260
D2940	Sedative filling	\$28
D2950	Core buildup, including any pins	\$45
D2951	Pin retention - per tooth, in addition to restoration	\$10
D2952	Post and core in addition to crown, indirectly fabricated	\$95
D2953	Each additional indirectly fabricated post - same tooth	\$95
D2954	Prefabricated post and core in addition to crown	\$70
D2955	Post removal (not in conjunction with endodontic therapy)	\$110
D2957	Each additional prefabricated post - same tooth	\$85
D2960	Labial veneer (resin laminate) - chairside	\$210
D2961	*Labial veneer (resin laminate) - laboratory	\$170
D2962	*Labial veneer (porcelain laminate) - laboratory	\$170
D2970	Temporary crown (fractured tooth)	\$150
D2971	Additional procedures to construct new crown under existing partial denture framework	\$140
D2975	Coping	\$100

ENDODONTIC SERVICES		
D3110	Pulp cap - direct (excluding final restoration)	\$25
D3120	Pulp cap - indirect (excluding final restoration)	\$30
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$15
D3221	Pulpal debridement, primary and permanent teeth	\$105
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$80
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$75
D3310	Endodontic therapy - anterior (excluding final restoration)	\$125
D3320	Endodontic therapy - bicuspid (excluding final restoration)	\$180
D3330	Endodontic therapy - molar (excluding final restoration)	\$275

Code	Description	Copayments
ENDODONTIC SERVICES CONT'D		
D3331	Treatment of root canal obstruction; non-surgical access	\$220
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$280
D3333	Internal root repair of perforation defects	\$295
D3346	Retreatment of previous root canal therapy - anterior	\$700
D3347	Retreatment of previous root canal therapy - bicuspid	\$800
D3348	Retreatment of previous root canal therapy - molar	\$900
D3351	Apexification/recalcification - initial visit (apical closure, calcific repair of perforations, root resorption, etc.)	\$260
D3352	Apexification/recalcification - interim medication replacement (apical closure, calcific repair of perforations, root resorption, etc.)	\$190
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure, calcific repair of perforations, root resorption, etc.)	\$370
D3410	Apicoectomy/periradicular surgery - anterior	\$85
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	\$495
D3425	Apicoectomy/periradicular surgery - molar (first root)	\$500
D3426	Apicoectomy/periradicular surgery - each additional root	\$260
D3430	Retrograde filling - per root	\$180
D3450	Root amputation - per root	\$460
D3470	Intentional reimplantation (including necessary splinting)	\$350
D3910	Surgical procedure for isolation of tooth with rubber dam	\$75
D3920	Hemisection (including any root removal), not including root canal therapy	\$300
D3950	Canal preparation and fitting of preformed dowel or post	\$80

PERIODONTIC SERVICES		
D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or tooth bounded spaces per quadrant	\$145
D4211	Gingivectomy/gingivoplasty - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	\$40
D4240	Gingival flap procedure, including root planing - 4 or more contiguous teeth or tooth bounded spaces per quadrant	\$325
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	\$250
D4245	Apically positioned flap	\$255
D4249	Clinical crown lengthening - hard tissue	\$350
D4260	Osseous surgery (including flap entry and closure) - 4 or more contiguous teeth or tooth bounded spaces per quadrant	\$225
D4261	Osseous surgery (including flap entry and closure) - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant	\$220
D4263	Bone replacement graft - first site in quadrant	\$200

Code	Description	Copayments
PERIODONTIC SERVICES CONT'D		
D4264	Bone replacement graft - each additional site in quadrant	\$120
D4266	Guided tissue regeneration - resorbable barrier, per site	\$191
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	\$224
D4270	Pedicle soft tissue graft procedure	\$359
D4271	Free soft tissue graft procedure (including donor site)	\$220
D4273	Subepithelial connective tissue graft procedures, per tooth	\$395
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	\$200
D4275	Soft tissue allograft	\$475
D4320	Provisional splinting - intracoronal	\$115
D4321	Provisional splinting - extracoronal	\$105
D4341	Periodontal scaling and root planing - 4 or more teeth per quadrant	\$50
D4342	Periodontal scaling and root planing - 1 to 3 teeth, per quadrant	\$50
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$30
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissues, per tooth, by report	\$45
D4910	Periodontal maintenance	\$45
D4920	Unscheduled dressing change (by someone other than the treating dental office)	\$38

PROSTHODONTICS - REMOVABLE		
D5110	*Complete denture - maxillary	\$230
D5120	*Complete denture - mandibular	\$230
D5130	*Immediate denture - maxillary (Includes limited follow-up care; does not include required future rebasing/relining procedure(s) or a complete new denture)	\$240
D5140	Immediate denture - mandibular (Includes limited follow-up care; does not include required future rebasing/relining procedure(s) or a complete new denture)	\$240
D5211	*Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$100
D5212	*Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$100
D5213	*Maxillary partial denture - cast metal framework with resin denture basins (including any conventional clasps, rests and teeth)	\$300
D5214	*Mandibular partial denture - cast metal framework with resin denture basins (including any conventional clasps, rests and teeth)	\$300

Schedule of Benefits

Code	Description	Copayments
PROSTHODONTICS - REMOVABLE CONT'D		
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$507
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$507
D5281	*Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	\$260
D5410	Adjustment - complete denture - maxillary	\$5
D5411	Adjustment - complete denture - mandibular	\$5
D5421	Adjustment - partial denture - maxillary	\$5
D5422	Adjustment - partial denture - mandibular	\$5
D5510	*Repair broken complete denture base	\$15
D5520	*Replace missing or broken tooth - complete denture (each tooth)	\$15
D5610	*Repair denture resin base	\$15
D5620	*Repair cast framework	\$55
D5630	*Repair or replace broken clasp	\$15
D5640	*Repair broken teeth - per tooth	\$15
D5650	*Add tooth to existing partial denture	\$15
D5660	*Add clasp to existing partial denture	\$30
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$205
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$205
D5710	*Rebase complete maxillary denture	\$80
D5711	*Rebase complete mandibular denture	\$80
D5720	*Rebase maxillary partial denture	\$80
D5721	*Rebase mandibular partial denture	\$80
D5730	*Reline complete maxillary denture (chairside)	\$50
D5731	*Reline complete mandibular denture (chairside)	\$50
D5740	*Reline partial maxillary denture (chairside)	\$50
D5741	*Reline partial mandibular denture (chairside)	\$50
D5750	*Reline complete maxillary denture (laboratory)	\$35
D5751	*Reline complete mandibular denture (laboratory)	\$35
D5760	*Reline partial maxillary denture (laboratory)	\$35
D5761	*Reline partial mandibular denture (laboratory)	\$35
D5810	*Interim complete denture - maxillary	\$275
D5811	*Interim complete denture - mandibular	\$275
D5820	*Interim partial denture - maxillary	\$250
D5821	*Interim partial denture - mandibular	\$250
D5850	Tissue conditioning - maxillary	\$30
D5851	Tissue conditioning - mandibular	\$30
D5867	Replacement of replaceable part of semi-precision or precision attachment (male or female component)	\$100
D5899	Denture cleaning	\$0

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Code	Description	Copayments
PROSTHODONTICS - FIXED		
D6210	*Pontic - cast high noble metal	\$310
D6211	*Pontic - cast predominantly base metal	\$310
D6212	*Pontic - cast noble metal	\$310
D6240	*Pontic - porcelain fused to high noble metal	\$310
D6241	*Pontic - porcelain fused to predominantly base metal	\$310
D6242	*Pontic - porcelain fused to noble metal	\$310
D6245	*Pontic - porcelain/ceramic	\$495
D6250	*Pontic - resin with high noble metal	\$310
D6251	*Pontic - resin with predominantly base metal	\$310
D6252	*Pontic - resin with noble metal	\$310
D6545	*Retainer - cast metal for resin bonded fixed prosthesis	\$265
D6548	*Retainer - porcelain/ceramic for resin bonded fixed prosthesis	\$600
D6600	*Inlay - porcelain/ceramic, two surfaces	\$700
D6601	*Inlay - porcelain/ceramic, three or more surfaces	\$925
D6602	*Inlay - cast high noble metal, two surfaces	\$600
D6603	*Inlay - cast high noble metal, three or more surfaces	\$700
D6604	*Inlay - cast predominantly base metal, two surfaces	\$500
D6605	*Inlay - cast predominantly base metal, three or more surfaces	\$900
D6606	*Inlay - cast noble metal, two surfaces	\$600
D6607	*Inlay - cast noble metal, three or more surfaces	\$800
D6608	*Onlay - porcelain/ceramic, two surfaces	\$500
D6609	*Onlay - porcelain/ceramic, three or more surfaces	\$900
D6610	*Onlay - cast high noble metal, two surfaces	\$900
D6611	*Onlay - cast high noble metal, three or more surfaces	\$800
D6613	*Onlay - cast predominantly base metal, three or more surfaces	\$700
D6615	*Onlay - cast noble metal, three or more surfaces	\$850
D6710	Crown - indirect resin based composite	\$290
D6720	*Crown - resin with high noble metal	\$310
D6721	*Crown - resin with predominantly base metal	\$310
D6722	*Crown - resin with noble metal	\$310
D6740	*Crown - porcelain/ceramic	\$310
D6750	*Crown - porcelain fused to high noble metal	\$310
D6751	*Crown - porcelain fused to predominantly base metal	\$310
D6752	*Crown - porcelain fused to noble metal	\$310
D6780	*Crown - 3/4 cast high noble metal	\$310
D6781	*Crown - 3/4 cast predominantly base metal	\$310
D6782	*Crown - 3/4 cast noble metal	\$310
D6783	*Crown - 3/4 porcelain/ceramic	\$310
D6790	*Crown - full cast high noble metal	\$310
D6791	*Crown - full cast predominantly base metal	\$310

1.800.848.3480

Code	Description	Copayments
PROSTHODONTICS - FIXED CONT'D		
D6792	*Crown - full cast noble metal	\$310
D6930	Recement fixed partial denture	\$15
D6940	Stress breaker	\$130
D6950	Precision attachment	\$200
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	\$161
D6971	Cast post as part of fixed partial denture retainer	\$160
D6972	Prefabricated post and core in addition to fixed partial denture retainer	\$125
D6973	Core build up for retainer, including pins	\$95
D6975	Coping - metal	\$100
D6976	Each additional indirectly fabricated post - same tooth	\$80
D6977	Each additional prefabricated post - same tooth	\$75
ORAL SURGERY		
D7111	Extraction, coronal remnants - deciduous tooth	\$33
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$10
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$30
D7220	Removal of impacted tooth - soft tissue	\$40
D7230	Removal of impacted tooth - partially bony	\$60
D7240	Removal of impacted tooth - completely bony	\$90
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$180
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$35
D7260	Oroantral fistula closure	\$165
D7280	Surgical access of an unerupted tooth	\$350
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$270
D7285	Biopsy of oral tissue - hard (bone, tooth)	\$390
D7286	Biopsy of oral tissue - soft	\$270
D7287	Exfoliative cytological sample collection	\$120
D7288	Brush biopsy - transepithelial sample collection	\$150
D7290	Surgical repositioning of teeth	\$300
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by	\$90
D7310	Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	\$40
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$40
D7320	Alveoloplasty not in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	\$60

Schedule of Benefits

Code	Description	Copayments
ORAL SURGERY CONT'D		
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$70
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm	\$50
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25cm	\$500
D7471	Removal of lateral exostosis (maxilla or mandible)	\$400
D7472	Removal of torus palatinus	\$45
D7473	Removal of torus mandibularis	\$45
D7490	Radical resection of maxilla or mandible	\$25
D7510	Incision and drainage of abscess - intraoral soft tissue	\$20
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated(includes drainage of multiple fascial spaces)	\$20
D7520	Incision and drainage of abscess - extraoral soft tissue	\$20
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated(includes drainage of multiple fascial spaces)	\$20
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	\$250
D7963	Frenuloplasty	\$300
D7970	Excision of hyperplastic tissue - per arch	\$200
D7971	Excision of pericoronal gingiva	\$100

PP3

Code	Description	Copayments
MISCELLANEOUS SERVICES		
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$20
D9211	Regional block anesthesia	\$22
D9215	Local anesthesia	\$0
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	\$22
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$47
D9450	Case presentation, detailed and extensive treatment planning	\$0
D9630	Other drugs and/or medicaments, by report (per quadrant)	\$25
D9910	Application of desensitizing medicament	\$25
D9941	Fabrication of athletic mouthguard	\$90
D9950	Occlusal analysis - mounted case	\$25
D9951	Occlusal adjustment - limited	\$35
D9952	Occlusal adjustment - complete	\$160
D9970	Enamel microabrasion - per visit	\$76
D9972	*External bleaching - per arch	\$150
ORTHODONTIA		
D8070	Comprehensive orthodontic treatment of the transitional dentition (full treatment case up to 24 months - including fixed/removable appliances)	\$2,000
D8080	Comprehensive orthodontic treatment of the adolescent dentition (full treatment case up to 24 months - including fixed/removable appliances)	\$2,000

Orthodontic treatment is prorated over 24 months and is available at a general dentist and at a current status. Solstice Benefits bears no liability towards a treatment unable to be completed due to a terminated status.

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Code	Description	Copayments
LAB FEES		

Copayments marked by "*" do not include the cost of metal and laboratory fees.

Attachment B

Group Medical Claims Experience



CITY OF HALLANDALE
Experience Exhibit
Claims Incurred 1/2011 - 12/2012
Paid Through 2/2013

Month	Number of Subscribers	Number of Members	Capitation	Medical Claims Incurred \$	Pharmacy	Total Costs	Premium Billed
2011/Jan	438	1,025	\$ 23,757	\$ 162,488	\$ 51,945	\$ 238,190	\$ 322,217
2011/Feb	437	1,022	\$ 23,365	\$ 188,046	\$ 55,417	\$ 266,828	\$ 321,172
2011/Mar	435	1,020	\$ 22,525	\$ 160,280	\$ 52,043	\$ 234,848	\$ 320,340
2011/Apr	434	1,018	\$ 22,471	\$ 180,818	\$ 43,181	\$ 246,470	\$ 319,354
2011/May	435	1,016	\$ 22,338	\$ 274,347	\$ 57,566	\$ 354,251	\$ 318,411
2011/June	433	1,008	\$ 22,146	\$ 327,319	\$ 62,190	\$ 411,656	\$ 316,128
2011/Jul	433	1,011	\$ 22,145	\$ 252,276	\$ 65,697	\$ 340,119	\$ 316,626
2011/Aug	434	1,014	\$ 22,238	\$ 161,388	\$ 61,576	\$ 245,202	\$ 316,425
2011/Sep	433	1,016	\$ 22,261	\$ 190,014	\$ 52,654	\$ 264,929	\$ 316,426
2011/Oct	434	1,019	\$ 22,254	\$ 104,963	\$ 65,520	\$ 192,737	\$ 325,457
2011/Nov	436	1,023	\$ 22,079	\$ 245,549	\$ 57,626	\$ 325,254	\$ 326,340
2011/Dec	436	1,024	\$ 22,200	\$ 129,216	\$ 69,710	\$ 221,126	\$ 326,722
2012/Jan	437	1,027	\$ 21,887	\$ 130,130	\$ 61,957	\$ 213,973	\$ 327,478
2012/Feb	441	1,033	\$ 22,070	\$ 249,671	\$ 64,046	\$ 335,788	\$ 329,367
2012/Mar	443	1,034	\$ 22,218	\$ 218,635	\$ 64,048	\$ 304,901	\$ 330,237
2012/Apr	445	1,040	\$ 22,312	\$ 205,739	\$ 48,607	\$ 276,658	\$ 332,052
2012/May	445	1,043	\$ 19,644	\$ 134,450	\$ 52,917	\$ 207,010	\$ 333,253
2012/June	447	1,051	\$ 19,647	\$ 193,642	\$ 56,092	\$ 269,382	\$ 334,482
2012/Jul	447	1,051	\$ 19,709	\$ 198,488	\$ 54,937	\$ 273,134	\$ 334,100
2012/Aug	446	1,046	\$ 19,517	\$ 293,587	\$ 59,524	\$ 372,628	\$ 333,205
2012/Sep	453	1,056	\$ 19,668	\$ 186,708	\$ 52,466	\$ 258,843	\$ 336,470
2012/Oct	450	1,048	\$ 19,543	\$ 260,312	\$ 59,029	\$ 338,883	\$ 347,471
2012/Nov	464	1,069	\$ 19,780	\$ 406,807	\$ 45,459	\$ 472,046	\$ 354,866
2012/Dec	464	1,065	\$ 19,782	\$ 679,417	\$ 53,045	\$ 752,244	\$ 354,320
Totals	10,600	24,779	\$ 515,559	\$ 5,534,289	\$ 1,367,253	\$ 7,417,101	\$ 7,892,921

Estimated Medical Cost Ratio: **93.97%**

This report:
shows by month, the number of subscribers, members, the categories of plan payment and the revenue (premium). It provides a view of cost versus revenue.



CITY OF HALLANDALE
High Cost Claimant Report
Claims Incurred 1/2012 - 12/2012
Paid Through 2/2013

ID NO	Total	Benefits Expense		Physician	MDC	High Cost % Expense		CM	High Cost Diagnosis Description
		Inpatient	Outpatient			Diagnosis Code	This Diagnosis		
1	\$ 306,502	\$ 266,430	\$ 645	\$ 39,427	08	824.9	66.1%	Y	FRACTURE
2	\$ 141,328	\$ 14,232	\$ 38,960	\$ 88,135	09	174.8	32.2%	Y	MALIGNANT NEOPLASM - BREAST
3	\$ 100,112	\$ 71,863	\$ 13,428	\$ 14,822	08	820.02	25.4%	Y	FRACTURE
4	\$ 85,331	\$ 32,863	\$ 31,706	\$ 20,762	17	V58.11	26.6%	Y	CHEMO/ANTINEOPLAS/RADIOTHERAPY (V CODES)
5	\$ 82,605	\$ 60,929	\$ 5,789	\$ 15,887	21	998.59	51.6%	Y	COMPLICATIONS OF SURGICAL AND MEDICAL CARE
6	\$ 42,365	\$ 32,296	\$ 4,509	\$ 5,560	06	153.6	69.8%	Y	MALIGNANT NEOPLASM - DIGESTIVE SYSTEM
7	\$ 38,361	\$ -	\$ 28,151	\$ 10,210	09	612.1	64.4%	Y	UNKNOWN
8	\$ 37,149	\$ 35,409	\$ 349	\$ 1,391	23	V57.89	95.3%	Y	REHAB/DME FITTING/AFTERCARE
9	\$ 35,872	\$ 26,076	\$ 2,036	\$ 7,761	12	185	90.1%	Y	MALIGNANT NEOPLASM - GENITOURINARY
10	\$ 33,641	\$ 10,709	\$ 17,151	\$ 5,780	06	789.00	26.9%	Y	SYMPTOMS - DIGESTIVE SYSTEM
11	\$ 31,982	\$ -	\$ 30,063	\$ 1,919	17	V58.11	71.6%	Y	CHEMO/ANTINEOPLAS/RADIOTHERAPY (V CODES)
12	\$ 31,295	\$ 4,882	\$ 23,800	\$ 2,612	RX	RX	74.8%	Y	Rx
13	\$ 30,853	\$ -	\$ 28,018	\$ 2,834	RX	RX	90.8%	Y	Rx
14	\$ 29,249	\$ -	\$ 19,278	\$ 9,971	08	718.87	37.1%	Y	ARTHROPATHIES-JOINT DISORDERS EXCL SPINE
15	\$ 28,911	\$ 9,134	\$ 16,653	\$ 3,125	RX	RX	41.7%	Y	Rx
16	\$ 28,159	\$ -	\$ 25,016	\$ 3,143	RX	RX	70.9%	Y	Rx
17	\$ 27,110	\$ 22,066	\$ 500	\$ 4,544	04	510.9	80.6%	Y	OTHER RESPIRATORY DISEASE
18	\$ 26,888	\$ -	\$ 19,241	\$ 7,647	RX	RX	71.6%	Y	Rx
19	\$ 26,739	\$ 4,737	\$ 10,455	\$ 11,547	11	593.4	23.1%	Y	OTHER URINARY DISEASES
20	\$ 26,378	\$ 11,203	\$ 485	\$ 14,691	14	650	41.9%	Y	NORMAL DELIVERY, AND OTHER INDICATIONS FOR CARE IN P
21	\$ 25,637	\$ -	\$ 25,545	\$ 93	RX	RX	99.6%	Y	Rx
22	\$ 24,943	\$ -	\$ 23,673	\$ 1,271	RX	RX	73.4%	Y	Rx
23	\$ 24,342	\$ -	\$ 23,981	\$ 361	RX	RX	98.5%	Y	Rx
24	\$ 23,945	\$ 8,286	\$ 2,832	\$ 12,828	14	651.01	41.9%	Y	NORMAL DELIVERY, AND OTHER INDICATIONS FOR CARE IN P
25	\$ 22,738	\$ 10,300	\$ 6,056	\$ 6,382	07	571.5	50.4%	Y	DISEASES OF LIVER
TOTALS	\$ 1,312,437	\$ 621,416	\$ 398,319	\$ 292,702					

This report:

lists the top 25 claimants with the highest benefits expense. The report provides specific clinical information for the highest cost diagnosis and the % of total benefits related to that diagnosis. Retail pharmacy and Navarro Over the Counter benefits expenses are included in Outpatient Benefits paid to simplify this report presentation. The Case Mgmt (CM) flag indicates that the member has an enrollment in Coventry's NAVCARE Case Mgmt application. It does not imply that the member is enrolled for the noted Dx.

Use this report to:

- > assess the impact of catastrophic claims on benefit trends;
- > identify claimants who could benefit from a case management program.



CITY OF HALLANDALE
High Cost Claimant Report
Claims Incurred 1/2011 - 12/2011
Paid Through 2/2012

ID NO	Total	Benefits Expense		Physician	MDC	High Cost % Expense		CM	High Cost Diagnosis Description
		Inpatient	Outpatient			Diagnosis Code	This Diagnosis		
1	\$ 153,459	\$ 134,922	\$ 5,806	\$ 12,732	06	008.45	70.3%	Y	INTESTINAL INFECTIOUS DISEASE
2	\$ 89,380	\$ 80,129	\$ 263	\$ 8,988	13	218.9	80.5%	Y	BENIGN NEOPLASM
3	\$ 70,671	\$ 3,574	\$ 50,902	\$ 16,196	RX	RX	32.0%	Y	Rx
4	\$ 56,882	\$ 8,122	\$ 42,844	\$ 5,917	RX	RX	73.0%	Y	Rx
5	\$ 41,068	\$ 32,438	\$ 1,324	\$ 7,306	08	715.36	34.9%	Y	ARTHROPATHIES-JOINT DISORDERS EXCL SPINE
6	\$ 38,663	\$ 22,797	\$ 1,584	\$ 14,282	04	493.91	64.0%	Y	ASTHMA
7	\$ 32,451	\$ -	\$ 32,320	\$ 131	RX	RX	99.6%	Y	Rx
8	\$ 30,998	\$ -	\$ 21,584	\$ 9,414	09	233.0	72.3%	Y	CARCINOMA IN SITU
9	\$ 29,708	\$ -	\$ 26,759	\$ 2,949	RX	RX	90.1%	Y	Rx
10	\$ 28,348	\$ -	\$ 16,963	\$ 11,385	RX	RX	59.8%	Y	Rx
11	\$ 26,144	\$ -	\$ 12,100	\$ 14,043	05	780.2	31.6%	Y	SYMPTOMS - ILL DEFINED
12	\$ 24,552	\$ -	\$ 8,696	\$ 15,856	09	174.9	50.5%	Y	MALIGNANT NEOPLASM - BREAST
13	\$ 23,907	\$ 10,339	\$ 3,955	\$ 9,613	14	659.71	50.1%	Y	NORMAL DELIVERY, AND OTHER INDICATIONS FOR CARE IN PREGNANCY, I
14	\$ 23,207	\$ -	\$ 22,399	\$ 808	RX	RX	95.9%	Y	Rx
15	\$ 23,007	\$ -	\$ 20,910	\$ 2,097	RX	RX	90.9%	Y	Rx
16	\$ 22,200	\$ -	\$ 20,022	\$ 2,178	09	610.8	49.1%	Y	DISORDERS OF BREAST
17	\$ 21,740	\$ -	\$ 19,477	\$ 2,263	RX	RX	36.6%	Y	Rx
18	\$ 21,532	\$ -	\$ 20,396	\$ 1,136	RX	RX	94.7%	Y	Rx
19	\$ 21,087	\$ -	\$ 15,215	\$ 5,872	13	620.2	78.9%	Y	OTHER FEMALE GENITAL DISORDERS
20	\$ 21,017	\$ -	\$ 19,332	\$ 1,685	RX	RX	90.3%	Y	Rx
21	\$ 20,753	\$ 4,954	\$ 8,407	\$ 7,392	13	218.9	38.7%	Y	BENIGN NEOPLASM
22	\$ 20,470	\$ 11,480	\$ 4,671	\$ 4,319	06	533.90	56.1%	Y	DISEASES OF ESOPHAGUS
23	\$ 20,458	\$ -	\$ 18,532	\$ 1,925	06	789.07	70.3%	Y	SYMPTOMS - DIGESTIVE SYSTEM
24	\$ 20,117	\$ 11,676	\$ 2,894	\$ 5,547	18	079.99	58.0%	Y	OTHER DISEASES DUE TO VIRUSES
25	\$ 19,931	\$ -	\$ 19,931	\$ -	94	TBM	90.6%	Y	TBM
TOTALS	\$ 901,749	\$ 320,430	\$ 417,286	\$ 164,032					

This report:

lists the top 25 claimants with the highest benefits expense. The report provides specific clinical information for the highest cost diagnosis and the % of total benefits related to that diagnosis. Retail pharmacy and Navarro Over the Counter benefits expenses are included in Outpatient Benefits paid to simplify this report presentation. The Case Mgmt (CM) flag indicates that the member has an enrollment in Coventry's NAVCARE Case Mgmt application. It does not imply that the member is enrolled for the noted Dx.

Use this report to:

- > assess the impact of catastrophic claims on benefit trends;
- > identify claimants who could benefit from a case management program.

Attachment C

Group Dental Benefit Summaries

Plan Benefit Highlights for: City of Hallandale

Group No: 10-3589

Effective Date: 10/01/2011

DELTA DENTAL PPOSM

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of calendar year that dependent turns 25		
Deductibles	\$50 per person / \$150 per family each plan year		
Deductibles waived for D & P?	Yes		
Maximums	\$2,000 per person , per plan year		
D & P counts toward maximum?	Yes		
Waiting Period(s)	Basic Benefits 0 Months	Major Benefits 0 Months	Orthodontics 0 Months

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays	100 %	100 %
Basic Services Fillings, simple tooth extractions	80 %	80 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	80 %
Oral Surgery Covered Under Basic Services	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations, bridges and dentures	70 %	70 %
Orthodontic Benefits adults and dependent children	50 %	50 %
Orthodontic Maximums Lifetime	\$ 1,000 Lifetime	\$ 1000 Lifetime
Other		

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

Customer Service
800-521-2651

Claims Address
P.O. Box 1809
Alpharetta, GA 30023-1809

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

BENEFIT HIGHLIGHTS

D2390	Resin-based composite crown, anterior	\$42.00
D2391	Resin-based composite - one surface, posterior	\$30.00
D2392	Resin-based composite - two surfaces, posterior	\$40.00
D2393	Resin-based composite - three surfaces, posterior	\$55.00
D2394	Resin-based composite - four or more surfaces, posterior	\$55.00
D2510	Inlay - metallic - one surface ^{1, 2}	\$170.00
D2520	Inlay - metallic - two surfaces ^{1, 2}	\$180.00
D2530	Inlay - metallic - three or more surfaces ^{1, 2}	\$190.00
D2543	Onlay - metallic - three surfaces ^{1, 2}	\$198.00
D2544	Onlay - metallic - four or more surfaces ^{1, 2}	\$206.00
D2710	Crown - resin-based composite (indirect) ¹	\$132.00
D2712	Crown - ¾ resin-based composite (indirect) ¹	\$132.00
D2740	Crown - porcelain/ceramic substrate ^{1, 3}	\$234.00
D2750	Crown - porcelain fused to high noble metal ^{1, 2, 3}	\$234.00
D2751	Crown - porcelain fused to predominantly base metal ^{1, 3}	\$234.00
D2752	Crown - porcelain fused to noble metal ^{1, 3}	\$234.00
D2780	Crown - ¾ cast high noble metal ^{1, 2}	\$234.00
D2781	Crown - ¾ cast predominantly base metal ¹	\$234.00
D2782	Crown - ¾ cast noble metal ¹	\$234.00
D2790	Crown - full cast high noble metal ^{1, 2}	\$234.00
D2791	Crown - full cast predominantly base metal ¹	\$234.00
D2792	Crown - full cast noble metal ¹	\$234.00
D2794	Crown - titanium ^{1, 2}	\$234.00
D2910	Recement inlay, onlay or partial coverage restoration	\$12.00
D2915	Recement cast or prefabricated post and core	\$12.00
D2920	Recement crown	\$12.00
D2930	Prefabricated stainless steel crown - primary tooth	\$42.00
D2931	Prefabricated stainless steel crown - permanent tooth	\$42.00
D2940	Protective restoration	No Cost
D2950	Core buildup, including any pins	\$18.00
D2951	Pin retention - per tooth, in addition to restoration	\$18.00
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i> ²	\$18.00
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> ²	\$18.00
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	\$18.00
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	\$18.00
D2970	Temporary crown (fractured tooth) - <i>palliative treatment only</i>	\$12.00
D3000-D3999 IV. ENDODONTICS		
D3110	Pulp cap - direct (excluding final restoration)	\$6.00
D3120	Pulp cap - indirect (excluding final restoration)	\$6.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$6.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.	\$6.00
D3310	<i>Root canal</i> - endodontic therapy, anterior tooth (excluding final restoration) ⁴	\$90.00
D3320	<i>Root canal</i> - endodontic therapy, bicuspid tooth (excluding final restoration) ⁴	\$144.00
D3330	<i>Root canal</i> - endodontic therapy, molar (excluding final restoration) ⁴	\$216.00
D3346	Retreatment of previous root canal therapy - anterior ⁴	\$90.00
D3347	Retreatment of previous root canal therapy - bicuspid ⁴	\$144.00
D3348	Retreatment of previous root canal therapy - molar ⁴	\$216.00
D3410	Apicoectomy/periradicular surgery - anterior ⁴	\$102.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root) ⁴	\$102.00
D3425	Apicoectomy/periradicular surgery - molar (first root) ⁴	\$102.00
D3426	Apicoectomy/periradicular surgery (each additional root) ⁴	\$60.00
D3430	Retrograde filling - per root ⁴	\$60.00
D3450	Root amputation, per root - <i>not covered in conjunction with a hemisection</i> ⁴	\$72.00

D5741	Reline mandibular partial denture (chairside) ⁷	\$36.00
D5750	Reline complete maxillary denture (laboratory) ⁷	\$60.00
D5751	Reline complete mandibular denture (laboratory) ⁷	\$60.00
D5760	Reline maxillary partial denture (laboratory) ⁷	\$60.00
D5761	Reline mandibular partial denture (laboratory) ⁷	\$60.00
D5820	Interim partial denture (maxillary) - <i>limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing</i> ⁵	\$30.00
D5821	Interim partial denture (mandibular) - <i>limited to initial placement of interim partial denture /stayplate to replace extracted anterior teeth during healing</i> ⁵	\$30.00
D5850	Tissue conditioning, maxillary ^{5,7}	\$12.00
D5851	Tissue conditioning, mandibular ^{5,7}	\$12.00

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered**D6000-D6199 VIII. IMPLANT SERVICES - Not Covered****D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])**

D6210	Pontic - cast high noble metal ^{2,8}	\$234.00
D6211	Pontic - cast predominantly base metal ⁸	\$234.00
D6212	Pontic - cast noble metal ⁸	\$234.00
D6240	Pontic - porcelain fused to high noble metal ^{2,3,8}	\$234.00
D6241	Pontic - porcelain fused to predominantly base metal ^{3,8}	\$234.00
D6242	Pontic - porcelain fused to noble metal ^{3,8}	\$234.00
D6602	Inlay - cast high noble metal, two surfaces ^{2,8}	\$180.00
D6603	Inlay - cast high noble metal, three or more surfaces ^{2,8}	\$190.00
D6604	Inlay - cast predominantly base metal, two surfaces ⁸	\$180.00
D6605	Inlay - cast predominantly base metal, three or more surfaces ⁸	\$190.00
D6606	Inlay - cast noble metal, two surfaces ⁸	\$180.00
D6607	Inlay - cast noble metal, three or more surfaces ⁸	\$190.00
D6611	Onlay - cast high noble metal, three or more surfaces ^{2,8}	\$198.00
D6613	Onlay - cast predominantly base metal, three or more surfaces ⁸	\$198.00
D6615	Onlay - cast noble metal, three or more surfaces ⁸	\$198.00
D6750	Crown - porcelain fused to high noble metal ^{2,3,8}	\$234.00
D6751	Crown - porcelain fused to predominantly base metal ^{3,8}	\$234.00
D6752	Crown - porcelain fused to noble metal ^{3,8}	\$234.00
D6780	Crown - ¾ cast high noble metal ^{2,8}	\$234.00
D6781	Crown - ¾ cast predominantly base metal ⁸	\$234.00
D6782	Crown - ¾ cast noble metal ⁸	\$234.00
D6790	Crown - full cast high noble metal ^{2,8}	\$234.00
D6791	Crown - full cast predominantly base metal ⁸	\$234.00
D6792	Crown - full cast noble metal ⁸	\$234.00
D6930	Recement fixed partial denture	\$18.00
D6940	Stress breaker ⁸	\$30.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated - <i>includes canal preparation</i> ²	\$18.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer - <i>base metal post; includes canal preparation</i>	\$18.00
D6976	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i> ²	\$18.00
D6977	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	\$18.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under local anesthetic.

D7111	Extraction, coronal remnants - deciduous tooth	\$8.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$8.00
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$18.00
D7220	Removal of impacted tooth - soft tissue	\$48.00
D7230	Removal of impacted tooth - partially bony	\$72.00

- ¹⁰ *In the event comprehensive orthodontic treatment is not required or is declined by the Enrollee, a fee of \$25.00 will apply. The Enrollee is also responsible for any incurred orthodontic diagnostic record fees.*
- ¹¹ *Includes adjustments and/or office visits up to 24 months. After 24 months, an additional office visit charge at the Contract Orthodontist's "filed fee" applies.*

18. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
19. Crown lengthening procedures.
20. Treatment required by reason of war declared or undeclared.

Orthodontic Limitations

The DeltaCare USA program provides coverage for orthodontic treatment plans provided through Contract Orthodontists. The start-up fees and the cost to the Enrollee for the treatment plan are listed in *Schedule A, Description of Benefits and Copayments* and subject to the following:

1. Orthodontic treatment must be provided by a Contract Orthodontist.
2. Plan benefits cover 24 months of usual and customary orthodontic treatment.
3. Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee and not Delta Dental will be responsible for payment of balance due for treatment provided after cancellation or termination. In such a case the Enrollee's payment shall be based on a maximum of \$2,300 for dependent children to age 19 and \$2,500 for adults and dependent adult children from age 19 to 25. The amount will be pro-rated over the number of months to completion of the treatment and, will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the Contract Orthodontist. Start-up fees are included in these amounts.
4. Start-up fees cover the initial examination, diagnosis, consultation and the retention phase of treatment of up to two years maximum. This includes initial construction, placement and adjustments to retainers and office visits for a maximum period of two years.
5. If treatment is not required or the Enrollee chooses not to start treatment after the diagnosis and consultation has been completed by the Contract Orthodontist, the Enrollee will be charged a consultation fee of \$25.00 in addition to diagnostic record fees.
6. Three (3) recementations or replacements of a bracket/band on the same tooth or a total of five (5) rebracketings/rebandings on different teeth during the covered course of treatment is a benefit. If any additional recementations or replacements of brackets/bands are performed, the Enrollee is responsible for the cost.
7. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the Enrollee's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the Contract Orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same Copayment amounts as for fixed appliances.

Orthodontic Exclusions

1. Pre-, mid- and post-treatment records which include cephalometric x-rays, tracings, photographs and study models.
2. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances.
3. Retreatment of orthodontic cases.
4. Changes in treatment necessitated by accident of any kind, and/or lack of patient cooperation.
5. Surgical procedures incidental to orthodontic treatment.
6. Myofunctional therapy.
7. Surgical procedures related to cleft palate, micrognathia or macrognathia.
8. Treatment related to temporomandibular joint disturbances and/or hormonal imbalance.
9. Supplemental appliances not routinely utilized in typical Phase II orthodontics.
10. Treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge at the Contract Orthodontist's "filed fee."
11. Restorative work caused by orthodontic treatment.
12. Phase I orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion. Phase I orthodontics is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.
13. Extractions solely for the purpose of orthodontics.

A restoration is a covered benefit only when required for restorative reasons (radiographic evidence of decay or missing tooth structure). Restorations placed for any other purposes including but not limited to cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth, or the anticipation of future fractures, are not covered benefits.

Porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. An allowance will be made for an acrylic crown. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

A crown placed on a specific tooth is allowable only once in a five-year period.

A pulp cap is a benefit only on a permanent tooth with an open apex.

4. FIXED BRIDGES

A fixed bridge is considered standard dental treatment when it is necessary to replace one missing permanent anterior tooth in a person 16 years old or older. Such treatment will be covered if the Enrollee's oral health and general dental condition permits.

Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. A fixed bridge used under these circumstances is considered optional dental treatment. The Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Fixed bridges are not a benefit when provided in connection with a partial denture on the same arch. If provided, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

Replacement of an existing nonfunctional bridge is limited to once in a five-year period from initial placement and shall be covered only when the replacement duplicates the original bridge.

Fixed bridges are not a benefit for Enrollees under the age of 16. A fixed bridge under these circumstances is considered optional dental treatment. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

5. RECONSTRUCTION

The DeltaCare USA program provides coverage for procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) are not covered benefits. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework is considered full mouth reconstruction and is not a benefit of the DeltaCare USA program. The program will allow for complete or partial denture(s).

6. SPECIALIZED TECHNIQUES

Precious metal for removable appliances, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization, are all considered optional treatment. If performed, the Enrollee must pay the difference in cost between the Contract Dentist's "filed fees" for the covered benefit and optional treatment, plus any copayment for the covered benefit.

7. PREVENTIVE CONTROL PROGRAMS

Soft tissue management programs are not covered. The periodontal pocket charting, root planing/scaling/curettage, oral hygiene instruction and prophylaxis are covered benefits and, if performed as part of a soft tissue management program, will be provided for listed copayments, if any. Irrigation, infusion, special tooth brush, etc., is considered as optional treatment. If performed, the Enrollee is responsible for the cost.

8. STAYPLATES

Stayplates in conjunction with fixed or removable appliances, are only a benefit to replace extracted anterior teeth for adults during a healing period and as anterior space maintainers for children.

Attachment D

Group Dental Claims Experience

**DELTA DENTAL INSURANCE COMPANY
DENTAL PLAN EXPERIENCE REPORT**

Prepared for:

CITY OF HALLANDALE
Group Number: 10-03589-
February 26, 2013



**DELTA DENTAL INSURANCE COMPANY
INCOME COST EXPERIENCE REPORT**

**CITY OF HALLANDALE
Group Number: 10-03589-
1/12 - 12/12**

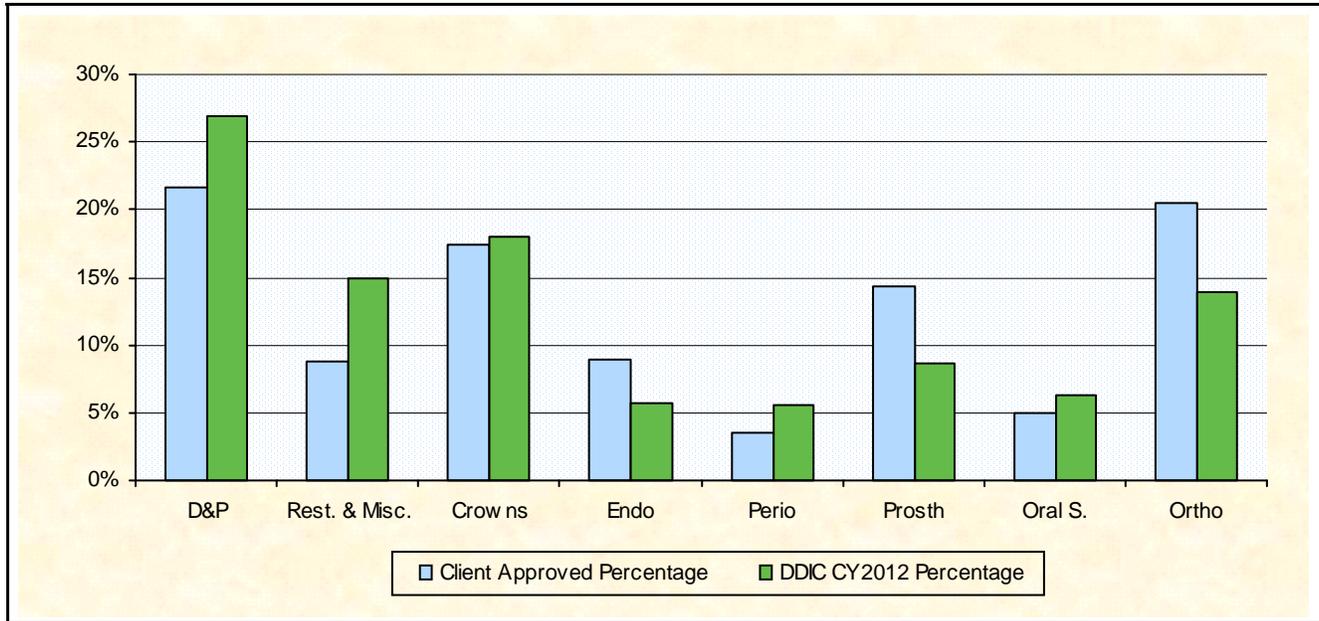
Date	Primary Enrollees	Premium*	Administration	\$ Claims Paid	# Claims Paid
1/12	148	\$12,431.11	\$2,122.04	\$6,037.70	55
2/12 +	150	12,292.57	2,098.40	5,836.10	46
3/12	151	12,599.05	2,150.72	5,889.00	36
4/12	152	12,573.84	2,146.41	8,934.70	45
5/12 +	154	12,613.03	2,153.10	9,017.30	64
6/12	155	12,841.13	2,192.04	12,318.80	67
7/12	155	12,964.29	2,213.07	7,857.90	49
8/12 +	154	12,834.14	2,190.85	9,823.90	52
9/12	156	12,750.17	2,176.51	7,208.80	43
10/12 +	165	12,880.32	2,198.73	9,307.90	64
11/12	167	14,472.88	2,470.59	5,680.30	37
12/12	169	14,171.99	2,419.23	12,799.80	54
Totals	1,876	\$155,424.52	\$26,531.69	\$100,712.20	612

**Premium is based on cash receipts plus receivables by month of accrual.*

+Indicates more than twenty claims processing days in the month.

**DELTA DENTAL INSURANCE COMPANY
PAYMENT BY PROCEDURE CLASSIFICATION REPORT**

**CITY OF HALLANDALE
Group Number: 10-03589-
All Dentists
1/12 - 12/12**

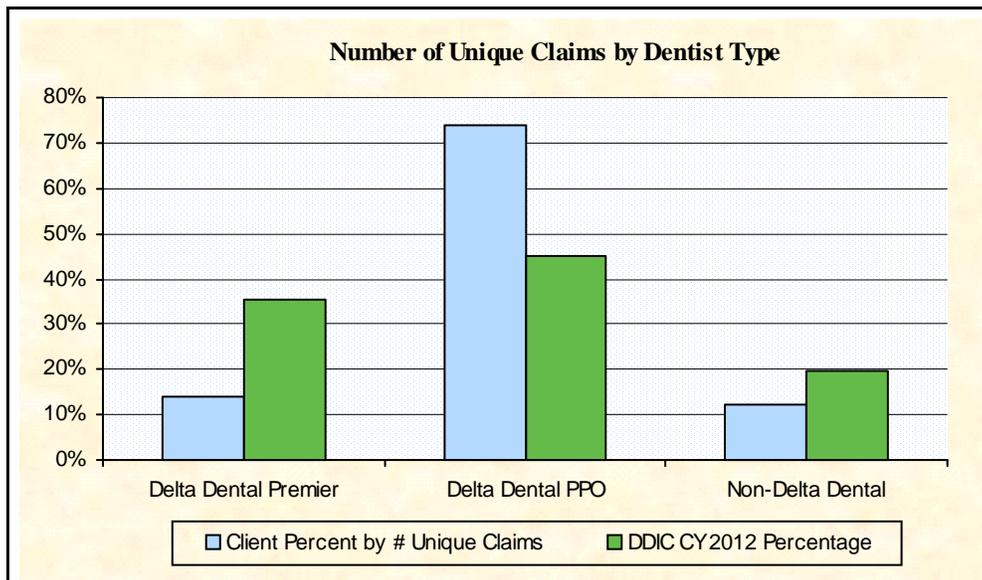


Dental Category	Amount Approved	\$ Claims Paid	# of Procedures	Approved Percentage	DDIC CY2012
Diagnostic	26,670.00	20,874.00	665	11.98%	14.58%
Preventive	21,421.00	16,283.40	402	9.62%	12.29%
Restorative	16,831.00	8,248.80	131	7.56%	12.44%
Crowns/Inlays	38,716.00	22,993.30	79	17.39%	18.02%
Endodontics	19,805.25	9,248.00	25	8.90%	5.77%
Periodontics	7,765.00	2,354.60	65	3.49%	5.58%
Prosthodontics/Removable	4,086.00	28.80	3	1.84%	1.96%
Prosthodontics/Fixed	27,971.00	9,670.60	33	12.57%	6.74%
Oral Surgery	11,074.00	4,506.90	50	4.98%	6.23%
Orthodontics	45,497.00	5,705.00	58	20.44%	13.88%
Miscellaneous	2,734.00	798.80	30	1.23%	2.50%
Total	\$222,570.25	\$100,712.20	1,541	100.00%	100.00%

DELTA DENTAL INSURANCE COMPANY NETWORK UTILIZATION REPORT

CITY OF HALLANDALE
Group Number: 10-03589-
1/12 - 12/12

Paid Claims for Period By Dentist Type	\$ Claims Paid	Percent by \$ Claims Paid	# Unique Claims	Percent by # Unique Claims	DDIC CY2012 Percent
Delta Dental PPO	\$76,795.90	76.3%	452	73.9%	44.9%
Delta Dental Premier®	\$13,740.20	13.6%	85	13.9%	35.6%
Non-Delta Dental	\$10,176.10	10.1%	75	12.3%	19.5%
Total	\$100,712.20	100.0%	612	100.0%	100.0%





**DELTA DENTAL INSURANCE COMPANY
BENEFIT COST SAVINGS REPORT**

**CITY OF HALLANDALE
Group Number: 10-03589-
1/12 - 12/12**

		Submitted	Savings
<u>CLAIMS BY DENTIST TYPE</u>			
Delta Dental PPO		188,183.00	86,143.00
Delta Dental Premier®		48,897.00	31,590.30
Non-Delta Dental		60,111.25	44,082.25
Total Claim Amounts for Period		\$297,191.25	\$161,815.55
<u>MAIN CONTAINMENT CATEGORIES</u>			
Optional Services		382.00	138.00
Ineligible Services		25,532.00	25,532.00
Contract Limitations		68,174.00	62,355.30
Non-Billable\Reduction to Fees: PPO		142,255.00	40,067.00
Non-Billable\Reduction to Fees: Premier		17,310.00	1,232.00
Non-Billable\Reduction to Fees: Non-Delta		26,045.25	11,812.25
<u>COB CONTAINMENT</u>			
Delta Payable	Delta Paid	COB Containment	Total Delta Paid
\$1,364.40	\$938.60	\$425.80	\$100,712.20
Total Network Savings to Amount Submitted		13.90% or	\$41,299.00



DELTA DENTAL INSURANCE COMPANY
DELTA DENTAL PPO FEE SAVINGS REPORT
(Excluding Orthodontics)

CITY OF HALLANDALE
Group Number: 10-03589-
1/12 - 12/12

Dental Category	Submitted Amount for PPO Dentists	Approved Amount for PPO Dentists	Estimated PPO Fee Savings*
Diagnostic	26,815.00	17,994.00	32.90%
Preventive	19,887.00	15,344.00	22.84%
Restorative	15,246.00	11,262.00	26.13%
Crowns/Inlays	39,468.00	29,883.00	24.29%
Endodontics	18,196.00	15,454.00	15.07%
Periodontics	6,232.00	4,601.00	26.17%
Prosthodontics/Removable	125.00	86.00	31.20%
Prosthodontics/Fixed	23,138.00	18,922.00	18.22%
Oral Surgery	11,902.00	8,256.00	30.63%
Miscellaneous	3,593.00	1,961.00	45.42%
Total	\$164,602.00	\$123,763.00	24.81%

Note: Some Delta Dental dentists submit fees at or close to their contracted fee amounts. The actual Delta Dental savings is higher than shown above.

* This report includes savings from contractual agreements with Delta Dental PPO dentists and does not include savings from the contractual agreement with the client.



DELTA DENTAL INSURANCE COMPANY
DELTA DENTAL PREMIER® FEE SAVINGS REPORT
(Excluding Orthodontics)

CITY OF HALLANDALE
Group Number: 10-03589-
1/12 - 12/12

Dental Category	Submitted Amount for Premier Dentists	Approved Amount for Premier Dentists	Estimated Premier Fee Savings*
Diagnostic	4,147.00	3,791.00	8.58%
Preventive	3,950.00	3,820.00	3.29%
Restorative	4,024.00	3,659.00	9.07%
Crowns/Inlays	3,433.00	3,386.00	1.37%
Endodontics	4,800.00	0.00	100.00%
Periodontics	1,565.00	1,565.00	0.00%
Prosthodontics/Removable	0.00	0.00	-
Prosthodontics/Fixed	7,455.00	6,899.00	7.46%
Oral Surgery	1,360.00	1,258.00	7.50%
Miscellaneous	563.00	553.00	1.78%
Total	\$31,297.00	\$24,931.00	20.34%

Note: Some Delta Dental dentists submit fees at or close to their contracted fee amounts. The actual Delta Dental savings is higher than shown above.

** This report includes savings from contractual agreements with Delta Dental Premier dentists and does not include savings from the contractual agreement with the client.*

DELTA DENTAL INSURANCE COMPANY GLOSSARY FOR STANDARD REPORTS

\$ Claims Paid: The amount of benefit paid by Delta Dental.

Claims Paid: The number of times claims were processed. (An individual claim will be counted every time it is processed/adjusted.)

of Procedures: The number of dental procedures included in the claims processed.

Unique Claims: The number of individual claims submitted for processing.

Administration: The fee charged for managing the benefit plan and processing the claims.

Approved: The amount the dentist is permitted to charge for each individual procedure. For Delta Dental dentists, the amount approved is equal to the lesser of the amount submitted or the appropriate maximum plan allowance. For non-Delta Dental dentists, the amount approved is equal to the amount submitted unless further documentation is required (e.g., x-rays).

Approved Percentage: The percent of total amount approved by dental category.

COB Containment: Delta tracks patients who are subject to coordination of benefits. If Delta Dental is the secondary carrier, savings are realized by coordinating benefits with the primary carrier.

Delta Payable is the amount that Delta would have paid in absence of another carrier.

Delta Paid is the amount that Delta paid after reducing the benefit by the payment of the other carrier.

Change in Reserve: Adjustment to claims paid to account for claims incurred during the report time period.

Savings: The amount submitted minus the amount allowed equals the amount contained. This represents savings on the face value of the claims submitted before coinsurance and deductibles are applied.

Contract Limitations: Savings resulting from contractual agreement with the client. This would include time limitations, non-covered services and consultant review. A partial benefit may be possible for an alternative service.

Crowns/Inlays (D2500 - D2999): Crowns, jackets and cast restorations for treatment of carious lesions.

DDIC CY2012: The Approved percentage by dental category for DDIC's total book of business for the previous year.

DDIC CY2012 Percent: The percent of number of claims by dentist type for DDIC's total book of business for the previous year.

Diagnostic (D0100 - D0999): Oral examinations, X-rays, tests and emergency exams.

Endodontics (D3000 - D3999): Treatment of the tooth pulp, e.g. root canal therapy.

Ineligible Services: These include services rendered before or after a patient's eligibility under the dental plan.

Miscellaneous (D9000 - D9999): Miscellaneous services such as palliative treatment of dental pain, anesthesia, professional consultation, bleaching, etc.

Non-Billable Procedures: Includes procedures which are not chargeable to Delta Dental or the patient. Examples include fees for completion of claim forms, infection control, and adjustments and repairs to appliances within six months of insertion. Delta Dental dentists have agreed to charge only the approved amount.

Optional Services: Services considered optional under the dental plan include crowns when a filling would suffice, fixed bridgework where a partial denture would be adequate, implants (an optional benefit is paid for a crown or partial, depending on the number of implants placed), or composite resin restorations on posterior teeth (an optional benefit is paid for the corresponding amalgam).

Oral Surgery (D7000 - D7999): Extractions and certain other surgical procedures, including pre- and post-operative care.

Orthodontics (D8000 - 8999): Use of appliances to treat poor alignment of teeth and/or jaws which interferes with their function.

DELTA DENTAL INSURANCE COMPANY GLOSSARY FOR STANDARD REPORTS

Periodontics (D4000 - D4999): Treatment of gums and bones supporting the teeth.

Preventive (D1000 - D1999): Prophylaxis treatments, fluoride treatments, space maintainers and sealants.

Primary Enrollees: The number of eligible enrollees, including adjustments for retroactivity.

Prosthodontics/Fixed (D6000 - D6999): Construction, adjustments and repairs to fixed dentures.

Prosthodontics/Removable (D5000 - D5999): Construction, adjustments and repairs to removable dentures and maxillofacial prosthetics.

Reduction to Fees (Delta Dental PPO/Premier): Delta Dental's contractual agreements with Delta Dental dentists allow us to control the actual fees charged to Delta Dental and the patient. Delta Dental dentists agree to accept Delta Dental's determination of maximum plan allowance charges and not charge the patient over the amount Delta Dental indicates as the patient's responsibility.

Restorative (D2000 - D2499): Amalgam, synthetic porcelain, plastic fillings, and prefabricated stainless steel restoration for treatment of carious lesions.

Submitted: The total claims amount reported as charged on submitted claims.

Total Network Savings: The savings, expressed as a percentage of the amount submitted, provided to the group due to Delta Dental's agreements with Delta Dental dentists. This would include containment provided under the "Non-Billable Procedures" (PPO and Premier) and the difference between the amount approved and submitted for the "Reduction to Fees" (PPO and Premier). There is no balance billing to the patient associated with these savings.

Total Expenses: The sum of the amount paid for claims and administration for ASC clients.

**DELTA DENTAL INSURANCE COMPANY
DENTAL PLAN EXPERIENCE REPORT**

Prepared for:

CITY OF HALLANDALE
Group Number: 10-03589-
January 30, 2012



**DELTA DENTAL INSURANCE COMPANY
INCOME COST EXPERIENCE REPORT**

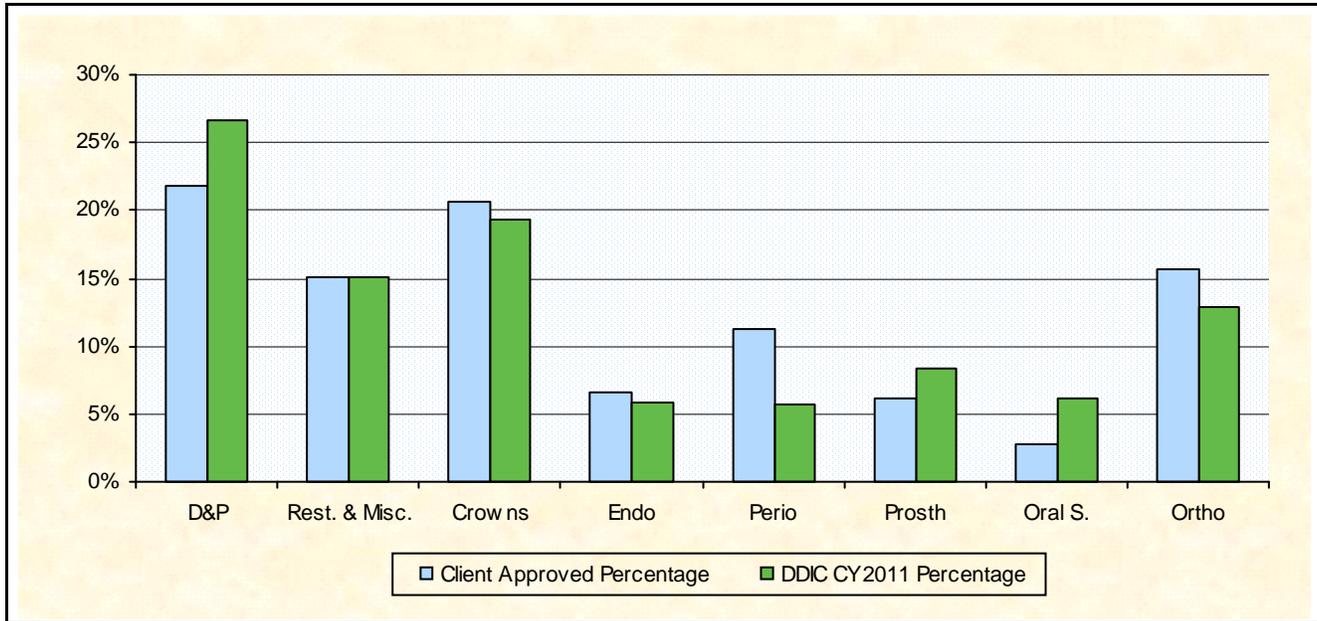
**CITY OF HALLANDALE
Group Number: 10-03589-
1/11 - 12/11**

Date	Primary Enrollees	Premium*	Administration	\$ Claims Paid	# Claims Paid
1/11	149	\$12,249.18	\$2,091.02	\$9,288.20	54
2/11	148	12,862.14	2,195.66	10,391.60	56
3/11+	146	12,026.67	2,053.04	8,199.00	62
4/11	146	12,463.30	2,127.58	5,769.40	58
5/11	145	12,601.84	2,151.22	9,411.50	63
6/11+	143	12,555.66	2,143.34	8,563.25	57
7/11	143	11,485.11	1,960.55	8,741.30	56
8/11+	142	12,015.49	2,051.12	8,155.10	51
9/11	143	12,238.00	2,089.10	8,723.90	48
10/11	149	12,277.19	2,095.79	7,091.10	54
11/11+	148	13,074.87	2,231.95	8,133.00	61
12/11	148	11,542.47	1,970.35	4,853.35	55
Totals	1,750	\$147,391.92	\$25,160.72	\$97,320.70	675

**Premium is based on cash receipts plus receivables by month of accrual.
+Indicates more than twenty claims processing days in the month.*

**DELTA DENTAL INSURANCE COMPANY
PAYMENT BY PROCEDURE CLASSIFICATION REPORT**

**CITY OF HALLANDALE
Group Number: 10-03589-
All Dentists
1/11 - 12/11**

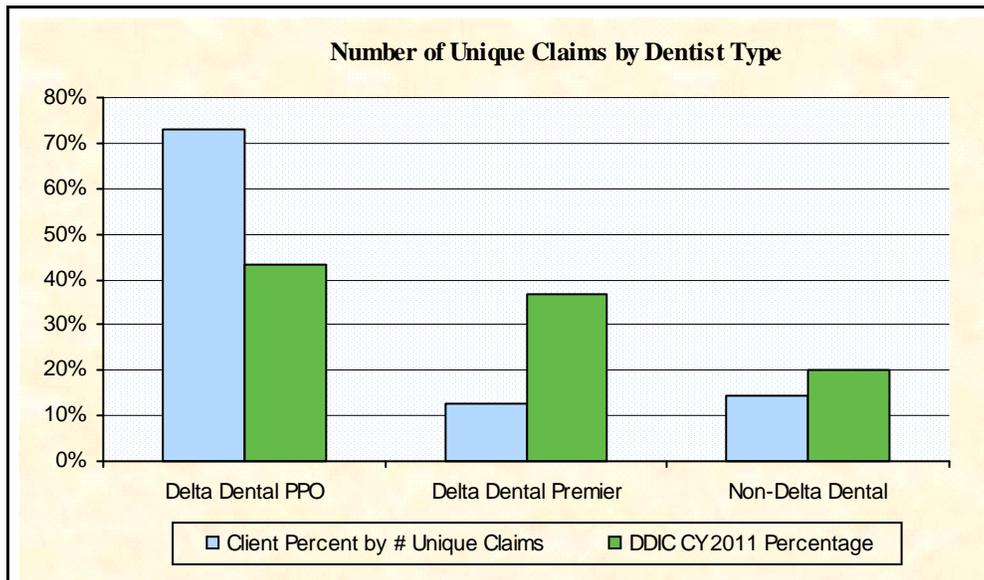


Dental Category	Amount Approved	\$ Claims Paid	# of Procedures	Approved Percentage	DDIC CY2011
Diagnostic	23,600.00	18,397.00	625	11.69%	14.42%
Preventive	20,429.00	15,929.00	405	10.12%	12.22%
Restorative	25,384.00	12,988.00	192	12.58%	12.67%
Crowns/Inlays	41,574.00	19,178.10	98	20.60%	19.37%
Endodontics	13,267.00	7,126.40	23	6.57%	5.91%
Periodontics	22,841.00	8,188.60	156	11.32%	5.66%
Prosthodontics/Removable	747.00	435.40	2	0.37%	2.09%
Prosthodontics/Fixed	11,638.00	4,538.10	15	5.77%	6.27%
Oral Surgery	5,628.00	2,933.20	29	2.79%	6.14%
Orthodontics	31,595.50	6,999.50	59	15.65%	12.85%
Miscellaneous	5,137.00	607.40	65	2.55%	2.40%
Total	\$201,840.50	\$97,320.70	1,669	100.00%	100.00%

DELTA DENTAL INSURANCE COMPANY NETWORK UTILIZATION REPORT

CITY OF HALLANDALE
Group Number: 10-03589-
1/11 - 12/11

Paid Claims for Period By Dentist Type	\$ Claims Paid	Percent by \$ Claims Paid	# Unique Claims	Percent by # Unique Claims	DDIC CY2011 Percent
Delta Dental PPO	\$71,166.90	73.1%	494	73.2%	43.3%
Delta Dental Premier®	\$14,407.80	14.8%	85	12.6%	36.6%
Non-Delta Dental	\$11,746.00	12.1%	96	14.2%	20.1%
Total	\$97,320.70	100.0%	675	100.0%	100.0%





**DELTA DENTAL INSURANCE COMPANY
BENEFIT COST SAVINGS REPORT**

**CITY OF HALLANDALE
Group Number: 10-03589-
1/11 - 12/11**

	Submitted	Savings
<u>CLAIMS BY DENTIST TYPE</u>		
Delta Dental PPO	205,560.50	106,926.70
Delta Dental Premier®	39,307.00	20,894.20
Non-Delta Dental	34,881.50	17,445.10
Total Claim Amounts for Period	\$279,749.00	\$145,266.00
<u>MAIN CONTAINMENT CATEGORIES</u>		
Optional Services	20,488.00	10,073.00
Ineligible Services	2,296.00	2,296.00
Contract Limitations	67,457.50	57,941.50
Non-Billable\Reduction to Fees: PPO	137,133.50	52,078.00
Non-Billable\Reduction to Fees: Premier	18,488.00	2,118.00
Non-Billable\Reduction to Fees: Non-Delta	19,737.00	5,501.50
<u>COB CONTAINMENT</u>		
Delta Payable	Delta Paid	COB Containment
\$165.00	\$0.00	\$165.00
		Total Delta Paid
		\$97,320.70
Total Network Savings to Amount Submitted		19.37% or \$54,196.00



**DELTA DENTAL INSURANCE COMPANY
DELTA DENTAL PREMIER® FEE SAVINGS REPORT**

**CITY OF HALLANDALE
Group Number: 10-03589-
1/11 - 12/11**

Dental Category	Submitted Amount for Premier Dentists	Approved Amount for Premier Dentists	Estimated Premier Fee Savings*
Diagnostic	4,159.00	3,336.00	19.79%
Preventive	3,605.00	3,453.00	4.22%
Restorative	5,919.00	5,546.00	6.30%
Crowns/Inlays	12,354.00	9,900.00	19.86%
Endodontics	1,100.00	850.00	22.73%
Periodontics	11,716.00	9,425.00	19.55%
Prosthodontics/Removable	86.00	75.00	12.79%
Prosthodontics/Fixed	0.00	0.00	-
Oral Surgery	166.00	166.00	0.00%
Orthodontics	0.00	0.00	-
Miscellaneous	202.00	202.00	0.00%
Total	\$39,307.00	\$32,953.00	16.17%

Note: Some Delta Dental dentists submit fees at or close to their contracted fee amounts. The actual Delta Dental savings is higher than shown above.

* This report includes savings from contractual agreements with Delta Dental Premier dentists and does not include savings from the contractual agreement with the client.



**DELTA DENTAL INSURANCE COMPANY
DELTA DENTAL PPO FEE SAVINGS REPORT**

**CITY OF HALLANDALE
Group Number: 10-03589-
1/11 - 12/11**

Dental Category	Submitted Amount for PPO Dentists	Approved Amount for PPO Dentists	Estimated PPO Fee Savings*
Diagnostic	28,096.00	16,248.00	42.17%
Preventive	19,617.00	14,701.00	25.06%
Restorative	29,652.00	17,683.00	40.36%
Crowns/Inlays	32,468.00	25,277.00	22.15%
Endodontics	9,178.00	7,152.00	22.07%
Periodontics	18,605.00	12,685.00	31.82%
Prosthodontics/Removable	672.00	672.00	0.00%
Prosthodontics/Fixed	12,384.00	11,508.00	7.07%
Oral Surgery	3,171.00	2,967.00	6.43%
Orthodontics	46,631.50	25,190.50	45.98%
Miscellaneous	5,086.00	3,555.00	30.10%
Total	\$205,560.50	\$137,638.50	33.04%

Note: Some Delta Dental dentists submit fees at or close to their contracted fee amounts. The actual Delta Dental savings is higher than shown above.

* This report includes savings from contractual agreements with Delta Dental PPO dentists and does not include savings from the contractual agreement with the client.

DELTA DENTAL INSURANCE COMPANY GLOSSARY FOR STANDARD REPORTS

\$ Claims Paid: The amount of benefit paid by Delta Dental.

Claims Paid: The number of times claims were processed. (An individual claim will be counted every time it is processed/adjusted.)

of Procedures: The number of dental procedures included in the claims processed.

Unique Claims: The number of individual claims submitted for processing.

Administration: The fee charged for managing the benefit plan and processing the claims.

Approved: The amount the dentist is permitted to charge for each individual procedure. For Delta Dental dentists, the amount approved is equal to the lesser of the amount submitted or the appropriate maximum plan allowance. For non-Delta Dental dentists, the amount approved is equal to the amount submitted unless further documentation is required (e.g., x-rays).

Approved Percentage: The percent of total amount approved by dental category.

COB Containment: Delta tracks patients who are subject to coordination of benefits. If Delta Dental is the secondary carrier, savings are realized by coordinating benefits with the primary carrier.

Delta Payable is the amount that Delta would have paid in absence of another carrier.

Delta Paid is the amount that Delta paid after reducing the benefit by the payment of the other carrier.

Change in Reserve: Adjustment to claims paid to account for claims incurred during the report time period.

Savings: The amount submitted minus the amount allowed equals the amount contained. This represents savings on the face value of the claims submitted before coinsurance and deductibles are applied.

Contract Limitations: Savings resulting from contractual agreement with the client. This would include time limitations, non-covered services and consultant review. A partial benefit may be possible for an alternative service.

Crowns/Inlays (D2500 - D2999): Crowns, jackets and cast restorations for treatment of carious lesions.

DDIC CY2011: The Approved percentage by dental category for DDIC's total book of business for the previous year.

DDIC CY2011 Percent: The percent of number of claims by dentist type for DDIC's total book of business for the previous year.

Diagnostic (D0100 - D0999): Oral examinations, X-rays, tests and emergency exams.

Endodontics (D3000 - D3999): Treatment of the tooth pulp, e.g. root canal therapy.

Ineligible Services: These include services rendered before or after a patient's eligibility under the dental plan.

Miscellaneous (D9000 - D9999): Miscellaneous services such as palliative treatment of dental pain, anesthesia, professional consultation, bleaching, etc.

Non-Billable Procedures: Includes procedures which are not chargeable to Delta Dental or the patient. Examples include fees for completion of claim forms, infection control, and adjustments and repairs to appliances within six months of insertion. Delta Dental dentists have agreed to charge only the approved amount.

Optional Services: Services considered optional under the dental plan include crowns when a filling would suffice, fixed bridgework where a partial denture would be adequate, implants (an optional benefit is paid for a crown or partial, depending on the number of implants placed), or composite resin restorations on posterior teeth (an optional benefit is paid for the corresponding amalgam).

Oral Surgery (D7000 - D7999): Extractions and certain other surgical procedures, including pre- and post-operative care.

Orthodontics (D8000 - 8999): Use of appliances to treat poor alignment of teeth and/or jaws which interferes with their function.

DELTA DENTAL INSURANCE COMPANY GLOSSARY FOR STANDARD REPORTS

Periodontics (D4000 - D4999): Treatment of gums and bones supporting the teeth.

Preventive (D1000 - D1999): Prophylaxis treatments, fluoride treatments, space maintainers and sealants.

Primary Enrollees: The number of eligible enrollees, including adjustments for retroactivity.

Prosthodontics/Fixed (D6000 - D6999): Construction, adjustments and repairs to fixed dentures.

Prosthodontics/Removable (D5000 - D5999): Construction, adjustments and repairs to removable dentures and maxillofacial prosthetics.

Reduction to Fees (Delta Dental PPO/Premier): Delta Dental's contractual agreements with Delta Dental dentists allow us to control the actual fees charged to Delta Dental and the patient. Delta Dental dentists agree to accept Delta Dental's determination of maximum plan allowance charges and not charge the patient over the amount Delta Dental indicates as the patient's responsibility.

Restorative (D2000 - D2499): Amalgam, synthetic porcelain, plastic fillings, and prefabricated stainless steel restoration for treatment of carious lesions.

Submitted: The total claims amount reported as charged on submitted claims.

Total Network Savings: The savings, expressed as a percentage of the amount submitted, provided to the group due to Delta Dental's agreements with Delta Dental dentists. This would include containment provided under the "Non-Billable Procedures" (PPO and Premier) and the difference between the amount approved and submitted for the "Reduction to Fees" (PPO and Premier). There is no balance billing to the patient associated with these savings.

Total Expenses: The sum of the amount paid for claims and administration for ASC clients.

**DELTA DENTAL INSURANCE COMPANY
DENTAL PLAN EXPERIENCE REPORT**

Prepared for:

CITY OF HALLANDALE
Group Number: 10-03589-
January 28, 2011

**DELTA DENTAL INSURANCE COMPANY
INCOME COST EXPERIENCE REPORT**

**CITY OF HALLANDALE
Group Number: 10-03589-
1/10 - 12/10**

Date	Primary Enrollees	Premium	\$ Claims Paid	# Claims Paid
1/10	145	\$12,190.42	\$10,655.00	78
2/10	143	12,711.01	11,095.20	59
3/10+	145	12,895.73	10,588.50	56
4/10	143	12,414.37	9,915.65	56
5/10	143	11,819.59	7,224.15	53
6/10+	143	12,531.89	7,103.30	50
7/10	143	12,531.89	4,589.45	42
8/10	142	12,400.00	8,391.90	60
9/10+	142	12,271.59	14,865.50	69
10/10	151	11,927.32	8,136.80	38
11/10	152	14,008.28	7,217.20	55
12/10+	151	12,986.70	10,735.05	73
Totals	1,743	\$150,688.79	\$110,517.70	689

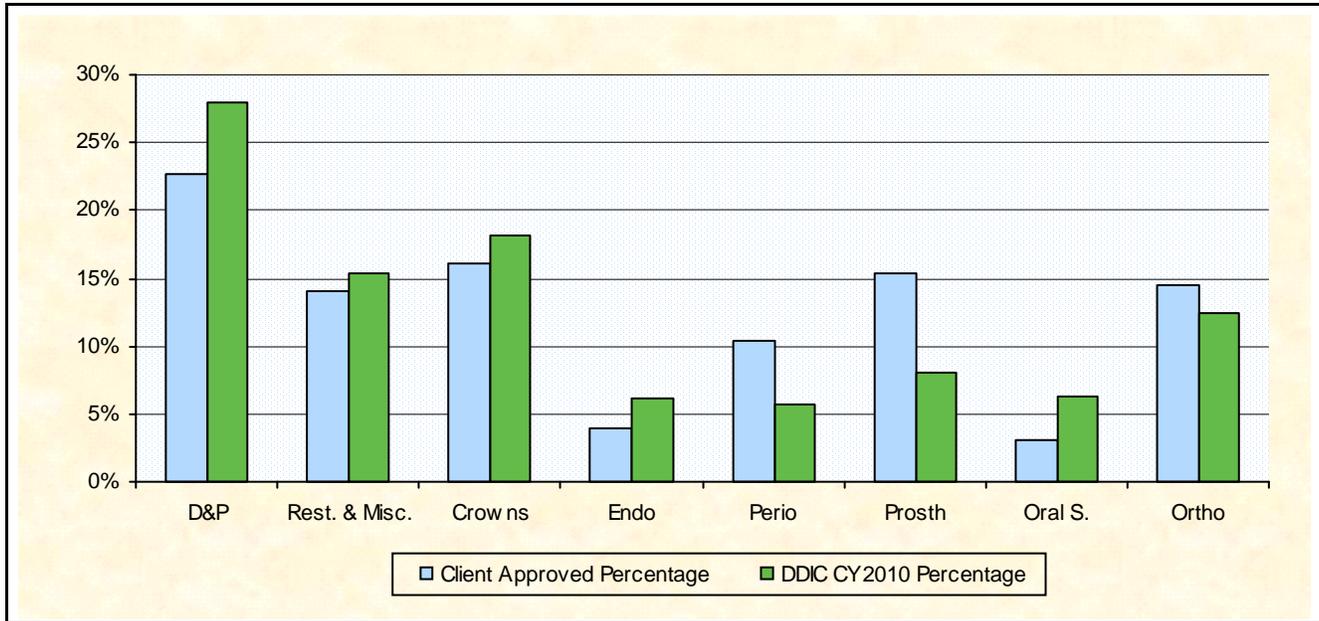
SUMMARY OF EXPERIENCE

	\$ Experience	Ratio%
Premium (a)	\$150,688.79	100.00%
Incurred Dental Expenses (b) <small>Claims Paid + Change in Reserve</small>	\$109,617.70	72.74%
Administration (c)	\$25,722.16	17.07%
Stabilization (a-b-c)	\$15,348.93	10.19%

+Indicates more than twenty claims processing days in the month.

**DELTA DENTAL INSURANCE COMPANY
PAYMENT BY PROCEDURE CLASSIFICATION REPORT**

**CITY OF HALLANDALE
Group Number: 10-03589-
All Dentists
1/10 - 12/10**

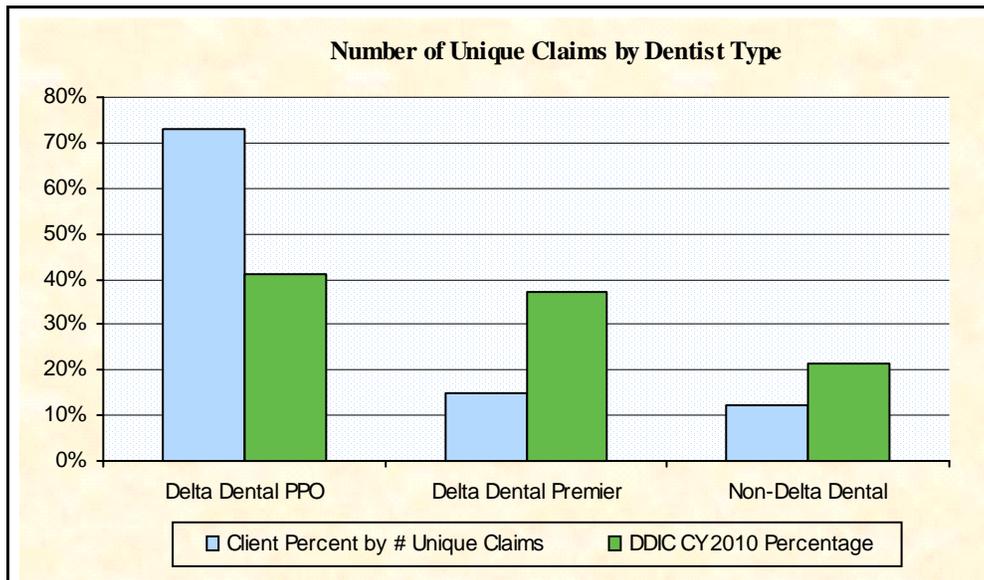


Dental Category	Amount Approved	\$ Claims Paid	# of Procedures	Approved Percentage	DDIC CY2010
Diagnostic	29,791.00	22,006.00	787	12.83%	15.07%
Preventive	22,889.00	17,025.90	455	9.85%	12.88%
Restorative	28,665.00	13,265.20	210	12.34%	12.95%
Crowns/Inlays	37,358.00	18,771.10	88	16.08%	18.13%
Endodontics	9,178.00	5,611.20	19	3.95%	6.10%
Periodontics	24,051.00	10,448.30	160	10.36%	5.72%
Prosthodontics/Removable	4,208.00	2,371.40	7	1.81%	2.26%
Prosthodontics/Fixed	31,459.00	11,898.80	52	13.54%	5.72%
Oral Surgery	7,096.00	4,883.20	33	3.06%	6.23%
Orthodontics	33,749.00	3,494.00	42	14.53%	12.51%
Miscellaneous	3,819.00	742.60	81	1.64%	2.42%
Total	\$232,263.00	\$110,517.70	1,934	100.00%	100.00%

DELTA DENTAL INSURANCE COMPANY NETWORK UTILIZATION REPORT

CITY OF HALLANDALE
Group Number: 10-03589-
1/10 - 12/10

Paid Claims for Period By Dentist Type	\$ Claims Paid	Percent by \$ Claims Paid	# Unique Claims	Percent by # Unique Claims	DDIC CY2010 Percent
Delta Dental PPO	\$75,339.50	68.2%	502	73.1%	41.3%
Delta Dental Premier®	\$19,477.60	17.6%	101	14.7%	37.3%
Non-Delta Dental	\$15,700.60	14.2%	84	12.2%	21.4%
Total	\$110,517.70	100.0%	687	100.0%	100.0%





**DELTA DENTAL INSURANCE COMPANY
BENEFIT COST SAVINGS REPORT**

**CITY OF HALLANDALE
Group Number: 10-03589-
1/10 - 12/10**

	Submitted	Savings	
<u>CLAIMS BY DENTIST TYPE</u>			
Delta Dental PPO	206,119.00	96,607.40	
Delta Dental Premier®	38,930.00	14,833.60	
Non-Delta Dental	72,629.00	48,017.00	
Total Claim Amounts for Period	\$317,678.00	\$159,458.00	
<u>MAIN CONTAINMENT CATEGORIES</u>			
Optional Services	30,953.00	18,341.40	
Ineligible Services	3,289.00	3,289.00	
Contract Limitations	84,510.50	66,280.60	
Non-Billable\Reduction to Fees: PPO	120,683.85	31,974.00	
Non-Billable\Reduction to Fees: Premier	22,099.00	4,037.00	
Non-Billable\Reduction to Fees: Non-Delta	25,486.00	8,344.00	
<u>COB CONTAINMENT</u>			
Delta Payable	Delta Paid	COB Containment	Total Delta Paid
\$1,059.20	\$515.50	\$543.70	\$110,517.70
Total Network Savings to Amount Submitted		11.34% or	\$36,011.00



**DELTA DENTAL INSURANCE COMPANY
DELTA DENTAL PPO FEE SAVINGS REPORT**

**CITY OF HALLANDALE
Group Number: 10-03589-
1/10 - 12/10**

Dental Category	Submitted Amount for PPO Dentists	Approved Amount for PPO Dentists	Estimated PPO Fee Savings*
Diagnostic	31,954.00	18,829.00	41.07%
Preventive	20,713.00	15,161.00	26.80%
Restorative	21,835.00	13,120.00	39.91%
Crowns/Inlays	42,342.00	25,736.00	39.22%
Endodontics	9,207.00	7,719.00	16.16%
Periodontics	24,120.00	18,437.00	23.56%
Prosthodontics/Removable	3,555.00	2,133.00	40.00%
Prosthodontics/Fixed	27,010.00	19,788.00	26.74%
Oral Surgery	7,406.00	4,646.00	37.27%
Orthodontics	13,506.00	10,106.00	25.17%
Miscellaneous	4,471.00	2,879.00	35.61%
Total	\$206,119.00	\$138,554.00	32.78%

Note: Some Delta Dental dentists submit fees at or close to their contracted fee amounts. The actual Delta Dental savings is higher than shown above.

* This report includes savings from contractual agreements with Delta Dental PPO dentists and does not include savings from the contractual agreement with the client.



DELTA DENTAL INSURANCE COMPANY
DELTA DENTAL PREMIER® FEE SAVINGS REPORT

CITY OF HALLANDALE
Group Number: 10-03589-
1/10 - 12/10

Dental Category	Submitted Amount for Premier Dentists	Approved Amount for Premier Dentists	Estimated Premier Fee Savings*
Diagnostic	7,555.00	5,689.00	24.70%
Preventive	5,401.00	4,963.00	8.11%
Restorative	8,109.00	7,142.00	11.93%
Crowns/Inlays	2,320.00	2,149.00	7.37%
Endodontics	0.00	0.00	-
Periodontics	785.00	785.00	0.00%
Prosthodontics/Removable	2,405.00	2,075.00	13.72%
Prosthodontics/Fixed	9,476.00	8,176.00	13.72%
Oral Surgery	2,433.00	1,070.00	56.02%
Orthodontics	0.00	0.00	-
Miscellaneous	446.00	240.00	46.19%
Total	\$38,930.00	\$32,289.00	17.06%

Note: Some Delta Dental dentists submit fees at or close to their contracted fee amounts. The actual Delta Dental savings is higher than shown above.

* This report includes savings from contractual agreements with Delta Dental Premier dentists and does not include savings from the contractual agreement with the client.

DELTA DENTAL INSURANCE COMPANY GLOSSARY FOR STANDARD REPORTS

\$ Claims Paid: The amount of benefit paid by Delta Dental.

Claims Paid: The number of times claims were processed. (An individual claim will be counted every time it is processed/adjusted.)

of Procedures: The number of dental procedures included in the claims processed.

Unique Claims: The number of individual claims submitted for processing.

Administration: The fee charged for managing the benefit plan and processing the claims.

Approved: The amount the dentist is permitted to charge for each individual procedure. For Delta Dental dentists, the amount approved is equal to the lesser of the amount submitted or the appropriate maximum plan allowance. For non-Delta Dental dentists, the amount approved is equal to the amount submitted unless further documentation is required (e.g., x-rays).

Approved Percentage: The percent of total amount approved by dental category.

COB Containment: Delta tracks patients who are subject to coordination of benefits. If Delta Dental is the secondary carrier, savings are realized by coordinating benefits with the primary carrier.

Delta Payable is the amount that Delta would have paid in absence of another carrier.

Delta Paid is the amount that Delta paid after reducing the benefit by the payment of the other carrier.

Change in Reserve: Adjustment to claims paid to account for claims incurred during the report time period.

Savings: The amount submitted minus the amount allowed equals the amount contained. This represents savings on the face value of the claims submitted before coinsurance and deductibles are applied.

Contract Limitations: Savings resulting from contractual agreement with the client. This would include time limitations, non-covered services and consultant review. A partial benefit may be possible for an alternative service.

Crowns/Inlays (D2500 - D2999): Crowns, jackets and cast restorations for treatment of carious lesions.

DDIC CY2009: The Approved percentage by dental category for DDIC's total book of business for the previous year.

DDIC CY2009 Percent: The percent of number of claims by dentist type for DDIC's total book of business for the previous year.

Diagnostic (D0100 - D0999): Oral examinations, X-rays, tests and emergency exams.

Endodontics (D3000 - D3999): Treatment of the tooth pulp, e.g. root canal therapy.

Ineligible Services: These include services rendered before or after a patient's eligibility under the dental plan.

Miscellaneous (D9000 - D9999): Miscellaneous services such as palliative treatment of dental pain, anesthesia, professional consultation, bleaching, etc.

Non-Billable Procedures: Includes procedures which are not chargeable to Delta Dental or the patient. Examples include fees for completion of claim forms, infection control, and adjustments and repairs to appliances within six months of insertion. Delta Dental dentists have agreed to charge only the approved amount.

Optional Services: Services considered optional under the dental plan include crowns when a filling would suffice, fixed bridgework where a partial denture would be adequate, implants (an optional benefit is paid for a crown or partial, depending on the number of implants placed), or composite resin restorations on posterior teeth (an optional benefit is paid for the corresponding amalgam).

Oral Surgery (D7000 - D7999): Extractions and certain other surgical procedures, including pre- and post-operative care.

Orthodontics (D8000 - 8999): Use of appliances to treat poor alignment of teeth and/or jaws which interferes with their function.

DELTA DENTAL INSURANCE COMPANY GLOSSARY FOR STANDARD REPORTS

Periodontics (D4000 - D4999): Treatment of gums and bones supporting the teeth.

Preventive (D1000 - D1999): Prophylaxis treatments, fluoride treatments, space maintainers and sealants.

Primary Enrollees: The number of eligible enrollees, including adjustments for retroactivity.

Prosthodontics/Fixed (D6000 - D6999): Construction, adjustments and repairs to fixed dentures.

Prosthodontics/Removable (D5000 - D5999): Construction, adjustments and repairs to removable dentures and maxillofacial prosthetics.

Reduction to Fees (Delta Dental PPO/Premier): Delta Dental's contractual agreements with Delta Dental dentists allow us to control the actual fees charged to Delta Dental and the patient. Delta Dental dentists agree to accept Delta Dental's determination of maximum plan allowance charges and not charge the patient over the amount Delta Dental indicates as the patient's responsibility.

Restorative (D2000 - D2499): Amalgam, synthetic porcelain, plastic fillings, and prefabricated stainless steel restoration for treatment of carious lesions.

Submitted: The total claims amount reported as charged on submitted claims.

Total Network Savings: The savings, expressed as a percentage of the amount submitted, provided to the group due to Delta Dental's agreements with Delta Dental dentists. This would include containment provided under the "Non-Billable Procedures" (PPO and Premier) and the difference between the amount approved and submitted for the "Reduction to Fees" (PPO and Premier). There is no balance billing to the patient associated with these savings.

Total Expenses: The sum of the amount paid for claims and administration for ASC clients.

Attachment E

Group Basic Life Benefit Summary and Certificate

Term Life and AD&D Insurance

Employee Benefit Booklet



FORT DEARBORN LIFE INSURANCE COMPANY
Downers Grove, Illinois

City of Hallandale Beach
Group Number: F006642-0001
Class 1-01

09/09/2004



® FORT DEARBORN LIFE INSURANCE COMPANY
(A stock life insurance company herein called "We", "Us", "Our")
300 East Randolph, Chicago, Illinois 60601
Administrative Office:
1020 31st Street, Downers Grove, IL. 60515-5591

CERTIFICATE (FL)

FOR OUR POLICYHOLDERS AND CERTIFICATEHOLDERS

To present inquiries or obtain information about coverage and to provide assistance in resolving complaints, please call our toll free number: 1-800-633-3696.

We agree to pay benefits subject to the provisions, definitions, limitations, and conditions of the master policy. The master policy (herein called the Policy) is a contract issued by Fort Dearborn Life Insurance Company to your Employer (herein called the Policyholder). The Policy may be changed at any time by a written agreement between Fort Dearborn Life Insurance Company and the Policyholder.

This is your certificate of coverage as long as you are eligible for insurance. It is not a contract or a part of one. Your benefits are described in plain English, but a few terms and provisions are written as required by insurance law.

PLEASE READ CAREFULLY

If you have any questions, please contact the Benefits Administrator at your place of employment or write to us. We will assist you in any way we can to help you understand your benefits.

President

Secretary

Group Insurance Certificate
Non-Participating
Term Life and AD&D Insurance

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Schedule of Benefits

Definitions

Eligibility and Effective Date Provisions

Group Term Life Insurance Benefit

Conversion of Life Insurance

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Accelerated Death - Terminal Illness Benefit

Accidental Death, Dismemberment and Loss of Sight Benefit Rider, form no. FDL1-504AD-1002

Termination Provisions

General Provisions

DEFINITIONS (FL)

This section tells You the meaning of special words and phrases used in this Certificate. To help You recognize these special words and phrases, the first letter of each word, or each word in the phrase, is capitalized wherever it appears.

Accident or Accidental means a sudden, unexpected event that was not reasonably foreseeable.

Actively at Work or Active Work means that you are:

1. performing the normal duties of your occupation; and
2. working the number of hours set forth in the Application.

Application means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the Policyholder applied.

Base Annual Salary means the gross annual compensation prior to before-tax payroll deductions, if any,

1. which you earn from your occupation with the Policyholder; and
2. which was used in the calculation and remittance of premium.

It does not include Salary from overtime, bonuses or any other form of extra pay. However, if your Salary is based in whole or in part on commissions, Base Annual Salary will include the amount paid in commissions during the preceding twelve-month calendar period. Your deferred contributions to a 401K plan or salary reduction contributions to a cafeteria plan which are maintained by the Policyholder will not be deducted when calculating gross annual compensation.

Basic Weekly Wage means the gross weekly compensation prior to before-tax payroll deductions, if any,

1. which you earn from your occupation with the Policyholder; and
2. which was used in the calculation and remittance of premium.

It does not include compensation from overtime, bonuses or any other form of extra pay. However, if your compensation is based in whole or in part on commissions, Basic Weekly Wage will include the weekly average paid in commissions during the preceding twelve-month calendar period. Your deferred contributions to a 401K plan or salary reduction contributions to a cafeteria plan which are maintained by the Policyholder will not be deducted when calculating gross weekly compensation.

Base Annual Salary/Basic Weekly Wage for each Insured who is a partner means the Insured's annual/average weekly compensation from the partnership during the calendar year prior to the date of the Insured's loss, as reported on the partnership federal income tax return as the "net Salary (loss) from self-employment" for that year.

If an Insured was not a partner during the calendar year prior to the date of loss, Base Annual Salary/Basic Weekly Wage means the Insured's annual/average weekly compensation (excluding dividends, capital gains, and return of capital) from the partnership prior to the date of the Insured's loss, determined in accordance with the terms of the applicable partnership agreement. In the event of a disagreement between Us and the claimant, an adjustment will be made, if warranted, after the Insured's subsequent federal income tax return is submitted to Us.

No benefits are payable when any of the above calculations result in an amount less than zero.

Base Annual Salary/Basic Weekly Wage for each Insured who is a sole proprietor or shareholder in a Subchapter S corporation or a member in a limited liability company means the Insured's annual/average weekly net taxable income (excluding dividends, capital gains, and return of capital) derived from the Policyholder for the calendar year prior to the date of the Insured's loss, as reported on his federal income tax return. The Insured's annual/average weekly net taxable income equals A minus B, where:

A = The Insured's annual/average weekly taxable income derived from the Policyholder for the prior calendar year (excluding dividends, capital gains, and return of capital), as reported on the Insured's federal income tax return; and

B = The Insured's annual/average weekly deductible work expenses attributable to his work for the Policyholder during the prior calendar year, as reported on the Insured's federal income tax return.

If an Insured was not a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company during the calendar year prior to the date of the Insured's loss, Base Annual Salary/Basic Weekly Wage means an Insured's annual/average weekly net taxable income derived from the Policyholder for the period he was a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company prior to the date of the Insured's loss. The Insured's annual/average weekly net taxable income will be based on the taxable income derived from the Policyholder for the period of the Insured's work as a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company for You, taking into account his deductible work expenses attributable to his work for the Policyholder during the same period.

No benefits are payable when any of the above calculations result in an amount less than zero.

Contributory means you pay a portion of the premium for this insurance coverage.

Employee means an Actively at Work full-time employee whose principal employment is with the Employer, at the Employer's usual place of business or such place(s) that the Employer's normal course of business may require, who is Actively at Work for the minimum hours per week as stated in the Application and is reported on the Employer's records for Social Security and withholding tax purposes.

Injury means bodily injury resulting directly from an Accident and independently of all other causes.

Insured means an Employee covered under the Policy.

Male Pronoun whenever used includes the female.

Noncontributory means the Policyholder pays 100% of the premium for this insurance.

Policy means the contract between the Policyholder and Us including the attached Application, which provides group insurance benefits.

Policyholder means the person, firm, or institution named in the Policy, including any covered subsidiaries or affiliates named in the Policy. If the Policyholder is a trust or association, the term Participating Employer shall be substituted for Policyholder.

Proof under the Accelerated Death Benefit means evidence satisfactory to Us that you are Terminally Ill. We reserve the right to determine, at our sole discretion, if Proof is acceptable.

Terminally Ill under the Accelerated Death Benefit means you have a life expectancy of 12 months or less, due to a medical condition.

Total Disability or Totally Disabled under the Waiver of Premium provision means you are completely unable to engage in any occupation for wage or profit because of Sickness or Injury.

You or Your means the Employee to whom this Certificate has been delivered.

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS (FL)

ELIGIBILITY

All Employees who belong to an eligible class and work the minimum number of hours as set forth in the Application are eligible for group insurance. An Employee must be **Actively at Work** for his insurance coverage to become effective.

EMPLOYER EFFECTIVE DATE OF COVERAGE
(Noncontributory Benefits)

If you are **Actively at Work**, you will become insured for Noncontributory benefits under the Policy on the day following completion of the Employee waiting period, if any, set forth in the Application.

If you waive all or a portion of your Noncontributory coverage and choose to enroll at a later date, you are considered a late applicant and must furnish evidence of insurability satisfactory to Us before coverage can become effective. Coverage will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

EMPLOYEE EFFECTIVE DATE OF COVERAGE
(Contributory Benefits)

You may apply for Contributory insurance coverage at any time. Your coverage will become effective as follows, provided you are **Actively at Work** on that date:

1. If you sign the enrollment form on or before the end of the waiting period, if any, as stated in the Application, coverage will become effective on the day following completion of the waiting period.
2. If you sign the enrollment form after the end of the waiting period, but within 31 days after that day, coverage will become effective the date you sign the enrollment form.
3. If you sign the enrollment form following this 31-day period, you are considered a late applicant and must furnish evidence of insurability satisfactory to Us before coverage can become effective. Coverage will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

DEFERRED EFFECTIVE DATE

You must be **Actively at Work** on the date your initial coverage or any increases in coverage are scheduled to begin. If:

1. you are absent from Active Work on the date such coverage would otherwise become effective; and
2. your absence is caused by an injury, illness or layoff,

the effective date of any initial coverage or increased coverage will be deferred until the first day you return to Active Work. You will be considered **Actively at Work** if you were actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled work days);
2. a holiday (except when such holiday is a scheduled work day);
3. a paid vacation;
4. any nonscheduled work day.

EFFECTIVE DATE IF WE REQUIRE EVIDENCE OF INSURABILITY

If you are required to submit evidence of insurability satisfactory to Fort Dearborn Life Insurance Company, insurance in the amount for which We require such evidence will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

EFFECTIVE DATE OF CHANGE IN AMOUNT OF BENEFITS

Any change in the amount of your benefits caused by a change in class, change in salary, age reduction or amendment to the Policy will become effective on the effective date of the change. If the change results in an increase in the amount of insurance, you must be Actively at Work on that date. If you are not Actively at Work, the increase will take effect on the day you are again Actively at Work.

ELIGIBILITY AFTER TERMINATION OF EMPLOYMENT

If your coverage ends due to termination of employment you must meet all the requirements of a new Employee if you are rehired at a later date.

GROUP TERM LIFE INSURANCE BENEFIT (FL)

BENEFIT

We will pay your beneficiary the amount of life insurance in force as of the date of your death provided:

1. you are insured under the Policy on the date of death, and
2. We receive proof of death.

The amount of insurance payable is based upon the Policyholder's Application, and it is set forth on the Schedule of Benefits.

BENEFICIARY

Your beneficiary designation must be made on a form which We provide or on a form accepted by Us. If you name two or more beneficiaries, payment of proceeds will be apportioned equally unless you had specified otherwise. The Policyholder may not be named as beneficiary.

Unless you provided otherwise, if a beneficiary dies before you, We will divide that beneficiary's share equally between any remaining named beneficiaries.

If no named beneficiary survives you or if you did not designate a beneficiary, We will pay the amount of insurance:

1. to your spouse, if living; if not,
2. in equal shares to your then living natural or adopted children, if any; if none,
3. in equal shares to your father and mother, if living; if not,
4. to your estate.

If a beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, We will not make payment until a claim is made by the person or entity which, by court order, has been granted control of the estate of such beneficiary. This provision does not prevent Us from making payment to or for the benefit of a minor beneficiary in accordance with the applicable state law.

If any benefits under this provision are to be paid to your estate, We may pay an amount not greater than \$5,000 to any person We consider to be equitably entitled by reason of having incurred funeral or other expenses incident to your death. Any and all payments made by Us shall fully discharge Us in the amount of such payment.

CHANGE OF BENEFICIARY

You may change your beneficiary at any time by completing a change request form, or a form accepted by Us, and sending it to the Policyholder. Your written request for change of beneficiary will not be effective until it is recorded by the Policyholder. After it has been so recorded, it will take effect on the later of the date you signed the change request form or the date you specifically requested. If you die before the change has been recorded, We will not alter any payment that We have already made. Any prior payment shall fully discharge Us from further liability in that amount.

CONVERSION OF LIFE INSURANCE

Conversion if Eligibility Terminates:

You may convert to an individual policy of life insurance if your life insurance, or a portion of it, ceases because:

1. you are no longer employed by the Policyholder; or
2. you are no longer in a class which is eligible for life insurance.

In either of these situations, you may convert all or any portion of your life insurance which was in force at the date of termination.

Conversion if Policy is Terminated or Amended:

You may also convert to an individual policy of life insurance if your life insurance ceases because:

1. life insurance benefits under the Policy cease; or
2. the Policy is amended making him ineligible for life insurance; however, in either of these situations,

you must have been insured under the Policy for at least five (5) years. The amount of insurance converted in either of these situations will be the lesser of:

1. the amount of life insurance in force, less any amount for which you become eligible under this or any other group policy within 31 days after the date your life insurance ceased; or
2. \$10,000.

Conditions for Conversion: (amended by form no. FDL1-23-1100)

We must receive written application and the first premium for the individual life insurance policy within 31 days after insurance under the Policy ceases. No evidence of insurability will be required. The individual policy will be a policy of whole life insurance. It will not contain disability benefits, accidental death and dismemberment benefits or any other supplemental benefits. The premium for the individual policy will be based on:

1. Our current rates based upon your attained age on your nearest birthday; and
2. on the amount of the individual policy.

If application is made for an individual policy, the coverage under the individual policy will be effective on the day following the 31-day period during which you could apply for conversion. If you die during a period when you would have been entitled to have an individual policy issued to you and if you die before such an individual policy becomes effective, We will pay your beneficiary the greatest amount of group term life insurance for which an individual policy could have been issued, provided:

1. your death occurred during the 31-day period within which you could have made application; and
2. We receive proof of death.

If life insurance benefits are paid under the Policy, payment will not be made under the converted policy, and premiums paid for the converted policy will be refunded.

WAIVER OF PREMIUM

We will continue your life insurance benefit under the Policy without the further payment of life insurance premium if you become Totally Disabled, provided:

1. you are insured under the Policy and are Actively at Work on or after the effective date of the Policy; and
2. you are under the age of 60; and
3. you provide Us with satisfactory written proof of Total Disability within 12 months after the date you became Totally Disabled; and
4. your Total Disability has continued without interruption for at least 6 months; and
5. you are still Totally Disabled when you submit the proof of disability; and
6. all required premium has been paid.

The premium will be waived from the date We receive satisfactory written proof of Total Disability. Premium will continue to be waived provided you:

1. remain Totally Disabled; and
2. provide satisfactory written proof of continuing Total Disability upon request. You are responsible for obtaining initial and continuing proof of disability.

You will be covered for the amount of life insurance in force as of the date Total Disability commenced. The amount of life insurance continued in force will be subject to any reduction in benefits as a result of age or amendment to the Policy. This life insurance coverage will continue without the payment of premium until you are no longer Totally Disabled or reach age 65, whichever occurs first.

We may have you examined at reasonable intervals during the period of claimed Total Disability. Continuation of life insurance under the Waiver of Premium provision shall end immediately and without notice if you refuse to be examined as and when required.

We will pay the amount of life insurance in force to your beneficiary if you die before furnishing satisfactory proof of Total Disability, provided:

1. you die within one year from the date you became Totally Disabled; and
2. We receive proof that you were continuously Totally Disabled until the date of death; and
3. We receive proof of death.

If continuation of life insurance under the Waiver of Premium provision ceases, and you are employed by the Policyholder, your life insurance will continue provided premium payments begin on the next premium due date.

If continuation of life insurance under the Waiver of Premium provision ceases, and you are no longer employed by the Policyholder, you may apply for an individual life insurance policy in accordance with the Conversion of Life Insurance provision of the Policy.

ACCELERATED DEATH - TERMINAL ILLNESS BENEFIT

The benefit paid under this provision may be taxable. If so, an Insured or his beneficiary may incur a tax obligation. As with all tax matters, the Insured or his beneficiary should consult a personal tax advisor to assess the impact of the benefit. Receipt of this benefit may adversely affect the Insured's eligibility for Medicaid or other governmental benefits or entitlements.

ELIGIBILITY

This benefit only applies to Insureds with life insurance benefit amounts of \$15,000 or more.

Coverage under the Accelerated Death - Terminal Illness Benefit is subject to the Deferred Effective Date provision. An Insured must be Actively at Work on the date his coverage under this benefit becomes effective. If he is not Actively at Work, the effective date of this coverage will be deferred until the first day he returns to Active Work.

BENEFIT

The benefit is 50% of the Insured's group term life insurance amount in force on the date that We receive Proof that he is Terminally Ill. This sum is limited to a maximum of \$150,000 and a minimum of \$7,500 and is payable only once to any one Insured.

If the Insured's group term life insurance will reduce, due to age, within 12 months after the date We receive Proof, the benefit will be 50% of the reduced group term life insurance benefit.

This benefit does not apply to Accidental Death and Dismemberment benefits.

BENEFIT PAYMENT

We will pay the benefit during the lifetime of an Insured who is Terminally Ill if he or his legal representative elects the Benefit and provides satisfactory Proof. The benefit will be paid in one sum to the Insured.

EXCEPTIONS

The benefit will not be payable:

1. for any amount of group term life insurance which is less than \$15,000; or
2. if the Insured becomes Terminally Ill as a result of:
 - a. attempted suicide, while sane or insane; or
 - b. self-inflicted injury; or
3. if the Insured's group term life insurance benefit has been assigned; or
4. if the Insured's group term life insurance benefit is payable to an irrevocable beneficiary, including notification to Us that such benefit or a portion of such benefit is to be paid to a former spouse as part of a divorce or separation agreement.

NOTICE AND PROOF OF CLAIM

The Insured must elect the benefit in writing on a form that is acceptable to Us. The Insured must furnish Proof that he is Terminally Ill, including certification by a Medical Provider.

EFFECT ON INSURANCE

The benefit is in lieu of the group term life insurance benefit that would have been paid upon the Insured's death.

When the benefit is paid:

1. the amount of group term life insurance otherwise payable upon the Insured's death will be reduced by the benefit;
2. the amount of group term life insurance which could otherwise have been converted to an individual contract will be reduced by the benefit; and
3. the premium due for group term life insurance will be calculated on the amount of such insurance remaining in force after deducting the benefit.

ACCIDENTAL DEATH, DISMEMBERMENT, AND LOSS OF SIGHT BENEFIT AMENDATORY RIDER (FL)

This Rider is made part of the Policy or Certificate to which it is attached. This Rider amends the Section entitled "Accidental Death, Dismemberment and Loss of Sight Benefit" and is subject to all the provisions of the Policy not in conflict with the provisions of this Rider.

If, while insured under this Policy, an Insured suffers an Injury in an Accident, We will pay for those Losses set forth in the subsection entitled "Table of Losses" below. The amount paid will be as stated in the Table of Losses but not more than the Principal Sum set forth in the Application. The Loss must:

1. occur within 365 days of the Accident; and
2. be the direct and sole result of the Accident; and
3. be independent of all other causes.

TABLE OF LOSSES

Principal Sum for Loss of:	One-half of the Principal Sum for Loss of:	One-Quarter the Principal Sum for Loss of:
Life	Sight of One Eye	Thumb and Index Finger of Same Hand
Both Hands	One Hand	
Both Feet	One Foot	
One Hand and One Foot	Speech or Hearing	
Speech and Hearing		
Sight of Both Eyes		
One Hand and the Sight of One Eye		
One Foot and the Sight of One Eye		

With respect to hand or foot, loss means actual and permanent severance from the body at or above the wrist or ankle joint, as applicable. With respect to eyes, speech and hearing, loss means entire and irrecoverable loss of sight, speech or hearing. With respect to thumb and index finger, loss means complete severance of entire digit at or above joints.

The total amount of AD&D benefits payable for all Losses for any Insured resulting from any one Accident will not be greater than the Principal Sum set forth in the Application.

Except as provided in a particular benefit, We will pay benefits for Loss of life to the same beneficiary(ies) named to receive life insurance benefits. Benefits for all other Losses will be paid to the Insured.

SEAT BELT BENEFIT

We will pay an additional benefit, the Seat Belt Benefit, of the lesser of the Insured's Principal Sum or \$25,000 if the Principal Sum under the AD&D Benefit is payable for Loss of the Insured's life as the result of an Accident which occurs while the Insured is driving or riding in an automobile, if:

1. the automobile is equipped with Seat Belts;
2. the Seat Belt was in actual use and properly fastened at the time of the Accident;
3. the position of the Seat Belt is certified in the official report of the Accident or by the investigating officer. A copy of the police Accident report must be submitted with the claim; and
4. the Insured was driving or riding in an automobile driven by a licensed driver who was neither:
 - a. intoxicated or driving while impaired. Intoxication and impairment shall be determined by the law of the jurisdiction in which the Accident occurs, with or without conviction; nor
 - b. under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by a licensed physician and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence.

If such certification is not available and if it is unclear whether the Insured was properly wearing a Seat Belt, then We will pay an additional benefit of \$1,000.

Seat Belt means those belts that form an occupant restraint system.

AIR BAG BENEFIT

We will pay an additional benefit, the Air Bag Benefit, equal to 5% of the Principal Sum of the AD&D Benefit if the Principal Sum under the AD&D Benefit is payable for Loss of the Insured's life as the result of an Accident which occurs while the Insured is driving or riding in an automobile provided that:

1. the Insured was positioned in a seat that was equipped with a factory-installed Air Bag;
2. the Insured was properly strapped in the Seat Belt when the Air Bag inflated; and
3. the police report establishes that the Air Bag inflated properly upon impact.

The maximum Air Bag Benefit payable is \$5,000.00. If it is unclear whether the Insured was properly wearing Seat Belt(s) or if it is unclear whether the Air Bag inflated properly, then the Air Bag Benefit will be \$1,000.

Air Bag means an inflatable supplemental passive restraint system installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications, that inflates upon collision to protect an individual from Injury and death. An Air Bag is not considered a Seat Belt.

REPATRIATION BENEFIT

We will pay an additional benefit, the Repatriation Benefit, of up to \$5,000 of the Principal Sum of the AD&D Benefit for the preparation and transportation of an Insured's body to a mortuary if:

1. the Principal Sum under the AD&D Benefit is payable for Loss of the Insured's life; and
2. the Insured's death occurs at least 75 miles away from the Insured's principal residence.

EDUCATION BENEFIT

We will pay an additional benefit, the Education Benefit, to the Insured Employee's Dependent Student if the Principal Sum under the AD&D Benefit is payable for Loss of the Insured Employee's life.

Definitions which apply to the Education Benefit:

Student means a Dependent Child who, on the date of the Insured Employee's death, is:

1. A full-time post-high school student in a school of higher education; or
2. A student in the 12th grade but who becomes a full-time post-high school student in a school of higher education within 365 days after the Insured Employee's death.

School of higher education means an institution which:

1. is legally authorized by the State in which it is located; and
2. provides either a program for:
 - a. Bachelor's degrees or not less than a two year program with full credit towards a Bachelor's degree; or
 - b. Gainful employment as long as such program is at least one year of training; and
3. is accredited by an Agency or association recognized by the U.S. Department of Education under the Higher Education Assistance Act as may be amended from time to time.

Eligible Dependent Child means any unmarried child of the Insured (whether natural, step, foster or adopted) who is:

1. at least 15 days but less than 18 years of age and dependent on the Insured for support and maintenance; and
2. not in active military service.

Eligibility will continue to age 23 for Dependent Children who are not employed full-time and are enrolled as a full-time student in a recognized school and dependent on the Insured Employee for support and maintenance.

Eligibility will continue past the age limit for Dependent Children who are primarily dependent upon the Insured for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. Proof of such incapacity must be provided to Us upon request. Note: No eligible person may be covered more than once under this Policy. If a person is covered as an Employee, he cannot be covered as a Spouse or Dependent Child of another Employee.

Amount of Benefit: The maximum Dependent Education Benefit for each dependent Student shall equal the lesser of the Insured Employee's Principal Sum or \$12,000.

Payment of Benefit: We will pay the Dependent Education Benefit in four equal annual installments. We will only pay one Dependent Education Benefit to any one dependent Student during any one school year. If the dependent Student is a minor, We will pay the benefit to the legal representative of the minor.

When Benefit Ends: A dependent Student will no longer be eligible to receive the Dependent Education Benefit upon the earlier of the following:

1. Our payment of the fourth installment of the Dependent Education Benefit on behalf of or to the dependent Student; or
2. At the end of the period during which Due Proof must be submitted if no Due Proof is submitted.

Special Child Education Benefit: If the Insured Employee's Eligible Dependent Child does not qualify as a Student, but is enrolled in an elementary or high school, We will pay a Child Education Benefit in the amount of \$1,000. This benefit is payable once upon proof that the Insured Employee has died as a result of an accident for which the Accidental Death & Dismemberment benefit is payable and that, within 12 months after the Insured Employee's death, the Insured Employee's Eligible Dependent Child is a full-time student in an elementary or high school.

LIMITATIONS

We will not pay any benefit for any Loss that, directly or indirectly, results in any way from or is contributed to by:

1. any disease or infirmity of mind or body, and any medical or surgical treatment thereof; or
2. any infection, except a pus-forming infection of an accidental cut or wound; or
3. suicide or attempted suicide, while sane or insane; or
4. any intentionally self-inflicted Accident; or
5. war, declared or undeclared, whether or not the Insured is a member of any armed forces; or
6. travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; or
7. commission of, participation in, or an attempt to commit an assault or felony; or
8. being under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by the Insured's licensed physician and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence; or
9. intoxication as defined by the laws of the jurisdiction in which the accident occurred. Conviction is not necessary for a determination of being intoxicated; or
10. active participation in a riot. "Riot" means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

NOTICE OF CLAIM

If an Insured incurs a loss that may result in a claim for benefits under this Policy, written notice must be given to Us at Our administrative office. This must be done within 20 days after the covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice must contain enough information to identify the claimant.

CLAIM FORMS

When We receive written notice of a claim, We will send the claimant forms with which to file proof of loss. If these forms are not given to the claimant within 15 days, he will be excused from filing the forms provided he sends Us written proof of loss detailing the occurrence, the character and extent of the loss for which claim is made.

PROOF OF LOSS

We must receive written proof of loss within 90 days after the date of the loss for which claim was made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof of loss within 90 days will not invalidate or reduce any claim. However, except in the absence of legal capacity, proof of loss must be furnished no later than one (1) year from the date such proof is required.

For the Education Benefit, Proof of Loss must:

1. Include proof of dependent Student status; and
2. Be submitted no later than
 - a. Two months after completion of course work for that particular school year if the dependent Student is enrolled in a school of higher learning at the time of the Insured's death. School year shall be deemed to begin on September 1st and end on August 31st; or
 - b. Within six (6) months after enrollment in a school of higher learning if the dependent Student is in the 12th grade at the time of the Insured's death. After the first year in a school of higher learning, due proof must be submitted in accordance with paragraph (1) in this Notice of Claim Section.

PHYSICAL EXAMINATION/AUTOPSY

Upon receipt of a claim, We may examine an Insured, at Our expense, at any reasonable time. We reserve the right to perform an autopsy, at Our expense, if it is not prohibited by any applicable local law(s).

LEGAL ACTION

No action at law or in equity may begin prior to 60 days after We receive valid written proof of loss. No such action may begin after the expiration of the applicable statute of limitations from the day written proof of loss was required.

(Amended by FDL1-504AD-1002)

- if denial is based on medical judgement, either (i) an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

If the claim has been denied, in whole or in part, you can appeal the denial to us for a full and fair review. You have at least 180 days to appeal from the claim denial.

You may:

- a) request a review upon written application within 180 days of the claim denial;
- b) request, free of charge, copies of all documents, records and other information relevant to your claim; and
- c) submit written comments, documents, records and other information relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Fort Dearborn will make a decision no more than 45 days after we receive your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, Fort Dearborn notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for your decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request. The written decision will include specific references to the Plan provisions on which the decision is based and any other notice(s), statement(s) or information required by applicable law.

Life Insurance Plans

A decision will be made by Fort Dearborn no more than 90 days after receipt of due proof of loss, except in special circumstances (such as the need to obtain further information), but in no case more than 180 days after the due proof of loss is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

If the claim is denied, in whole or in part, you will receive a written notice giving the following:

- the reason for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed;
- the steps that you have to follow to have the claim reviewed;
- a statement of your right to bring a civil action on denial of your appeal.

Any denied claim may be appealed to Fort Dearborn for a full and fair review. You may:

- a) request a review upon written application within 60 days of receipt of claim denial;
- b) review pertinent documents; and
- c) submit issues and comments in writing.

A decision will be made by Fort Dearborn no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to obtain additional evidence), but in no case more than 120 days after the request for review is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

C. ERISA NOTICE OF YOUR RIGHTS

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

Examine, without charge, at the Plan Administrator's office and at other locations, such as work sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. Receive a summary of the Plan's annual financial report. The Plan Administrator is required to furnish each participant with a copy of this summary annual report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employers, your union, or any other persons, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, United States Department of Labor, 200 Constitution Avenue, NW Washington DC 20210.

D. PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute a contract between the Company and any participant or to be consideration or an inducement for the employment of any participant or employee. Nothing contained in this Plan shall be deemed to give any participant or employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any participant or employee at any time regardless of the effect which such discharge shall have upon him or her as a participant of this Plan.



**FORT DEARBORN LIFE
INSURANCE COMPANY**

Administrative Office:

1020 31st Street • Downers Grove, Illinois 60515-5591

AMENDATORY RIDER



ATTACHED TO AND MADE A PART OF POLICY NUMBER: F006642-0001

Policyholder: CITY OF HALLANDALE BEACH

Effective Date of Change: JANUARY 1, 2010

The above Policy is amended as follows:

Reduction of benefits for Class 2 Only – Elected Officials, has been deleted.

All other conditions and provisions remain unchanged.

FORT DEARBORN LIFE INSURANCE COMPANY®

A handwritten signature in black ink, appearing to read 'Anthony F. Trani'.

Anthony F. Trani
President

Group Life and AD&D Insurance

Employee Benefit Booklet



FORT DEARBORN LIFE INSURANCE COMPANY
Downers Grove, Illinois

City of Hallandale Beach

Group Number: F006642-0001

Class 1-02



® FORT DEARBORN LIFE INSURANCE COMPANY
(A stock life insurance company herein called "We", "Us", "Our")
300 East Randolph, Chicago, Illinois 60601
Administrative Office:
1020 31st Street, Downers Grove, IL. 60515-5591

CERTIFICATE (FL)
FOR OUR POLICYHOLDERS AND CERTIFICATEHOLDERS
To present inquiries or obtain information about coverage and to provide assistance in resolving complaints, please call our toll free number: 1-800-633-3696.

We agree to pay benefits subject to the provisions, definitions, limitations, and conditions of the master policy. The master policy (herein called the Policy) is a contract issued by Fort Dearborn Life Insurance Company to your Employer (herein called the Policyholder). The Policy may be changed at any time by a written agreement between Fort Dearborn Life Insurance Company and the Policyholder. This is your certificate of coverage as long as you are eligible for insurance. It is not a contract or a part of one. Your benefits are described in plain English, but a few terms and provisions are written as required by insurance law.

PLEASE READ CAREFULLY

If you have any questions, please contact the Benefits Administrator at your place of employment or write to us. We will assist you in any way we can to help you understand your benefits.

President

Secretary

<p>Group Insurance Certificate Non-Participating Term Life and AD&D Insurance</p>
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General Provisions

SCHEDULE OF BENEFITS

POLICYHOLDER: CITY OF HALLANDALE BEACH

POLICY NUMBER: F006642-0001

CLASS OF INSUREDS	DEFINITION
1- 02	Elected Officials.

Basic Life Benefit: \$25,000.

Basic AD&D Benefit: \$25,000.

Waiver of Premium benefits is not applicable for this class.

DEFINITIONS (FL)

This section tells You the meaning of special words and phrases used in this Certificate. To help You recognize these special words and phrases, the first letter of each word, or each word in the phrase, is capitalized wherever it appears.

Accident or **Accidental** means a sudden, unexpected event that was not reasonably foreseeable.

Actively at Work or **Active Work** means that you are:

1. performing the normal duties of your occupation; and
2. working the number of hours set forth in the Application.

Application means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the Policyholder applied.

Base Annual Salary means the gross annual compensation prior to before-tax payroll deductions, if any,

1. which you earn from your occupation with the Policyholder; and
2. which was used in the calculation and remittance of premium.

It does not include Salary from overtime, bonuses or any other form of extra pay. However, if your Salary is based in whole or in part on commissions, Base Annual Salary will include the amount paid in commissions during the preceding twelve-month calendar period. Your deferred contributions to a 401K plan or salary reduction contributions to a cafeteria plan which are maintained by the Policyholder will not be deducted when calculating gross annual compensation.

Basic Weekly Wage means the gross weekly compensation prior to before-tax payroll deductions, if any,

1. which you earn from your occupation with the Policyholder; and
2. which was used in the calculation and remittance of premium.

It does not include compensation from overtime, bonuses or any other form of extra pay. However, if your compensation is based in whole or in part on commissions, Basic Weekly Wage will include the weekly average paid in commissions during the preceding twelve-month calendar period. Your deferred contributions to a 401K plan or salary reduction contributions to a cafeteria plan which are maintained by the Policyholder will not be deducted when calculating gross weekly compensation.

Base Annual Salary/Basic Weekly Wage for each Insured who is a partner means the Insured's annual/average weekly compensation from the partnership during the calendar year prior to the date of the Insured's loss, as reported on the partnership federal income tax return as the "net Salary (loss) from self-employment" for that year.

If an Insured was not a partner during the calendar year prior to the date of loss, Base Annual Salary/Basic Weekly Wage means the Insured's annual/average weekly compensation (excluding dividends, capital gains, and return of capital) from the partnership prior to the date of the Insured's loss, determined in accordance with the terms of the applicable partnership agreement. In the event of a disagreement between Us and the claimant, an adjustment will be made, if warranted, after the Insured's subsequent federal income tax return is submitted to Us.

No benefits are payable when any of the above calculations result in an amount less than zero.

Base Annual Salary/Basic Weekly Wage for each Insured who is a sole proprietor or shareholder in a Subchapter S corporation or a member in a limited liability company means the Insured's annual/average weekly net taxable income (excluding dividends, capital gains, and return of capital) derived from the Policyholder for the calendar year prior to the date of the Insured's loss, as reported on his federal income tax return. The Insured's annual/average weekly net taxable income equals A minus B, where:

A = The Insured's annual/average weekly taxable income derived from the Policyholder for the prior calendar year (excluding dividends, capital gains, and return of capital), as reported on the Insured's federal income tax return; and

B = The Insured's annual/average weekly deductible work expenses attributable to his work for the Policyholder during the prior calendar year, as reported on the Insured's federal income tax return.

If an Insured was not a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company during the calendar year prior to the date of the Insured's loss, Base Annual Salary/Basic Weekly Wage means an Insured's annual/average weekly net taxable income derived from the Policyholder for the period he was a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company prior to the date of the Insured's loss. The Insured's annual/average weekly net taxable income will be based on the taxable income derived from the Policyholder for the period of the Insured's work as a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company for You, taking into account his deductible work expenses attributable to his work for the Policyholder during the same period.

No benefits are payable when any of the above calculations result in an amount less than zero.

Contributory means you pay a portion of the premium for this insurance coverage.

Employee means an Actively at Work full-time employee whose principal employment is with the Employer, at the Employer's usual place of business or such place(s) that the Employer's normal course of business may require, who is Actively at Work for the minimum hours per week as stated in the Application and is reported on the Employer's records for Social Security and withholding tax purposes.

Injury means bodily injury resulting directly from an Accident and independently of all other causes.

Insured means an Employee covered under the Policy.

Male Pronoun whenever used includes the female.

Noncontributory means the Policyholder pays 100% of the premium for this insurance.

Policy means the contract between the Policyholder and Us including the attached Application, which provides group insurance benefits.

Policyholder means the person, firm, or institution named in the Policy, including any covered subsidiaries or affiliates named in the Policy. If the Policyholder is a trust or association, the term Participating Employer shall be substituted for Policyholder.

You or Your means the Employee to whom this Certificate has been delivered.

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS (FL)

ELIGIBILITY

All Employees who belong to an eligible class and work the minimum number of hours as set forth in the Application are eligible for group insurance. An Employee must be **Actively at Work** for his insurance coverage to become effective.

EMPLOYER EFFECTIVE DATE OF COVERAGE
(Noncontributory Benefits)

If you are Actively at Work, you will become insured for Noncontributory benefits under the Policy on the day following completion of the Employee waiting period, if any, set forth in the Application.

If you waive all or a portion of your Noncontributory coverage and choose to enroll at a later date, you are considered a late applicant and must furnish evidence of insurability satisfactory to Us before coverage can become effective. Coverage will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

EMPLOYEE EFFECTIVE DATE OF COVERAGE
(Contributory Benefits)

You may apply for Contributory insurance coverage at any time. Your coverage will become effective as follows, provided you are Actively at Work on that date:

1. If you sign the enrollment form on or before the end of the waiting period, if any, as stated in the Application, coverage will become effective on the day following completion of the waiting period.
2. If you sign the enrollment form after the end of the waiting period, but within 31 days after that day, coverage will become effective the date you sign the enrollment form.
3. If you sign the enrollment form following this 31-day period, you are considered a late applicant and must furnish evidence of insurability satisfactory to Us before coverage can become effective. Coverage will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

DEFERRED EFFECTIVE DATE

You must be Actively at Work on the date your initial coverage or any increases in coverage are scheduled to begin. If:

1. you are absent from Active Work on the date such coverage would otherwise become effective; and
2. your absence is caused by an injury, illness or layoff,

the effective date of any initial coverage or increased coverage will be deferred until the first day you return to Active Work. You will be considered Actively at Work if you were actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled work days);
2. a holiday (except when such holiday is a scheduled work day);
3. a paid vacation;
4. any nonscheduled work day.

EFFECTIVE DATE IF WE REQUIRE EVIDENCE OF INSURABILITY

If you are required to submit evidence of insurability satisfactory to Fort Dearborn Life Insurance Company, insurance in the amount for which We require such evidence will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

EFFECTIVE DATE OF CHANGE IN AMOUNT OF BENEFITS

Any change in the amount of your benefits caused by a change in class, change in salary, age reduction or amendment to the Policy will become effective on the effective date of the change. If the change results in an increase in the amount of insurance, you must be Actively at Work on that date. If you are not Actively at Work, the increase will take effect on the day you are again Actively at Work.

ELIGIBILITY AFTER TERMINATION OF EMPLOYMENT

If your coverage ends due to termination of employment you must meet all the requirements of a new Employee if you are rehired at a later date.

GROUP TERM LIFE INSURANCE BENEFIT (FL)

BENEFIT

We will pay your beneficiary the amount of life insurance in force as of the date of your death provided:

1. you are insured under the Policy on the date of death, and
2. We receive proof of death.

The amount of insurance payable is based upon the Policyholder's Application, and it is set forth on the Schedule of Benefits.

BENEFICIARY

Your beneficiary designation must be made on a form which We provide or on a form accepted by Us. If you name two or more beneficiaries, payment of proceeds will be apportioned equally unless you had specified otherwise. The Policyholder may not be named as beneficiary.

Unless you provided otherwise, if a beneficiary dies before you, We will divide that beneficiary's share equally between any remaining named beneficiaries.

If no named beneficiary survives you or if you did not designate a beneficiary, We will pay the amount of insurance:

1. to your spouse, if living; if not,
2. in equal shares to your then living natural or adopted children, if any; if none,
3. in equal shares to your father and mother, if living; if not,
4. to your estate.

If a beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, We will not make payment until a claim is made by the person or entity which, by court order, has been granted control of the estate of such beneficiary. This provision does not prevent Us from making payment to or for the benefit of a minor beneficiary in accordance with the applicable state law.

If any benefits under this provision are to be paid to your estate, We may pay an amount not greater than \$5,000 to any person We consider to be equitably entitled by reason of having incurred funeral or other expenses incident to your death. Any and all payments made by Us shall fully discharge Us in the amount of such payment.

CHANGE OF BENEFICIARY

You may change your beneficiary at any time by completing a change request form, or a form accepted by Us, and sending it to the Policyholder. Your written request for change of beneficiary will not be effective until it is recorded by the Policyholder. After it has been so recorded, it will take effect on the later of the date you signed the change request form or the date you specifically requested. If you die before the change has been recorded, We will not alter any payment that We have already made. Any prior payment shall fully discharge Us from further liability in that amount.

CONVERSION OF LIFE INSURANCE

Conversion if Eligibility Terminates:

You may convert to an individual policy of life insurance if your life insurance, or a portion of it, ceases because:

1. you are no longer employed by the Policyholder; or
2. you are no longer in a class which is eligible for life insurance.

In either of these situations, you may convert all or any portion of your life insurance which was in force at the date of termination.

Conversion if Policy is Terminated or Amended:

You may also convert to an individual policy of life insurance if your life insurance ceases because:

1. life insurance benefits under the Policy cease; or
2. the Policy is amended making him ineligible for life insurance; however, in either of these situations,

you must have been insured under the Policy for at least five (5) years. The amount of insurance converted in either of these situations will be the lesser of:

1. the amount of life insurance in force, less any amount for which you become eligible under this or any other group policy within 31 days after the date your life insurance ceased; or
2. \$10,000.

Conditions for Conversion: (amended by form no. FDL1-23-1100)

We must receive written application and the first premium for the individual life insurance policy within 31 days after insurance under the Policy ceases. No evidence of insurability will be required. The individual policy will be a policy of whole life insurance. It will not contain disability benefits, accidental death and dismemberment benefits or any other supplemental benefits. The premium for the individual policy will be based on:

1. Our current rates based upon your attained age on your nearest birthday; and
2. on the amount of the individual policy.

If application is made for an individual policy, the coverage under the individual policy will be effective on the day following the 31-day period during which you could apply for conversion. If you die during a period when you would have been entitled to have an individual policy issued to you and if you die before such an individual policy becomes effective, We will pay your beneficiary the greatest amount of group term life insurance for which an individual policy could have been issued, provided:

1. your death occurred during the 31-day period within which you could have made application; and
2. We receive proof of death.

If life insurance benefits are paid under the Policy, payment will not be made under the converted policy, and premiums paid for the converted policy will be refunded.

ACCIDENTAL DEATH, DISMEMBERMENT, AND LOSS OF SIGHT BENEFIT AMENDATORY RIDER (FL)

This Rider is made part of the Policy or Certificate to which it is attached. This Rider amends the Section entitled "Accidental Death, Dismemberment and Loss of Sight Benefit" and is subject to all the provisions of the Policy not in conflict with the provisions of this Rider.

If, while insured under this Policy, an Insured suffers an Injury in an Accident, We will pay for those Losses set forth in the subsection entitled "Table of Losses" below. The amount paid will be as stated in the Table of Losses but not more than the Principal Sum set forth in the Application. The Loss must:

1. occur within 365 days of the Accident; and
2. be the direct and sole result of the Accident; and
3. be independent of all other causes.

TABLE OF LOSSES

Principal Sum for Loss of:	One-half of the Principal Sum for Loss of:	One-Quarter the Principal Sum for Loss of:
Life	Sight of One Eye	Thumb and Index Finger of Same Hand
Both Hands	One Hand	
Both Feet	One Foot	
One Hand and One Foot	Speech or Hearing	
Speech and Hearing		
Sight of Both Eyes		
One Hand and the Sight of One Eye		
One Foot and the Sight of One Eye		

With respect to hand or foot, loss means actual and permanent severance from the body at or above the wrist or ankle joint, as applicable. With respect to eyes, speech and hearing, loss means entire and irrecoverable loss of sight, speech or hearing. With respect to thumb and index finger, loss means complete severance of entire digit at or above joints.

The total amount of AD&D benefits payable for all Losses for any Insured resulting from any one Accident will not be greater than the Principal Sum set forth in the Application.

Except as provided in a particular benefit, We will pay benefits for Loss of life to the same beneficiary(ies) named to receive life insurance benefits. Benefits for all other Losses will be paid to the Insured.

SEAT BELT BENEFIT

We will pay an additional benefit, the Seat Belt Benefit, of the lesser of the Insured's Principal Sum or \$25,000 if the Principal Sum under the AD&D Benefit is payable for Loss of the Insured's life as the result of an Accident which occurs while the Insured is driving or riding in an automobile, if:

1. the automobile is equipped with Seat Belts;
2. the Seat Belt was in actual use and properly fastened at the time of the Accident;
3. the position of the Seat Belt is certified in the official report of the Accident or by the investigating officer. A copy of the police Accident report must be submitted with the claim; and
4. the Insured was driving or riding in an automobile driven by a licensed driver who was neither:
 - a. intoxicated or driving while impaired. Intoxication and impairment shall be determined by the law of the jurisdiction in which the Accident occurs, with or without conviction; nor
 - b. under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by a licensed physician and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence.

If such certification is not available and if it is unclear whether the Insured was properly wearing a Seat Belt, then We will pay an additional benefit of \$1,000.

Seat Belt means those belts that form an occupant restraint system.

AIR BAG BENEFIT

We will pay an additional benefit, the Air Bag Benefit, equal to 5% of the Principal Sum of the AD&D Benefit if the Principal Sum under the AD&D Benefit is payable for Loss of the Insured's life as the result of an Accident which occurs while the Insured is driving or riding in an automobile provided that:

1. the Insured was positioned in a seat that was equipped with a factory-installed Air Bag;
2. the Insured was properly strapped in the Seat Belt when the Air Bag inflated; and
3. the police report establishes that the Air Bag inflated properly upon impact.

The maximum Air Bag Benefit payable is \$5,000.00. If it is unclear whether the Insured was properly wearing Seat Belt(s) or if it is unclear whether the Air Bag inflated properly, then the Air Bag Benefit will be \$1,000.

Air Bag means an inflatable supplemental passive restraint system installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications, that inflates upon collision to protect an individual from Injury and death. An Air Bag is not considered a Seat Belt.

REPATRIATION BENEFIT

We will pay an additional benefit, the Repatriation Benefit, of up to \$5,000 of the Principal Sum of the AD&D Benefit for the preparation and transportation of an Insured's body to a mortuary if:

1. the Principal Sum under the AD&D Benefit is payable for Loss of the Insured's life; and
2. the Insured's death occurs at least 75 miles away from the Insured's principal residence.

EDUCATION BENEFIT

We will pay an additional benefit, the Education Benefit, to the Insured Employee's Dependent Student if the Principal Sum under the AD&D Benefit is payable for Loss of the Insured Employee's life.

Definitions which apply to the Education Benefit:

Student means a Dependent Child who, on the date of the Insured Employee's death, is:

1. A full-time post-high school student in a school of higher education; or
2. A student in the 12th grade but who becomes a full-time post-high school student in a school of higher education within 365 days after the Insured Employee's death.

School of higher education means an institution which:

1. is legally authorized by the State in which it is located; and
2. provides either a program for:
 - a. Bachelor's degrees or not less than a two year program with full credit towards a Bachelor's degree; or
 - b. Gainful employment as long as such program is at least one year of training; and
3. is accredited by an Agency or association recognized by the U.S. Department of Education under the Higher Education Assistance Act as may be amended from time to time.

Eligible Dependent Child means any unmarried child of the Insured (whether natural, step, foster or adopted) who is:

1. at least 15 days but less than 18 years of age and dependent on the Insured for support and maintenance; and
2. not in active military service.

Eligibility will continue to age 23 for Dependent Children who are not employed full-time and are enrolled as a full-time student in a recognized school and dependent on the Insured Employee for support and maintenance.

Eligibility will continue past the age limit for Dependent Children who are primarily dependent upon the Insured for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. Proof of such incapacity must be provided to Us upon request. Note: No eligible person may be covered more than once under this Policy. If a person is covered as an Employee, he cannot be covered as a Spouse or Dependent Child of another Employee.

Amount of Benefit: The maximum Dependent Education Benefit for each dependent Student shall equal the lesser of the Insured Employee's Principal Sum or \$12,000.

Payment of Benefit: We will pay the Dependent Education Benefit in four equal annual installments. We will only pay one Dependent Education Benefit to any one dependent Student during any one school year. If the dependent Student is a minor, We will pay the benefit to the legal representative of the minor.

When Benefit Ends: A dependent Student will no longer be eligible to receive the Dependent Education Benefit upon the earlier of the following:

1. Our payment of the fourth installment of the Dependent Education Benefit on behalf of or to the dependent Student; or
2. At the end of the period during which Due Proof must be submitted if no Due Proof is submitted.

Special Child Education Benefit: If the Insured Employee's Eligible Dependent Child does not qualify as a Student, but is enrolled in an elementary or high school, We will pay a Child Education Benefit in the amount of \$1,000. This benefit is payable once upon proof that the Insured Employee has died as a result of an accident for which the Accidental Death & Dismemberment benefit is payable and that, within 12 months after the Insured Employee's death, the Insured Employee's Eligible Dependent Child is a full-time student in an elementary or high school.

LIMITATIONS

We will not pay any benefit for any Loss that, directly or indirectly, results in any way from or is contributed to by:

1. any disease or infirmity of mind or body, and any medical or surgical treatment thereof; or
2. any infection, except a pus-forming infection of an accidental cut or wound; or
3. suicide or attempted suicide, while sane or insane; or
4. any intentionally self-inflicted Accident; or
5. war, declared or undeclared, whether or not the Insured is a member of any armed forces; or
6. travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; or
7. commission of, participation in, or an attempt to commit an assault or felony; or
8. being under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by the Insured's licensed physician and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence; or
9. intoxication as defined by the laws of the jurisdiction in which the accident occurred. Conviction is not necessary for a determination of being intoxicated; or
10. active participation in a riot. "Riot" means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

NOTICE OF CLAIM

If an Insured incurs a loss that may result in a claim for benefits under this Policy, written notice must be given to Us at Our administrative office. This must be done within 20 days after the covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice must contain enough information to identify the claimant.

CLAIM FORMS

When We receive written notice of a claim, We will send the claimant forms with which to file proof of loss. If these forms are not given to the claimant within 15 days, he will be excused from filing the forms provided he sends Us written proof of loss detailing the occurrence, the character and extent of the loss for which claim is made.

PROOF OF LOSS

We must receive written proof of loss within 90 days after the date of the loss for which claim was made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof of loss within 90 days will not invalidate or reduce any claim. However, except in the absence of legal capacity, proof of loss must be furnished no later than one (1) year from the date such proof is required.

For the Education Benefit, Proof of Loss must:

1. Include proof of dependent Student status; and
2. Be submitted no later than
 - a. Two months after completion of course work for that particular school year if the dependent Student is enrolled in a school of higher learning at the time of the Insured's death. School year shall be deemed to begin on September 1st and end on August 31st; or
 - b. Within six (6) months after enrollment in a school of higher learning if the dependent Student is in the 12th grade at the time of the Insured's death. After the first year in a school of higher learning, due proof must be submitted in accordance with paragraph (1) in this Notice of Claim Section.

PHYSICAL EXAMINATION/AUTOPSY

Upon receipt of a claim, We may examine an Insured, at Our expense, at any reasonable time. We reserve the right to perform an autopsy, at Our expense, if it is not prohibited by any applicable local law(s).

LEGAL ACTION

No action at law or in equity may begin prior to 60 days after We receive valid written proof of loss. No such action may begin after the expiration of the applicable statute of limitations from the day written proof of loss was required.

(Amended by FDL1-504AD-1002)

TERMINATION PROVISIONS (FL)

Termination of the Policy under any conditions will not prejudice any claim, for a disability that began prior to termination of the Policy.

TERMINATION OF EMPLOYEE COVERAGE

Your insurance coverage will end on the earliest of:

1. the date you are no longer a member of a covered class; or
2. the date the Policy is canceled or, if applicable, the date the Participating Employer's participation terminates; or
3. the effective date of an amendment to the Policy which terminates insurance for the class to which you belong;
4. the date you stop making any required contribution toward payment of premiums; or
5. the date you are no longer Actively at Work; however,

if you are no longer Actively at Work as a result of a disability, layoff, or leave of absence, you may continue to be eligible for group insurance coverage, except short term disability coverage, as follows:

- | | |
|-------------------------|--|
| Disability | Until the end of the twelfth month following the month in which the disability began or until the end of the elected official's term, provided all premiums are paid when due. |
| Layoff | Until the end of the month following the month during which the layoff began, provided all premiums are paid when due. |
| Leave of Absence | Until the end of the month following the month in which the leave of absence began, provided all premiums are paid when due. |

GENERAL PROVISIONS (FL)

ENTIRE CONTRACT

The Policy, the Application and the enrollment forms of the Insureds are considered to be the entire contract.

STATEMENTS

We consider any statements made by You, in the absence of fraud, to be representations and not warranties. No such statement shall be used in defense to a claim under the Policy unless it is contained in a written application.

INCONTESTABILITY

We will not contest the validity of the Policy, except for nonpayment of premium, after it has been in force for two (2) years from its effective date. We will not contest the validity of your insurance after your insurance has been in force for two (2) years during your lifetime.

MISSTATEMENT OF AGE

If you misstated your age or the age of a Dependent, the true age will be used to determine:

1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

Premiums will be adjusted to reflect the premiums that would have been paid if the true age had been known.

CONFORMITY WITH STATE LAW

If any part of the Policy does not conform to a state statute in the state in which it is issued or delivered, it is amended to conform with the minimum requirements of the statutes of that state.

ASSIGNMENT

You may assign the life insurance benefits under the Policy, and you may assign to anyone other than the Policyholder any incident of ownership you may possess. We are not responsible for the validity or legal effect of any assignment. Collateral assignments, by whatever name called, are not permitted.

RETENTION OF DISCRETION

Fort Dearborn Life Insurance Company shall have the exclusive right to interpret the terms of the Certificate, Schedule of Benefits, Riders and Endorsements. The decision about whether to pay any claim, in whole or in part, is within the sole discretion of Fort Dearborn Life and such decisions shall be final and conclusive.

***ERISA INFORMATION STATEMENT**

The benefits described in your certificate and this ERISA Information Statement (collectively the "Summary Plan Description" a/k/a the SPD) are insured by a Policy issued by Fort Dearborn Life Insurance Company. This SPD describes the provisions of the Plan in effect as of the Effective Date of the Policy. It is not the intention of the SPD to cover all situations that may arise, but to provide you with a general understanding of your benefits. In the case of any item not covered by the SPD, or in the event of any conflict between the SPD and the Policy, the Plan will always control. You should not rely on any oral explanation, description, or interpretation of the Plan because the written terms of the Plan will govern. Your right to any benefit depends on the actual facts and terms and conditions of the particular Plan; no rights accrue by reason of or arising out of any statement shown in or omitted from, this SPD.

A. ADMINISTRATION OF THE PLAN

The Plan Administrator is responsible for the administration of the Plan. The Plan Administrator has full discretionary authority and control over the Plan. This authority provides the Plan Administrator with the power necessary to operate, manage and administer the Plan. This authority includes, but is not limited to, the power to interpret the Plan and determine who is eligible to participate, to determine the amount of benefits that may be paid to a participant or his or her beneficiary, and the status and rights of participants and beneficiaries. The Plan Administrator also has the authority to prescribe the rules and procedures under which the Plan shall operate, to request information, and to employ or appoint persons to aid the Plan Administrator in the administration of the Plan.

Failure by the Plan or the Plan Administrator to insist upon compliance with any provisions of the Plans at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by the person authorized by the Plan Administrator to sign the waiver.

The Plan may be amended, terminated or suspended in whole or in part, at any time without the consent of the employees or beneficiaries. Any amendment, termination or suspension shall be in writing, and attached to the Plan. Any amendment, termination or suspension shall be executed according to the Employer's authorized procedures. Any such authorization may be specific to the Plan or persons authorized to act on behalf of the Employer or may be general as to duties of such person. Except for termination or suspensions, any amendments affecting the Policy must also be approved in writing by an officer of Fort Dearborn Life Insurance Company (the "Insurer") and shall be effective as of the date agreed to, in writing by the Plan Sponsor and the Insurer. Notwithstanding anything to the contrary in this document, the Policy shall terminate according to the provisions in the Policy.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. The Plan's life benefits are provided pursuant to an insurance policy issued to the Company. The Insurer's services shall be limited to, and the Plan Administrator has the full discretionary and final authority to:

- resolve all matters when a review pursuant to the claims procedures has been requested;
- interpret, establish and enforce rules and procedures for the administration of the Policy and any claim under it; and
- determine eligibility of Employees and Dependents for benefits and their entitlement to and the amount of benefits.

***This ERISA addendum only applies if the Policy is part of or is an ERISA Plan.**

11/1/03

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of any Plan fiduciary, to the extent provided in ERISA Section 405(a).

The Employer makes no promise to continue these benefits in the future and rights to future benefits will never vest. Retirement does not give any retiree any vested right to continue to participate or receive Plan benefits.

B. CLAIMS PROCEDURE

***Disability Insurance Plans**

***(Applies to the Waiver of Premium based on disability in Life Certificates).**

When you or your Beneficiary are eligible to receive benefits, you or your Beneficiary, or your authorized representative (collectively, "you") must notify the Plan Administrator by submitting the proper form. You may do this by sending notice of your claim to the Plan Administrator who has been appointed to assist Fort Dearborn in the claims processing for this Plan or by contacting Fort Dearborn directly at:

Claims Department
Fort Dearborn Life Insurance Company
1020 31st Street
Downers Grove, IL. 60515-5591
1-800-348-4512

Fort Dearborn will give you a written response to your claim, usually within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, Fort Dearborn notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision shall be tolled from the date on which we send you notice of the extension until the date we receive your response to our request. This period will be no longer than 45 days after we have requested the information. At that time we will decide your claim based on the information we have at that time.

If the claim is denied, in whole or in part, you will receive a written notice giving the following:

- the reason for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed;
- the steps that you have to follow to have the claim reviewed;
- a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal; and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request; and

- if denial is based on medical judgement, either (i) an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

If the claim has been denied, in whole or in part, you can appeal the denial to us for a full and fair review. You have at least 180 days to appeal from the claim denial.

You may:

- a) request a review upon written application within 180 days of the claim denial;
- b) request, free of charge, copies of all documents, records and other information relevant to your claim; and
- c) submit written comments, documents, records and other information relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Fort Dearborn will make a decision no more than 45 days after we receive your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, Fort Dearborn notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for your decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request. The written decision will include specific references to the Plan provisions on which the decision is based and any other notice(s), statement(s) or information required by applicable law.

Life Insurance Plans

A decision will be made by Fort Dearborn no more than 90 days after receipt of due proof of loss, except in special circumstances (such as the need to obtain further information), but in no case more than 180 days after the due proof of loss is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

If the claim is denied, in whole or in part, you will receive a written notice giving the following:

- the reason for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed;
- the steps that you have to follow to have the claim reviewed;
- a statement of your right to bring a civil action on denial of your appeal.

Any denied claim may be appealed to Fort Dearborn for a full and fair review. You may:

- a) request a review upon written application within 60 days of receipt of claim denial;
- b) review pertinent documents; and
- c) submit issues and comments in writing.

A decision will be made by Fort Dearborn no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to obtain additional evidence), but in no case more than 120 days after the request for review is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

C. ERISA NOTICE OF YOUR RIGHTS

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

Examine, without charge, at the Plan Administrator's office and at other locations, such as work sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. Receive a summary of the Plan's annual financial report. The Plan Administrator is required to furnish each participant with a copy of this summary annual report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employers, your union, or any other persons, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, United States Department of Labor, 200 Constitution Avenue, NW Washington DC 20210.

D. PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute a contract between the Company and any participant or to be consideration or an inducement for the employment of any participant or employee. Nothing contained in this Plan shall be deemed to give any participant or employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any participant or employee at any time regardless of the effect which such discharge shall have upon him or her as a participant of this Plan.



**FORT DEARBORN LIFE
INSURANCE COMPANY**

Administrative Office:

1020 31st Street • Downers Grove, Illinois 60515-5591

Group Life Insurance

Employee Benefit Booklet



FORT DEARBORN LIFE INSURANCE COMPANY
Downers Grove, Illinois

City of Hallandale Beach

Group Number: F006642-0001

Class 1-03

11/12/2004



® FORT DEARBORN LIFE INSURANCE COMPANY
(A stock life insurance company herein called "We", "Us", "Our")
300 East Randolph, Chicago, Illinois 60601
Administrative Office:
1020 31st Street, Downers Grove, IL. 60515-5591

CERTIFICATE (FL)
FOR OUR POLICYHOLDERS AND CERTIFICATEHOLDERS

To present inquiries or obtain information about coverage and to provide assistance in resolving complaints, please call our toll free number: 1-800-633-3696.

We agree to pay benefits subject to the provisions, definitions, limitations, and conditions of the master policy. The master policy (herein called the Policy) is a contract issued by Fort Dearborn Life Insurance Company to your Employer (herein called the Policyholder). The Policy may be changed at any time by a written agreement between Fort Dearborn Life Insurance Company and the Policyholder.

This is your certificate of coverage as long as you are eligible for insurance. It is not a contract or a part of one. Your benefits are described in plain English, but a few terms and provisions are written as required by insurance law.

PLEASE READ CAREFULLY

If you have any questions, please contact the Benefits Administrator at your place of employment or write to us. We will assist you in any way we can to help you understand your benefits.

President

Secretary

Group Insurance Certificate
Non-Participating
Term Life Insurance

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SCHEDULE OF BENEFITS

POLICYHOLDER: CITY OF HALLANDALE BEACH

POLICY NUMBER: F006642-0001

**CLASS OF
INSUREDS**

DEFINITION

1- 03

Retirees who retired on or after August 1, 2004.

Basic Life Benefit: \$15,000.

All references to "actively at work" and "active work" are hereby deleted in this certificate.

DEFINITIONS (FL)

This section tells You the meaning of special words and phrases used in this Certificate. To help You recognize these special words and phrases, the first letter of each word, or each word in the phrase, is capitalized wherever it appears.

Accident or Accidental means a sudden, unexpected event that was not reasonably foreseeable.

Actively at Work or Active Work means that you are:

1. performing the normal duties of your occupation; and
2. working the number of hours set forth in the Application.

Application means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the Policyholder applied.

Base Annual Salary means the gross annual compensation prior to before-tax payroll deductions, if any,

1. which you earn from your occupation with the Policyholder; and
2. which was used in the calculation and remittance of premium.

It does not include Salary from overtime, bonuses or any other form of extra pay. However, if your Salary is based in whole or in part on commissions, Base Annual Salary will include the amount paid in commissions during the preceding twelve-month calendar period. Your deferred contributions to a 401K plan or salary reduction contributions to a cafeteria plan which are maintained by the Policyholder will not be deducted when calculating gross annual compensation.

Basic Weekly Wage means the gross weekly compensation prior to before-tax payroll deductions, if any,

1. which you earn from your occupation with the Policyholder; and
2. which was used in the calculation and remittance of premium.

It does not include compensation from overtime, bonuses or any other form of extra pay. However, if your compensation is based in whole or in part on commissions, Basic Weekly Wage will include the weekly average paid in commissions during the preceding twelve-month calendar period. Your deferred contributions to a 401K plan or salary reduction contributions to a cafeteria plan which are maintained by the Policyholder will not be deducted when calculating gross weekly compensation.

Base Annual Salary/Basic Weekly Wage for each Insured who is a partner means the Insured's annual/average weekly compensation from the partnership during the calendar year prior to the date of the Insured's loss, as reported on the partnership federal income tax return as the "net Salary (loss) from self-employment" for that year.

If an Insured was not a partner during the calendar year prior to the date of loss, Base Annual Salary/Basic Weekly Wage means the Insured's annual/average weekly compensation (excluding dividends, capital gains, and return of capital) from the partnership prior to the date of the Insured's loss, determined in accordance with the terms of the applicable partnership agreement. In the event of a disagreement between Us and the claimant, an adjustment will be made, if warranted, after the Insured's subsequent federal income tax return is submitted to Us.

No benefits are payable when any of the above calculations result in an amount less than zero.

Base Annual Salary/Basic Weekly Wage for each Insured who is a sole proprietor or shareholder in a Subchapter S corporation or a member in a limited liability company means the Insured's annual/average weekly net taxable income (excluding dividends, capital gains, and return of capital) derived from the Policyholder for the calendar year prior to the date of the Insured's loss, as reported on his federal income tax return. The Insured's annual/average weekly net taxable income equals A minus B, where:

A = The Insured's annual/average weekly taxable income derived from the Policyholder for the prior calendar year (excluding dividends, capital gains, and return of capital), as reported on the Insured's federal income tax return; and

B = The Insured's annual/average weekly deductible work expenses attributable to his work for the Policyholder during the prior calendar year, as reported on the Insured's federal income tax return.

If an Insured was not a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company during the calendar year prior to the date of the Insured's loss, Base Annual Salary/Basic Weekly Wage means an Insured's annual/average weekly net taxable income derived from the Policyholder for the period he was a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company prior to the date of the Insured's loss. The Insured's annual/average weekly net taxable income will be based on the taxable income derived from the Policyholder for the period of the Insured's work as a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company for You, taking into account his deductible work expenses attributable to his work for the Policyholder during the same period.

No benefits are payable when any of the above calculations result in an amount less than zero.

Contributory means you pay a portion of the premium for this insurance coverage.

Employee means an Actively at Work full-time employee whose principal employment is with the Employer, at the Employer's usual place of business or such place(s) that the Employer's normal course of business may require, who is Actively at Work for the minimum hours per week as stated in the Application and is reported on the Employer's records for Social Security and withholding tax purposes.

Injury means bodily injury resulting directly from an Accident and independently of all other causes.

Insured means an Employee covered under the Policy.

Male Pronoun whenever used includes the female.

Noncontributory means the Policyholder pays 100% of the premium for this insurance.

Policy means the contract between the Policyholder and Us including the attached Application, which provides group insurance benefits.

Policyholder means the person, firm, or institution named in the Policy, including any covered subsidiaries or affiliates named in the Policy. If the Policyholder is a trust or association, the term Participating Employer shall be substituted for Policyholder.

You or Your means the Employee to whom this Certificate has been delivered.

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS (FL)

ELIGIBILITY

All Employees who belong to an eligible class and work the minimum number of hours as set forth in the Application are eligible for group insurance. An Employee must be **Actively at Work** for his insurance coverage to become effective.

EMPLOYER EFFECTIVE DATE OF COVERAGE
(Noncontributory Benefits)

If you are **Actively at Work**, you will become insured for Noncontributory benefits under the Policy on the day following completion of the Employee waiting period, if any, set forth in the Application.

If you waive all or a portion of your Noncontributory coverage and choose to enroll at a later date, you are considered a late applicant and must furnish evidence of insurability satisfactory to Us before coverage can become effective. Coverage will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

EMPLOYEE EFFECTIVE DATE OF COVERAGE
(Contributory Benefits)

You may apply for Contributory insurance coverage at any time. Your coverage will become effective as follows, provided you are **Actively at Work** on that date:

1. If you sign the enrollment form on or before the end of the waiting period, if any, as stated in the Application, coverage will become effective on the day following completion of the waiting period.
2. If you sign the enrollment form after the end of the waiting period, but within 31 days after that day, coverage will become effective the date you sign the enrollment form.
3. If you sign the enrollment form following this 31-day period, you are considered a late applicant and must furnish evidence of insurability satisfactory to Us before coverage can become effective. Coverage will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

DEFERRED EFFECTIVE DATE

You must be **Actively at Work** on the date your initial coverage or any increases in coverage are scheduled to begin. If:

1. you are absent from Active Work on the date such coverage would otherwise become effective; and
2. your absence is caused by an injury, illness or layoff,

the effective date of any initial coverage or increased coverage will be deferred until the first day you return to Active Work. You will be considered **Actively at Work** if you were actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled work days);
2. a holiday (except when such holiday is a scheduled work day);
3. a paid vacation;
4. any nonscheduled work day.

EFFECTIVE DATE IF WE REQUIRE EVIDENCE OF INSURABILITY

If you are required to submit evidence of insurability satisfactory to Fort Dearborn Life Insurance Company, insurance in the amount for which We require such evidence will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

EFFECTIVE DATE OF CHANGE IN AMOUNT OF BENEFITS

Any change in the amount of your benefits caused by a change in class, change in salary, age reduction or amendment to the Policy will become effective on the effective date of the change. If the change results in an increase in the amount of insurance, you must be Actively at Work on that date. If you are not Actively at Work, the increase will take effect on the day you are again Actively at Work.

ELIGIBILITY AFTER TERMINATION OF EMPLOYMENT

If your coverage ends due to termination of employment you must meet all the requirements of a new Employee if you are rehired at a later date.

GROUP TERM LIFE INSURANCE BENEFIT (FL)

BENEFIT

We will pay your beneficiary the amount of life insurance in force as of the date of your death provided:

1. you are insured under the Policy on the date of death, and
2. We receive proof of death.

The amount of insurance payable is based upon the Policyholder's Application, and it is set forth on the Schedule of Benefits.

BENEFICIARY

Your beneficiary designation must be made on a form which We provide or on a form accepted by Us. If you name two or more beneficiaries, payment of proceeds will be apportioned equally unless you had specified otherwise. The Policyholder may not be named as beneficiary.

Unless you provided otherwise, if a beneficiary dies before you, We will divide that beneficiary's share equally between any remaining named beneficiaries.

If no named beneficiary survives you or if you did not designate a beneficiary, We will pay the amount of insurance:

1. to your spouse, if living; if not,
2. in equal shares to your then living natural or adopted children, if any; if none,
3. in equal shares to your father and mother, if living; if not,
4. to your estate.

If a beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, We will not make payment until a claim is made by the person or entity which, by court order, has been granted control of the estate of such beneficiary. This provision does not prevent Us from making payment to or for the benefit of a minor beneficiary in accordance with the applicable state law.

If any benefits under this provision are to be paid to your estate, We may pay an amount not greater than \$5,000 to any person We consider to be equitably entitled by reason of having incurred funeral or other expenses incident to your death. Any and all payments made by Us shall fully discharge Us in the amount of such payment.

CHANGE OF BENEFICIARY

You may change your beneficiary at any time by completing a change request form, or a form accepted by Us, and sending it to the Policyholder. Your written request for change of beneficiary will not be effective until it is recorded by the Policyholder. After it has been so recorded, it will take effect on the later of the date you signed the change request form or the date you specifically requested. If you die before the change has been recorded, We will not alter any payment that We have already made. Any prior payment shall fully discharge Us from further liability in that amount.

CONVERSION OF LIFE INSURANCE

Conversion if Eligibility Terminates:

You may convert to an individual policy of life insurance if your life insurance, or a portion of it, ceases because:

1. you are no longer employed by the Policyholder; or
2. you are no longer in a class which is eligible for life insurance.

In either of these situations, you may convert all or any portion of your life insurance which was in force at the date of termination.

Conversion if Policy is Terminated or Amended:

You may also convert to an individual policy of life insurance if your life insurance ceases because:

1. life insurance benefits under the Policy cease; or
2. the Policy is amended making him ineligible for life insurance; however, in either of these situations,

you must have been insured under the Policy for at least five (5) years. The amount of insurance converted in either of these situations will be the lesser of:

1. the amount of life insurance in force, less any amount for which you become eligible under this or any other group policy within 31 days after the date your life insurance ceased; or
2. \$10,000.

Conditions for Conversion: (amended by form no. FDL1-23-1100)

We must receive written application and the first premium for the individual life insurance policy within 31 days after insurance under the Policy ceases. No evidence of insurability will be required. The individual policy will be a policy of whole life insurance. It will not contain disability benefits, accidental death and dismemberment benefits or any other supplemental benefits. The premium for the individual policy will be based on:

1. Our current rates based upon your attained age on your nearest birthday; and
2. on the amount of the individual policy.

If application is made for an individual policy, the coverage under the individual policy will be effective on the day following the 31-day period during which you could apply for conversion. If you die during a period when you would have been entitled to have an individual policy issued to you and if you die before such an individual policy becomes effective, We will pay your beneficiary the greatest amount of group term life insurance for which an individual policy could have been issued, provided:

1. your death occurred during the 31-day period within which you could have made application; and
2. We receive proof of death.

~~If life insurance benefits are paid under the Policy, payment will not be made under the converted policy, and premiums paid for the converted policy will be refunded.~~

TERMINATION PROVISIONS (FL)

Termination of the Policy under any conditions will not prejudice any claim, for a disability that began prior to termination of the Policy.

TERMINATION OF EMPLOYEE COVERAGE

Your insurance coverage will end on the earliest of:

1. the date you are no longer a member of a covered class; or
2. the date the Policy is canceled or, if applicable, the date the Participating Employer's participation terminates; or
3. the effective date of an amendment to the Policy which terminates insurance for the class to which you belong;
4. the date you stop making any required contribution toward payment of premiums; or
5. the date you are no longer Actively at Work; however,

if you are no longer Actively at Work as a result of a disability, layoff, or leave of absence, you may continue to be eligible for group insurance coverage, except short term disability coverage, as follows:

Disability	Until the end of the twelfth month following the month in which the disability began, provided all premiums are paid when due.
Layoff	Until the end of the month following the month during which the layoff began, provided all premiums are paid when due.
Leave of Absence	Until the end of the month following the month in which the leave of absence began, provided all premiums are paid when due.

GENERAL PROVISIONS (FL)

ENTIRE CONTRACT

The Policy, the Application and the enrollment forms of the Insureds are considered to be the entire contract.

STATEMENTS

We consider any statements made by You, in the absence of fraud, to be representations and not warranties. No such statement shall be used in defense to a claim under the Policy unless it is contained in a written application.

INCONTESTABILITY

We will not contest the validity of the Policy, except for nonpayment of premium, after it has been in force for two (2) years from its effective date. We will not contest the validity of your insurance after your insurance has been in force for two (2) years during your lifetime.

MISSTATEMENT OF AGE

If you misstated your age or the age of a Dependent, the true age will be used to determine:

1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

Premiums will be adjusted to reflect the premiums that would have been paid if the true age had been known.

CONFORMITY WITH STATE LAW

If any part of the Policy does not conform to a state statute in the state in which it is issued or delivered, it is amended to conform with the minimum requirements of the statutes of that state.

ASSIGNMENT

You may assign the life insurance benefits under the Policy, and you may assign to anyone other than the Policyholder any incident of ownership you may possess. We are not responsible for the validity or legal effect of any assignment. Collateral assignments, by whatever name called, are not permitted.

RETENTION OF DISCRETION

Fort Dearborn Life Insurance Company shall have the exclusive right to interpret the terms of the Certificate, Schedule of Benefits, Riders and Endorsements. The decision about whether to pay any claim, in whole or in part, is within the sole discretion of Fort Dearborn Life and such decisions shall be final and conclusive.

***ERISA INFORMATION STATEMENT**

The benefits described in your certificate and this ERISA Information Statement (collectively the "Summary Plan Description" a/k/a the SPD) are insured by a Policy issued by Fort Dearborn Life Insurance Company. This SPD describes the provisions of the Plan in effect as of the Effective Date of the Policy. It is not the intention of the SPD to cover all situations that may arise, but to provide you with a general understanding of your benefits. In the case of any item not covered by the SPD, or in the event of any conflict between the SPD and the Policy, the Plan will always control. You should not rely on any oral explanation, description, or interpretation of the Plan because the written terms of the Plan will govern. Your right to any benefit depends on the actual facts and terms and conditions of the particular Plan; no rights accrue by reason of or arising out of any statement shown in or omitted from, this SPD.

A. ADMINISTRATION OF THE PLAN

The Plan Administrator is responsible for the administration of the Plan. The Plan Administrator has full discretionary authority and control over the Plan. This authority provides the Plan Administrator with the power necessary to operate, manage and administer the Plan. This authority includes, but is not limited to, the power to interpret the Plan and determine who is eligible to participate, to determine the amount of benefits that may be paid to a participant or his or her beneficiary, and the status and rights of participants and beneficiaries. The Plan Administrator also has the authority to prescribe the rules and procedures under which the Plan shall operate, to request information, and to employ or appoint persons to aid the Plan Administrator in the administration of the Plan.

Failure by the Plan or the Plan Administrator to insist upon compliance with any provisions of the Plans at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by the person authorized by the Plan Administrator to sign the waiver.

The Plan may be amended, terminated or suspended in whole or in part, at any time without the consent of the employees or beneficiaries. Any amendment, termination or suspension shall be in writing, and attached to the Plan. Any amendment, termination or suspension shall be executed according to the Employer's authorized procedures. Any such authorization may be specific to the Plan or persons authorized to act on behalf of the Employer or may be general as to duties of such person. Except for termination or suspensions, any amendments affecting the Policy must also be approved in writing by an officer of Fort Dearborn Life Insurance Company (the "Insurer") and shall be effective as of the date agreed to, in writing by the Plan Sponsor and the Insurer. Notwithstanding anything to the contrary in this document, the Policy shall terminate according to the provisions in the Policy.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. The Plan's life benefits are provided pursuant to an insurance policy issued to the Company. The Insurer's services shall be limited to, and the Plan Administrator has the full discretionary and final authority to:

- resolve all matters when a review pursuant to the claims procedures has been requested;
- interpret, establish and enforce rules and procedures for the administration of the Policy and any claim under it; and
- determine eligibility of Employees and Dependents for benefits and their entitlement to and the amount of benefits.

***This ERISA addendum only applies if the Policy is part of or is an ERISA Plan.**

11/1/03

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of any Plan fiduciary, to the extent provided in ERISA Section 405(a).

The Employer makes no promise to continue these benefits in the future and rights to future benefits will never vest. Retirement does not give any retiree any vested right to continue to participate or receive Plan benefits.

B. CLAIMS PROCEDURE

***Disability Insurance Plans**

***(Applies to the Waiver of Premium based on disability in Life Certificates).**

When you or your Beneficiary are eligible to receive benefits, you or your Beneficiary, or your authorized representative (collectively, "you") must notify the Plan Administrator by submitting the proper form. You may do this by sending notice of your claim to the Plan Administrator who has been appointed to assist Fort Dearborn in the claims processing for this Plan or by contacting Fort Dearborn directly at:

Claims Department
Fort Dearborn Life Insurance Company
1020 31st Street
Downers Grove, IL. 60515-5591
1-800-348-4512

Fort Dearborn will give you a written response to your claim, usually within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, Fort Dearborn notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision shall be tolled from the date on which we send you notice of the extension until the date we receive your response to our request. This period will be no longer than 45 days after we have requested the information. At that time we will decide your claim based on the information we have at that time.

If the claim is denied, in whole or in part, you will receive a written notice giving the following:

- the reason for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed;
- the steps that you have to follow to have the claim reviewed;
- a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal; and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request; and

- if denial is based on medical judgement, either (i) an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

If the claim has been denied, in whole or in part, you can appeal the denial to us for a full and fair review. You have at least 180 days to appeal from the claim denial.

You may:

- a) request a review upon written application within 180 days of the claim denial;
- b) request, free of charge, copies of all documents, records and other information relevant to your claim; and
- c) submit written comments, documents, records and other information relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Fort Dearborn will make a decision no more than 45 days after we receive your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, Fort Dearborn notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for your decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request. The written decision will include specific references to the Plan provisions on which the decision is based and any other notice(s), statement(s) or information required by applicable law.

Life Insurance Plans

A decision will be made by Fort Dearborn no more than 90 days after receipt of due proof of loss, except in special circumstances (such as the need to obtain further information), but in no case more than 180 days after the due proof of loss is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

If the claim is denied, in whole or in part, you will receive a written notice giving the following:

- the reason for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed;
- the steps that you have to follow to have the claim reviewed;
- a statement of your right to bring a civil action on denial of your appeal.

Any denied claim may be appealed to Fort Dearborn for a full and fair review. You may:

- a) request a review upon written application within 60 days of receipt of claim denial;
- b) review pertinent documents; and
- c) submit issues and comments in writing.

A decision will be made by Fort Dearborn no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to obtain additional evidence), but in no case more than 120 days after the request for review is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

C. ERISA NOTICE OF YOUR RIGHTS

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

Examine, without charge, at the Plan Administrator's office and at other locations, such as work sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. Receive a summary of the Plan's annual financial report. The Plan Administrator is required to furnish each participant with a copy of this summary annual report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employers, your union, or any other persons, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, United States Department of Labor, 200 Constitution Avenue, NW Washington DC 20210.

D. PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute a contract between the Company and any participant or to be consideration or an inducement for the employment of any participant or employee. Nothing contained in this Plan shall be deemed to give any participant or employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any participant or employee at any time regardless of the effect which such discharge shall have upon him or her as a participant of this Plan.



**FORT DEARBORN LIFE
INSURANCE COMPANY**

Administrative Office:

1020 31st Street • Downers Grove, Illinois 60515-5591

Group Life Insurance

Employee Benefit Booklet



FORT DEARBORN LIFE INSURANCE COMPANY
Downers Grove, Illinois

City of Hallandale Beach

Group Number: F006642-0001

Class 1-04



® FORT DEARBORN LIFE INSURANCE COMPANY
(A stock life insurance company herein called "We", "Us", "Our")
300 East Randolph, Chicago, Illinois 60601
Administrative Office:
1020 31st Street, Downers Grove, IL. 60515-5591

CERTIFICATE (FL)
FOR OUR POLICYHOLDERS AND CERTIFICATEHOLDERS

To present inquiries or obtain information about coverage and to provide assistance in resolving complaints, please call our toll free number: 1-800-633-3696.

We agree to pay benefits subject to the provisions, definitions, limitations, and conditions of the master policy. The master policy (herein called the Policy) is a contract issued by Fort Dearborn Life Insurance Company to your Employer (herein called the Policyholder). The Policy may be changed at any time by a written agreement between Fort Dearborn Life Insurance Company and the Policyholder.

This is your certificate of coverage as long as you are eligible for insurance. It is not a contract or a part of one. Your benefits are described in plain English, but a few terms and provisions are written as required by insurance law.

PLEASE READ CAREFULLY

If you have any questions, please contact the Benefits Administrator at your place of employment or write to us. We will assist you in any way we can to help you understand your benefits.

President

Secretary

Group Insurance Certificate
Non-Participating
Term Life Insurance

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SCHEDULE OF BENEFITS

POLICYHOLDER: CITY OF HALLANDALE BEACH

POLICY NUMBER: F006642-0001

**CLASS OF
INSUREDS**

DEFINITION

1-04

Retirees who retired prior to August 1, 2004.

Basic Life Benefit: \$13,000.

All references to "actively at work" and "active work" are hereby deleted in this certificate

DEFINITIONS (FL)

This section tells You the meaning of special words and phrases used in this Certificate. To help You recognize these special words and phrases, the first letter of each word, or each word in the phrase, is capitalized wherever it appears.

Accident or Accidental means a sudden, unexpected event that was not reasonably foreseeable.

Actively at Work or Active Work means that you are:

1. performing the normal duties of your occupation; and
2. working the number of hours set forth in the Application.

Application means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the Policyholder applied.

Base Annual Salary means the gross annual compensation prior to before-tax payroll deductions, if any,

1. which you earn from your occupation with the Policyholder; and
2. which was used in the calculation and remittance of premium.

It does not include Salary from overtime, bonuses or any other form of extra pay. However, if your Salary is based in whole or in part on commissions, Base Annual Salary will include the amount paid in commissions during the preceding twelve-month calendar period. Your deferred contributions to a 401K plan or salary reduction contributions to a cafeteria plan which are maintained by the Policyholder will not be deducted when calculating gross annual compensation.

Basic Weekly Wage means the gross weekly compensation prior to before-tax payroll deductions, if any,

1. which you earn from your occupation with the Policyholder; and
2. which was used in the calculation and remittance of premium.

It does not include compensation from overtime, bonuses or any other form of extra pay. However, if your compensation is based in whole or in part on commissions, Basic Weekly Wage will include the weekly average paid in commissions during the preceding twelve-month calendar period. Your deferred contributions to a 401K plan or salary reduction contributions to a cafeteria plan which are maintained by the Policyholder will not be deducted when calculating gross weekly compensation.

Base Annual Salary/Basic Weekly Wage for each Insured who is a partner means the Insured's annual/average weekly compensation from the partnership during the calendar year prior to the date of the Insured's loss, as reported on the partnership federal income tax return as the "net Salary (loss) from self-employment" for that year.

If an Insured was not a partner during the calendar year prior to the date of loss, Base Annual Salary/Basic Weekly Wage means the Insured's annual/average weekly compensation (excluding dividends, capital gains, and return of capital) from the partnership prior to the date of the Insured's loss, determined in accordance with the terms of the applicable partnership agreement. In the event of a disagreement between Us and the claimant, an adjustment will be made, if warranted, after the Insured's subsequent federal income tax return is submitted to Us.

No benefits are payable when any of the above calculations result in an amount less than zero.

Base Annual Salary/Basic Weekly Wage for each Insured who is a sole proprietor or shareholder in a Subchapter S corporation or a member in a limited liability company means the Insured's annual/average weekly net taxable income (excluding dividends, capital gains, and return of capital) derived from the Policyholder for the calendar year prior to the date of the Insured's loss, as reported on his federal income tax return. The Insured's annual/average weekly net taxable income equals A minus B, where:

A = The Insured's annual/average weekly taxable income derived from the Policyholder for the prior calendar year (excluding dividends, capital gains, and return of capital), as reported on the Insured's federal income tax return; and

B = The Insured's annual/average weekly deductible work expenses attributable to his work for the Policyholder during the prior calendar year, as reported on the Insured's federal income tax return.

If an Insured was not a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company during the calendar year prior to the date of the Insured's loss, Base Annual Salary/Basic Weekly Wage means an Insured's annual/average weekly net taxable income derived from the Policyholder for the period he was a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company prior to the date of the Insured's loss. The Insured's annual/average weekly net taxable income will be based on the taxable income derived from the Policyholder for the period of the Insured's work as a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company for You, taking into account his deductible work expenses attributable to his work for the Policyholder during the same period.

No benefits are payable when any of the above calculations result in an amount less than zero.

Contributory means you pay a portion of the premium for this insurance coverage.

Employee means an Actively at Work full-time employee whose principal employment is with the Employer, at the Employer's usual place of business or such place(s) that the Employer's normal course of business may require, who is Actively at Work for the minimum hours per week as stated in the Application and is reported on the Employer's records for Social Security and withholding tax purposes.

Injury means bodily injury resulting directly from an Accident and independently of all other causes.

Insured means an Employee covered under the Policy.

Male Pronoun whenever used includes the female.

Noncontributory means the Policyholder pays 100% of the premium for this insurance.

Policy means the contract between the Policyholder and Us including the attached Application, which provides group insurance benefits.

Policyholder means the person, firm, or institution named in the Policy, including any covered subsidiaries or affiliates named in the Policy. If the Policyholder is a trust or association, the term Participating Employer shall be substituted for Policyholder.

You or Your means the Employee to whom this Certificate has been delivered.

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS (FL)

ELIGIBILITY

All Employees who belong to an eligible class and work the minimum number of hours as set forth in the Application are eligible for group insurance. An Employee must be **Actively at Work** for his insurance coverage to become effective.

EMPLOYER EFFECTIVE DATE OF COVERAGE

(Noncontributory Benefits)

If you are **Actively at Work**, you will become insured for Noncontributory benefits under the Policy on the day following completion of the Employee waiting period, if any, set forth in the Application.

If you waive all or a portion of your Noncontributory coverage and choose to enroll at a later date, you are considered a late applicant and must furnish evidence of insurability satisfactory to Us before coverage can become effective. Coverage will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

(Contributory Benefits)

You may apply for Contributory insurance coverage at any time. Your coverage will become effective as follows, provided you are **Actively at Work** on that date:

1. If you sign the enrollment form on or before the end of the waiting period, if any, as stated in the Application, coverage will become effective on the day following completion of the waiting period.
2. If you sign the enrollment form after the end of the waiting period, but within 31 days after that day, coverage will become effective the date you sign the enrollment form.
3. If you sign the enrollment form following this 31-day period, you are considered a late applicant and must furnish evidence of insurability satisfactory to Us before coverage can become effective. Coverage will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

DEFERRED EFFECTIVE DATE

You must be **Actively at Work** on the date your initial coverage or any increases in coverage are scheduled to begin. If:

1. you are absent from Active Work on the date such coverage would otherwise become effective; and
2. your absence is caused by an injury, illness or layoff,

the effective date of any initial coverage or increased coverage will be deferred until the first day you return to Active Work. You will be considered **Actively at Work** if you were actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled work days);
2. a holiday (except when such holiday is a scheduled work day);
3. a paid vacation;
4. any nonscheduled work day.

EFFECTIVE DATE IF WE REQUIRE EVIDENCE OF INSURABILITY

If you are required to submit evidence of insurability satisfactory to Fort Dearborn Life Insurance Company, insurance in the amount for which We require such evidence will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

EFFECTIVE DATE OF CHANGE IN AMOUNT OF BENEFITS

Any change in the amount of your benefits caused by a change in class, change in salary, age reduction or amendment to the Policy will become effective on the effective date of the change. If the change results in an increase in the amount of insurance, you must be Actively at Work on that date. If you are not Actively at Work, the increase will take effect on the day you are again Actively at Work.

ELIGIBILITY AFTER TERMINATION OF EMPLOYMENT

If your coverage ends due to termination of employment you must meet all the requirements of a new Employee if you are rehired at a later date.

GROUP TERM LIFE INSURANCE BENEFIT (FL)

BENEFIT

We will pay your beneficiary the amount of life insurance in force as of the date of your death provided:

1. you are insured under the Policy on the date of death, and
2. We receive proof of death.

The amount of insurance payable is based upon the Policyholder's Application, and it is set forth on the Schedule of Benefits.

BENEFICIARY

Your beneficiary designation must be made on a form which We provide or on a form accepted by Us. If you name two or more beneficiaries, payment of proceeds will be apportioned equally unless you had specified otherwise. The Policyholder may not be named as beneficiary.

Unless you provided otherwise, if a beneficiary dies before you, We will divide that beneficiary's share equally between any remaining named beneficiaries.

If no named beneficiary survives you or if you did not designate a beneficiary, We will pay the amount of insurance:

1. to your spouse, if living; if not,
2. in equal shares to your then living natural or adopted children, if any; if none,
3. in equal shares to your father and mother, if living; if not,
4. to your estate.

If a beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, We will not make payment until a claim is made by the person or entity which, by court order, has been granted control of the estate of such beneficiary. This provision does not prevent Us from making payment to or for the benefit of a minor beneficiary in accordance with the applicable state law.

If any benefits under this provision are to be paid to your estate, We may pay an amount not greater than \$5,000 to any person We consider to be equitably entitled by reason of having incurred funeral or other expenses incident to your death. Any and all payments made by Us shall fully discharge Us in the amount of such payment.

CHANGE OF BENEFICIARY

You may change your beneficiary at any time by completing a change request form, or a form accepted by Us, and sending it to the Policyholder. Your written request for change of beneficiary will not be effective until it is recorded by the Policyholder. After it has been so recorded, it will take effect on the later of the date you signed the change request form or the date you specifically requested. If you die before the change has been recorded, We will not alter any payment that We have already made. Any prior payment shall fully discharge Us from further liability in that amount.

CONVERSION OF LIFE INSURANCE

Conversion if Eligibility Terminates:

You may convert to an individual policy of life insurance if your life insurance, or a portion of it, ceases because:

1. you are no longer employed by the Policyholder; or
2. you are no longer in a class which is eligible for life insurance.

In either of these situations, you may convert all or any portion of your life insurance which was in force at the date of termination.

Conversion if Policy is Terminated or Amended:

You may also convert to an individual policy of life insurance if your life insurance ceases because:

1. life insurance benefits under the Policy cease; or
2. the Policy is amended making him ineligible for life insurance; however, in either of these situations,

you must have been insured under the Policy for at least five (5) years. The amount of insurance converted in either of these situations will be the lesser of:

1. the amount of life insurance in force, less any amount for which you become eligible under this or any other group policy within 31 days after the date your life insurance ceased; or
2. \$10,000.

Conditions for Conversion: (amended by form no. FDL1-23-1100)

We must receive written application and the first premium for the individual life insurance policy within 31 days after insurance under the Policy ceases. No evidence of insurability will be required. The individual policy will be a policy of whole life insurance. It will not contain disability benefits, accidental death and dismemberment benefits or any other supplemental benefits. The premium for the individual policy will be based on:

1. Our current rates based upon your attained age on your nearest birthday; and
2. on the amount of the individual policy.

If application is made for an individual policy, the coverage under the individual policy will be effective on the day following the 31-day period during which you could apply for conversion. If you die during a period when you would have been entitled to have an individual policy issued to you and if you die before such an individual policy becomes effective, We will pay your beneficiary the greatest amount of group term life insurance for which an individual policy could have been issued, provided:

1. your death occurred during the 31-day period within which you could have made application; and
2. We receive proof of death.

If life insurance benefits are paid under the Policy, payment will not be made under the converted policy, and premiums paid for the converted policy will be refunded.

TERMINATION PROVISIONS (FL)

Termination of the Policy under any conditions will not prejudice any claim, for a disability that began prior to termination of the Policy.

TERMINATION OF EMPLOYEE COVERAGE

Your insurance coverage will end on the earliest of:

1. the date you are no longer a member of a covered class; or
2. the date the Policy is canceled or, if applicable, the date the Participating Employer's participation terminates; or
3. the effective date of an amendment to the Policy which terminates insurance for the class to which you belong;
4. the date you stop making any required contribution toward payment of premiums; or
5. the date you are no longer Actively at Work; however,

if you are no longer Actively at Work as a result of a disability, layoff, or leave of absence, you may continue to be eligible for group insurance coverage, except short term disability coverage, as follows:

Disability	Until the end of the twelfth month following the month in which the disability began, provided all premiums are paid when due.
Layoff	Until the end of the month following the month during which the layoff began, provided all premiums are paid when due.
Leave of Absence	Until the end of the month following the month in which the leave of absence began, provided all premiums are paid when due.

GENERAL PROVISIONS (FL)

ENTIRE CONTRACT

The Policy, the Application and the enrollment forms of the Insureds are considered to be the entire contract.

STATEMENTS

We consider any statements made by You, in the absence of fraud, to be representations and not warranties. No such statement shall be used in defense to a claim under the Policy unless it is contained in a written application.

INCONTESTABILITY

We will not contest the validity of the Policy, except for nonpayment of premium, after it has been in force for two (2) years from its effective date. We will not contest the validity of your insurance after your insurance has been in force for two (2) years during your lifetime.

MISSTATEMENT OF AGE

If you misstated your age or the age of a Dependent, the true age will be used to determine:

1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

Premiums will be adjusted to reflect the premiums that would have been paid if the true age had been known.

CONFORMITY WITH STATE LAW

If any part of the Policy does not conform to a state statute in the state in which it is issued or delivered, it is amended to conform with the minimum requirements of the statutes of that state.

ASSIGNMENT

You may assign the life insurance benefits under the Policy, and you may assign to anyone other than the Policyholder any incident of ownership you may possess. We are not responsible for the validity or legal effect of any assignment. Collateral assignments, by whatever name called, are not permitted.

RETENTION OF DISCRETION

Fort Dearborn Life Insurance Company shall have the exclusive right to interpret the terms of the Certificate, Schedule of Benefits, Riders and Endorsements. The decision about whether to pay any claim, in whole or in part, is within the sole discretion of Fort Dearborn Life and such decisions shall be final and conclusive.

***ERISA INFORMATION STATEMENT**

The benefits described in your certificate and this ERISA Information Statement (collectively the "Summary Plan Description" a/k/a the SPD) are insured by a Policy issued by Fort Dearborn Life Insurance Company. This SPD describes the provisions of the Plan in effect as of the Effective Date of the Policy. It is not the intention of the SPD to cover all situations that may arise, but to provide you with a general understanding of your benefits. In the case of any item not covered by the SPD, or in the event of any conflict between the SPD and the Policy, the Plan will always control. You should not rely on any oral explanation, description, or interpretation of the Plan because the written terms of the Plan will govern. Your right to any benefit depends on the actual facts and terms and conditions of the particular Plan; no rights accrue by reason of or arising out of any statement shown in or omitted from, this SPD.

A. ADMINISTRATION OF THE PLAN

The Plan Administrator is responsible for the administration of the Plan. The Plan Administrator has full discretionary authority and control over the Plan. This authority provides the Plan Administrator with the power necessary to operate, manage and administer the Plan. This authority includes, but is not limited to, the power to interpret the Plan and determine who is eligible to participate, to determine the amount of benefits that may be paid to a participant or his or her beneficiary, and the status and rights of participants and beneficiaries. The Plan Administrator also has the authority to prescribe the rules and procedures under which the Plan shall operate, to request information, and to employ or appoint persons to aid the Plan Administrator in the administration of the Plan.

Failure by the Plan or the Plan Administrator to insist upon compliance with any provisions of the Plans at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by the person authorized by the Plan Administrator to sign the waiver.

The Plan may be amended, terminated or suspended in whole or in part, at any time without the consent of the employees or beneficiaries. Any amendment, termination or suspension shall be in writing, and attached to the Plan. Any amendment, termination or suspension shall be executed according to the Employer's authorized procedures. Any such authorization may be specific to the Plan or persons authorized to act on behalf of the Employer or may be general as to duties of such person. Except for termination or suspensions, any amendments affecting the Policy must also be approved in writing by an officer of Fort Dearborn Life Insurance Company (the "Insurer") and shall be effective as of the date agreed to, in writing by the Plan Sponsor and the Insurer. Notwithstanding anything to the contrary in this document, the Policy shall terminate according to the provisions in the Policy.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. The Plan's life benefits are provided pursuant to an insurance policy issued to the Company. The Insurer's services shall be limited to, and the Plan Administrator has the full discretionary and final authority to:

- resolve all matters when a review pursuant to the claims procedures has been requested;
- ~~interpret, establish and enforce rules and procedures for the administration of the Policy and any claim under it; and~~
- determine eligibility of Employees and Dependents for benefits and their entitlement to and the amount of benefits.

***This ERISA addendum only applies if the Policy is part of or is an ERISA Plan.**

11/1/03

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of any Plan fiduciary, to the extent provided in ERISA Section 405(a).

The Employer makes no promise to continue these benefits in the future and rights to future benefits will never vest. Retirement does not give any retiree any vested right to continue to participate or receive Plan benefits.

B. CLAIMS PROCEDURE

***Disability Insurance Plans**

***(Applies to the Waiver of Premium based on disability in Life Certificates).**

When you or your Beneficiary are eligible to receive benefits, you or your Beneficiary, or your authorized representative (collectively, "you") must notify the Plan Administrator by submitting the proper form. You may do this by sending notice of your claim to the Plan Administrator who has been appointed to assist Fort Dearborn in the claims processing for this Plan or by contacting Fort Dearborn directly at:

Claims Department
Fort Dearborn Life Insurance Company
1020 31st Street
Downers Grove, IL. 60515-5591
1-800-348-4512

Fort Dearborn will give you a written response to your claim, usually within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, Fort Dearborn notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision shall be tolled from the date on which we send you notice of the extension until the date we receive your response to our request. This period will be no longer than 45 days after we have requested the information. At that time we will decide your claim based on the information we have at that time.

If the claim is denied, in whole or in part, you will receive a written notice giving the following:

- the reason for the denial;
 - the Policy provisions on which the denial is based;
 - an explanation of what other information, if any, may be needed to process the claim and why it is needed;
 - the steps that you have to follow to have the claim reviewed;
 - a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal; and
-
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request; and

- if denial is based on medical judgement, either (i) an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

If the claim has been denied, in whole or in part, you can appeal the denial to us for a full and fair review. You have at least 180 days to appeal from the claim denial.

You may:

- a) request a review upon written application within 180 days of the claim denial;
- b) request, free of charge, copies of all documents, records and other information relevant to your claim; and
- c) submit written comments, documents, records and other information relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Fort Dearborn will make a decision no more than 45 days after we receive your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, Fort Dearborn notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for your decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request. The written decision will include specific references to the Plan provisions on which the decision is based and any other notice(s), statement(s) or information required by applicable law.

Life Insurance Plans

A decision will be made by Fort Dearborn no more than 90 days after receipt of due proof of loss, except in special circumstances (such as the need to obtain further information), but in no case more than 180 days after the due proof of loss is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

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- the steps that you have to follow to have the claim reviewed;
- a statement of your right to bring a civil action on denial of your appeal.

Any denied claim may be appealed to Fort Dearborn for a full and fair review. You may:

- a) request a review upon written application within 60 days of receipt of claim denial;
- b) review pertinent documents; and
- c) submit issues and comments in writing.

A decision will be made by Fort Dearborn no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to obtain additional evidence), but in no case more than 120 days after the request for review is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

C. ERISA NOTICE OF YOUR RIGHTS

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

Examine, without charge, at the Plan Administrator's office and at other locations, such as work sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. Receive a summary of the Plan's annual financial report. The Plan Administrator is required to furnish each participant with a copy of this summary annual report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employers, your union, or any other persons, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, United States Department of Labor, 200 Constitution Avenue, NW Washington DC 20210.

D. PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute a contract between the Company and any participant or to be consideration or an inducement for the employment of any participant or employee. Nothing contained in this Plan shall be deemed to give any participant or employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any participant or employee at any time regardless of the effect which such discharge shall have upon him or her as a participant of this Plan.



**FORT DEARBORN LIFE
INSURANCE COMPANY**

Administrative Office:

1020 31st Street • Downers Grove, Illinois 60515-5591

Attachment 7

Group Supplemental Life Benefit Summary

Plan Highlights

Voluntary Group Term Life Insurance



City of Hallandale Beach

ELIGIBILITY

Employees: Each Active, Full-time employee working 30 or more hours per week, except any person working on a temporary or seasonal basis.

Dependents: You or your spouse must be insured in order for Dependent children to be covered.

Dependents are:

- Your legal spouse under age 70.
- Your unmarried financially dependent children* age 14 days to 20 years (to 26 years if full-time student).

*natural and adopted children upon finalization of adoption; stepchildren and foster children living with you.

Upper age limits do not apply to handicapped children.

A person may not have coverage as both an Employee and Dependent.

Only one insured spouse may cover Dependent children.

BENEFIT AMOUNT

Employee and Spouse: Choose from a minimum of \$10,000 to a maximum of \$500,000 (in \$10,000 increments) for yourself and/or your spouse. The benefit amounts chosen need not be the same.

Eligible Dependent Child(ren): Age 14 days to 6 months: \$1,000

Age 6 months to 20 years of age (26, if full-time student): choice of \$2,500, \$5,000; \$7,500 or \$10,000

Choose one benefit amount for all eligible children in family.

GUARANTEE ISSUE (INITIAL ELIGIBILITY PERIOD ONLY)

Employee:

Under age 60: \$100,000

Age 60 but under age 70: \$10,000

Age 70 or older: none

Spouse:

Under age 60: \$30,000

Age 60 or older: none

Guarantee Issue is subject to underwriting rules and is not available in all circumstances.

CONTRIBUTION REQUIREMENTS

Coverage is employee paid.

BENEFIT REDUCTION DUE TO AGE

Age Original Benefit Reduced to:

75	60%
80	35%
85	27.5%
90	20%
95	7.5%
100	5%

RATE

See attached Rate Sheet.

FEATURES

- Accelerated Death Benefit (expressed as Living Benefit Rider in some states and Imminent Death Benefit in PA)
- Conversion Privilege
- Portability
- Waiver of Premium

EXCLUSIONS

Death by suicide is not covered during the first two years an insured's insurance is in force. Insurance coverage is incontestable after it has been in force two years during the insured's lifetime, except for non-payment of premium.

For a comprehensive list of exclusions and limitations, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

This Plan Highlights is a brief description of the key features of the RSL insurance plan. It is not a certificate of insurance or evidence of coverage. Insurance is provided under group policy form LRS-8349, et al.

Attachment 8

Group Supplemental Life Claims Experience

Coverage: All

Client Name: City of Hallandale

Policy Number: VG - 001640

Summary Exhibit

Policy Effective Date	04/01/1986
Policy Termination Date	N/A
Start of Period	04/01/2010
End of Period	04/01/2013
Number of Months	36
Premium	\$112,831.00
Paid Claims (Open)	\$0.00
Paid Claims (Closed)	\$131,594.20
Total Paid Claims	\$131,594.20
IBNR	\$4,871.20
Reserves	\$0.00
Total Incurred	\$136,465.40
Incurred Loss Ratio	120.9%
Valuation Date	N/A

<u>Current Rates</u>			
Policy	Sub Policy	Coverage	Current Rate
VG-001640	01	Employee / Spouse Life	Step Rates
VG-001640	01	Dependent Life	Step Rates

Please note that the information provided within this report is a snapshot as of 4/16/2013. This information can change frequently and does not necessarily indicate that rate action is required or recommended.

Coverage: All

Client Name: City of Hallandale

Policy Number: VG - 001640

Premium Exhibit

Time Period	Sub Policy	Bill Group	Payment Date	Due Date	Premium
4/1/2010 - 4/1/2013	01	1	04/23/2010	04/01/2010	\$2,169.96
	01	1	05/11/2010	04/01/2010	(\$33.99)
	01	1	06/03/2010	04/01/2010	(\$39.38)
	01	1	12/01/2010	04/01/2010	\$67.84
	01	1	05/11/2010	05/01/2010	\$2,123.31
	01	1	06/03/2010	05/01/2010	(\$39.38)
	01	1	12/01/2010	05/01/2010	\$67.84
	01	1	06/03/2010	06/01/2010	\$2,078.23
	01	1	12/01/2010	06/01/2010	\$67.84
	01	1	07/26/2010	07/01/2010	\$2,078.23
	01	1	09/27/2010	07/01/2010	(\$22.56)
	01	1	12/01/2010	07/01/2010	\$67.84
	01	1	08/23/2010	08/01/2010	\$2,083.48
	01	1	09/27/2010	08/01/2010	(\$22.56)
	01	1	12/01/2010	08/01/2010	\$67.84
	01	1	09/27/2010	09/01/2010	\$2,060.92
	01	1	12/01/2010	09/01/2010	\$67.84
	01	1	12/01/2010	10/01/2010	\$3,163.45
	01	1	06/02/2011	10/01/2010	\$119.84
	01	1	12/01/2010	11/01/2010	\$3,210.73
	01	1	06/02/2011	11/01/2010	\$119.84
	01	1	01/13/2011	12/01/2010	\$3,181.18
	01	1	06/02/2011	12/01/2010	\$119.84
	01	1	03/01/2011	01/01/2011	\$3,299.42
	01	1	06/02/2011	01/01/2011	\$119.84
	01	1	03/03/2011	02/01/2011	\$3,296.58
	01	1	06/02/2011	02/01/2011	\$119.84
	01	1	04/11/2011	03/01/2011	\$3,406.97
	01	1	05/01/2011	04/01/2011	\$3,399.74
	01	1	08/08/2011	04/01/2011	(\$88.33)
	01	1	06/02/2011	05/01/2011	\$3,311.41
	01	1	07/15/2011	06/01/2011	\$3,250.49
	01	1	08/08/2011	07/01/2011	\$3,250.49
	01	1	09/12/2011	08/01/2011	\$3,250.49
	01	1	10/01/2011	09/01/2011	\$3,250.49
	01	1	11/03/2011	09/01/2011	\$109.21
	01	1	11/03/2011	10/01/2011	\$3,242.37
	01	1	12/28/2011	11/01/2011	\$3,215.52
	01	1	01/26/2012	11/01/2011	\$27.20
	01	1	12/28/2011	12/01/2011	\$3,204.00
	01	1	01/26/2012	12/01/2011	\$27.20
	01	1	01/26/2012	01/01/2012	\$3,255.39
	01	1	03/01/2012	02/01/2012	\$3,255.39

Coverage: All

Client Name: City of Hallandale

Policy Number: VG - 001640

Premium Exhibit

Time Period	Sub Policy	Bill Group	Payment Date	Due Date	Premium
4/1/2010 - 4/1/2013	01	1	04/11/2012	03/01/2012	\$3,264.67
	01	1	05/10/2012	04/01/2012	\$3,268.34
	01	1	08/22/2012	04/01/2012	\$4.39
	01	1	09/11/2012	04/01/2012	\$38.70
	01	1	10/01/2012	04/01/2012	(\$50.05)
	01	1	06/11/2012	05/01/2012	\$3,325.04
	01	1	08/22/2012	05/01/2012	\$0.95
	01	1	09/11/2012	05/01/2012	\$26.41
	01	1	10/01/2012	05/01/2012	(\$50.05)
	01	1	07/12/2012	06/01/2012	\$3,337.27
	01	1	09/11/2012	06/01/2012	\$26.41
	01	1	10/01/2012	06/01/2012	(\$50.05)
	01	1	08/22/2012	07/01/2012	\$3,334.49
	01	1	09/11/2012	07/01/2012	\$26.41
	01	1	10/01/2012	07/01/2012	(\$38.35)
	01	1	09/11/2012	08/01/2012	\$3,342.01
	01	1	10/01/2012	09/01/2012	\$3,342.01
	01	1	11/02/2012	09/01/2012	\$25.51
	01	1	11/02/2012	10/01/2012	\$3,472.47
	01	1	01/01/2013	11/01/2012	\$3,474.20
01	1	01/02/2013	12/01/2012	\$3,368.28	
01	1	02/01/2013	01/01/2013	\$3,471.59	
01	1	04/01/2013	01/01/2013	\$24.10	
01	1	03/04/2013	02/01/2013	\$3,475.67	
01	1	04/01/2013	03/01/2013	\$3,408.69	

Total Premium for Bill Group : \$112,831.00

Total Premium for Sub Policy : \$112,831.00

Total Premium : \$112,831.00

Claims Exhibit

Claim Number	Gender	Date of Birth	Date of Loss	Gross Benefit	Total Paid	Reserve
2011-01-13-0125-VGTL-01-01	M	10/29/1953	12/15/2010	\$100,000.00	\$101,115.86	
2012-11-20-0151-VGTL-01-02	F	05/16/1952	10/15/2012	\$30,000.00	\$30,478.34	
Total Claims:					\$131,594.20	\$0.00

Paid Premium and Claims are posted as of 4/16/2013.

Attachment =

Group Long-term Disability Benefit Summary and Certificate

Long-Term Disability Insurance



*Developed for the Employees of
City of Hallandale Beach*

Protecting Your Family Securing Your Future

“As long as you've got your health . . .”

If you're physically healthy, you can work, play, take care of your family and enjoy life.

But, if something were to happen to you, all your hard work – and everything you have – could be lost unless you take steps to protect your income.

If asked to name your most valuable assets, you might list your home, your furnishings or your automobiles.

But what about your *paycheck*?

You insure your home and your auto. Shouldn't you insure your income as well?

After all, it's your income that enables you to buy and enjoy all of your other assets.

Having adequate insurance coverage is not only the basis for a sound financial blueprint, it helps to provide the protection you need to ensure that your family, your home and your finances will be protected.

By purchasing this disability insurance through your employer, you also benefit from:

- Affordable group rates
- Convenient payroll deduction

How This Program Protects You

If you suffer a covered disability while insured by this plan, you'll receive monetary benefits designed to help you maintain your normal lifestyle.

This program covers disabling injuries or sicknesses that last beyond the benefit waiting period, whether they occur on or off the job.

Please take a few minutes now to read this program description and learn how this valuable program helps protect your income and your lifestyle.

Eligibility For Coverage

You must be an active, full-time employee of City of Hallandale Beach, regularly working a minimum of 30 hours per week, excluding Police and Fire Department employees covered under the Policy/Fire Pension Plan to receive coverage under this plan.

Eligibility Waiting Period

All employees who meet the eligibility requirements are eligible to participate in this program on the first of the month on or after 30 days of active service.

You can enroll any time within 31 days following the date you become eligible for coverage. If you decide to enroll later, you will have to provide acceptable evidence of good health. This may require a medical examination, at your cost.

You will be asked to complete an enrollment form, indicating your wish to participate and your authorization for payroll deductions.

When Coverage Takes Effect

If you meet these eligibility requirements, your coverage takes effect on the later of the program's effective date, the date you become eligible, the date we receive your completed enrollment form, or the date you authorize any necessary payroll deductions.

If you have to submit evidence of good health, your coverage takes effect on the date we agree, in writing, to cover you. If you're not actively at work on the date your coverage would otherwise take effect, you'll be covered on the date you return to work.

How Disability is Defined

To receive benefits under this plan, you must be disabled (as defined below) as a result of a covered injury or sickness, and you must be under the appropriate care of a licensed, practicing physician who is qualified to treat your disability.

Disabled means that, because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation or solely due to injury or sickness you are unable to earn 80% or more of your indexed covered earnings. After benefits have been payable for 24 months, you are disabled if your injury or sickness makes you unable to perform the material duties of any occupation for which you are (or may reasonably become) qualified by education, training or experience, or solely due to injury or sickness you are unable to earn 80% or more of your indexed covered earnings.

Injury means any accidental loss or bodily harm that results directly and independently of all other causes from an accident.

Sickness means any physical or mental illness.

Appropriate Care means the determination of an accurate and medically supported diagnosis of your disability, or ongoing medical treatment, conforming to generally accepted medical standards regarding care and frequency of treatments, by a licensed physician.

Physician means a licensed doctor practicing within the scope of his/her license and rendering care and treatment to an employee that is appropriate for the condition and locality. A physician cannot be the employee, his/her spouse, the immediate family of either the employee or spouse, or a person living in the employee's household.

Benefit Waiting Period

Before collecting benefits, you must satisfy the benefit waiting period following your date of disability. For your plan, this period is 90 days of continuous disability.

Benefits

This plan offers two levels of coverage.

The basic level, for which your employer pays, provides a monthly benefit up to 50% of your covered monthly earnings — to the program maximum of \$1,000 per month.

The optional level allows you to change both the percentage of your monthly benefit amount to 60% of your monthly covered earnings and your maximum monthly benefit to \$5,000.

Your benefit amount will be reduced by any amounts payable to you by any of the sources listed under the “Effects of Other Income Benefits” section.

Covered earnings means your wages or salary, excluding overtime pay, bonuses, commissions and other extra compensation.

Family Survivor Benefit

The plan also includes a Family Survivor Benefit feature. With this feature, if you die after collecting disability benefits for 3 or more consecutive months, we will pay a survivor benefit based on 100% of the total of your last month's benefit plus the amount of any disability earnings by which this benefit had been reduced for that month. This plan pays a single lump sum equal to 3 months of benefits.

We pay this benefit directly to your lawful spouse, or to your children in equal shares, if there is no lawful spouse.

If you have no lawful spouse or children, we pay this benefit to your estate.

Return-To-Work Incentives

This plan includes benefits to encourage you to return to work as soon as medically feasible. These return-to-work incentives offer you both the opportunity and the encouragement to successfully return to productive employment – *without* risking your eligibility for income replacement benefits under this plan.

Residual Disability “Work Incentive” Benefits

If you can work part-time at your regular occupation, or perform some work at any occupation (including limited or modified job duties or schedules) on a full- or part-time basis for less pay, you may qualify for residual disability benefits under this plan – even if you attempt to return to work before you have fulfilled the benefit waiting period. (Benefit payments, however, do not begin until the full benefit waiting period has been satisfied.)

For the first 24 months of residual disability, you may earn up to the same level you earned before becoming disabled, through a combination of your work earnings during any month you return to work, plus the benefit amount this plan pays. We reduce the plan benefit paid to the extent necessary to ensure that your benefits and other incomes combined do not exceed 100% of your pre-disability covered earnings amount.

After you have received residual disability benefits for 24 months, your benefit is reduced by 50% of any earnings you receive, and we may reduce it further, if necessary, to keep your combined benefits plus earnings to no more than 80% of your indexed covered earnings amount.

Recurrent Disability Feature

If you return to work after receiving benefits under this plan, then again become disabled from the same or a related cause, you will *not* have to fulfill another benefit waiting period, if you have worked less than 6 consecutive months. The disability would be considered a continuation of your initial claim. (Of course, if the second disability recurs after 6 months, or results from a cause unrelated to the first, you must file a new claim and fulfill a new benefit waiting period.)

Rehabilitation Services

If you are offered a rehabilitative assistance program agreed to by us and your employer during the course of your benefit waiting period or while benefits are payable, you will be expected to cooperate with the implementation of that assistance program. Disability benefits, if payable, may be suspended during any period in which you refuse to cooperate in such assistance, if offered. (Refer to the Exclusions section.)

Indexed Covered Earnings are the same as covered earnings for the first 12 months of benefit payments. After the 12th month of benefit payments, we apply an increase to your covered earnings amount, and refer to this as “indexed covered earnings,” in order to calculate the maximum benefit payable under this plan when combined with other income benefits you may be eligible to receive. The amount of the increase we apply is the lesser of either 10% or the rate specified in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPIW) for the preceding calendar year. We do not reduce indexed covered earnings if the CPIW drops. If the CPIW is ever discontinued, we will use a comparable national index to calculate indexed covered earnings.

Effects of Other Income Benefits

Disability insurance is designed to help you meet your financial obligations if you cannot work as a result of a covered injury or sickness. However, this plan is structured to prevent your total benefits and post-disability earnings from equaling or exceeding pre-disability earnings. Therefore, we reduce this plan's benefits by an amount equal to any Social Security retirement and/or disability benefits payable to you, your dependents, or a qualified third party on behalf of you or your dependents.

Other income sources that **WILL** reduce your benefits under this plan include:

- Employer-paid portion of company retirement plan benefits.
- Amounts payable under local, state, provincial or federal government disability or retirement plan or law as it pertains to the employer.
- Amounts payable by any franchise or group insurance or similar plan.
- Amounts payable by company sponsored sick leave or salary continuation plans.
- Benefits payable by a Canadian and/or Quebec provincial pension plan.
- Benefits payable under work-loss provisions of any "no fault" auto insurance.
- Amounts payable under the Railroad Retirement Act.
- Amounts of any wage or salary earned for work performed.
- Any amounts paid on account of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.
- Amounts payable under any workers' compensation (including temporary or permanent disability benefits), occupational disease, and unemployment compensation. This includes damages, compromises or settlements paid in place of such benefits, whether or not liability is admitted.

Income sources that **WILL NOT** reduce your benefits under this plan are:

- Benefits paid by personal, individual disability income policies.
- Individual deferred compensation agreements.
- Employee savings plans, including thrift plans, stock options or stock bonuses.
- Individual retirement funds, such as IRA or 401(k) plans.
- Profit-sharing, investment or other retirement or savings plans maintained in addition to an employer-sponsored pension plan.

Minimum Disability Benefit

Your benefits from this plan will never be less than either \$100 per month or 10% of your monthly benefit amount, whichever is greater. However, if there is an overpayment due, the minimum benefit may be reduced or not apply in order to recover the overpayment.

Benefit Period

Once you qualify for benefits under this plan, you continue to receive them until the end of the benefit period, or until you no longer qualify for benefits, whichever occurs first. (We will ask you to periodically furnish proof of your continuing disability.)

This plan pays long-term disability benefits monthly.

Age at Commencement of Disability	Duration of Benefit Period
Age 62 or younger	To age 65 or the date the 42 nd monthly benefit is payable, if later.
63 years	36 monthly payments
64 years	30 monthly payments
65 years	24 monthly payments
66 years	21 monthly payments
67 years	18 monthly payments
68 years	15 monthly payments
69 years or older	12 monthly payments

Benefits payable under this plan will terminate on the earliest of any date indicated below:

- The date we determine you are no longer disabled.
- The date the maximum benefit period ends (see above schedule).
- The date you refuse to participate in rehabilitation services.
- The date you cease to get appropriate care.
- The date you die.

Limitations

This plan provides only limited benefits for some conditions and excludes others from coverage, as listed below.

Pre-Existing Conditions

Pre-existing conditions are those for which you have incurred expenses, taken prescription drugs or medicines, received medical treatment, care or services (including diagnostic measures,) or for which a reasonable person would have consulted a physician during the 3 months immediately prior to the most recent effective date of insurance.

This plan does *not* pay benefits for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured under this plan for 12 consecutive months. If you were insured under the employer-sponsored disability plan with a pre-existing condition limitation immediately prior to the effective date of this plan, we will credit you for all time served toward that limitation period, for similar or lower benefit amounts. If benefits under this plan are higher than under your prior plan, you do not receive credit for the higher benefit levels. This limitation also applies to newly added or increased benefits.

Limitation to Mental/Nervous Conditions

This plan limits benefits for disabilities caused by or contributed to by any one or more of the following conditions:

- Alcoholism
- Anxiety-disorders
- Delusional (paranoid) or depressive disorders
- Drug addiction or abuse
- Eating disorders
- Mental illness
- Somatoform disorders (including psychosomatic illnesses).

Benefits for these conditions have a lifetime limit of 24 months for outpatient treatment. The plan also pays benefits during periods of hospital confinement for these conditions, as long as hospitalization lasts for more than 14 consecutive days and occurs before the 24-month lifetime outpatient limit is exhausted. Once the 24-month outpatient benefits are exhausted, the plan pays no further benefits for these conditions.

Exclusions

This plan does not pay benefits for a disability which results, directly or indirectly, from any of the following:

- Suicide, attempted suicide, or whenever you injure yourself on purpose
- War or any act of war, whether or not declared
- Active participation in a riot
- Commission of a felony
- The revocation, restriction or non-renewal of your license, permit or certification necessary for you to perform the duties of your occupation, unless solely due to injury or sickness otherwise covered by the policy.

Further no benefits will be payable for any periods during which you:

- Are incarcerated in a penal or corrections institution
- Are engaged in the activities of active duty service in the military, navy or air force of any country or international organization. An Injury or Sickness that occurs while engaged in Reserve or National Guard training is not excluded until training extends beyond 31 days.
- refuse to participate in rehabilitation efforts as required by us
- Are not receiving appropriate care
- Refuse to participate in a transitional work arrangement or other modified work arrangement. (These work arrangements may be offered to you by your employer, or an affiliated company while you are disabled; they may be of the same or any other occupation as once held by you prior to the disability; and they may include, but are not limited to: reassigned duties, work site modification, flexible work arrangements, job adaptations or specialized equipment.)
- Fail to cooperate with us in the administration of the claim. (Such cooperation includes, but is not limited to providing information or documents needed to determine whether benefits are payable or the actual benefit amount due.)

Termination of Coverage

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

- the date you are no longer an employee of the employer sponsoring the plan
- the date you are no longer a member of an eligible class of employees
- the date the plan is terminated by the insurer or the employer
- the day after the last date for which premium has been paid by you or the employer.
- the date you become eligible for a plan of benefits intended to replace this coverage.

If you are disabled and receiving benefits under this plan, your benefits and coverage will continue until the expiration of your benefit period, or until you no longer qualify for benefits under the plan, whichever comes first.

How Much Your Coverage Will Cost

The cost of the basic insurance program is paid for by your employer. However, you can supplement your basic coverage with the additional benefit option offered below.

This optional plan offers you the opportunity to enhance your coverage by electing to change your gross monthly benefit to 60% of covered earnings per month and to change your maximum monthly benefit amount to \$5,000.

The cost of this coverage is \$0.23 per \$100 of monthly covered earnings.

Please indicate your disability plan choice (or your decision not to select coverage) on your enrollment form. You must authorize payroll deductions for any portion of the premiums for which you pay.

Costs are subject to change.

To calculate the cost of your coverage, follow these steps:

Step 1. Enter your gross or pre-tax monthly pay (not counting commissions, bonuses, overtime or other extra compensation). Please note this amount cannot exceed \$8,333.

\$ _____

Step 2. Enter the rate.

\$ 0.23

Step 3. Multiply gross pay (line 1) by the rate.

\$ _____

Step 4. Divide by 100 to determine the amount of premium that will be deducted from your paycheck each month.

\$ _____

(Please Note: All benefits in this plan are paid on a monthly basis, regardless of your regular pay period.)

This information is a brief description of the important features of this plan. It is not a contract. Terms and conditions of the coverage are set forth in Group Policy No. FLK-960075, on Policy Form TL-004700, issued in Florida and subject to its laws. The availability of this offer may change. Please keep this material as a reference, and file it with your certificate, should you become insured.

Licensed Resident Agent: Stephen C Zilberfarb #E108462

*Coverage is underwritten by
Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, PA 19192*

12/12
Class 1



GO YOUSM



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**Group Disability
Insurance Certificate**

City of Hallandale Beach

IMPORTANT NOTICES

If you reside in one of the following states, please read the important notices below:

Arizona, Florida and Maryland residents:

The group policy is issued in the state of Florida and will be governed by its laws. If you reside in a state other than Florida, this certificate of insurance may not provide all of the benefits and protections provided by the laws of your state. PLEASE READ YOUR CERTIFICATE CAREFULLY.

Texas residents:

IMPORTANT NOTICE: To obtain information or make a complaint:

You may call the Life Insurance Company of North America, Group Insurance's toll-free telephone number for information or to make a complaint at 1-800-547-5515.

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at 1-800-252-3439.

You may write the Texas Department of Insurance:

P O Box 149104

Austin, TX 78714-9104

FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the agent or company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

AVISO IMPORTANTE: Para obtener informacion o para someter una queja:

Usted Puede llamar al numero de telefono gratis del Life Insurance Company of North America, Group Insurance Division para informacion o para someter una queja al 1-800-547-5515.

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al 1-800-252-3439.

Puede escribir al Departamento de Seguros de Texas:

P O Box 149104

Austin, TX 78714-9104

FAX # (512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call the Life Insurance Company of North America, Group Insurance Division's toll-free telephone number for information or to make a complaint at **1-800-441-1832**.

FOREWORD

Disability insurance provides individuals and their families with financial protection. The Disability Insurance Benefit described in this booklet will help secure your family's financial security in the event of your disability.

The need for disability insurance protection depends on individual circumstances and financial situations. A portion of the cost of this coverage is provided by your Employer. You may need to contribute to the remaining cost of coverage through payroll deduction so that your benefit program is more comprehensive and responsive to your needs.

The following pages describe the main provisions of the disability insurance plan available to you.

Insurance benefits described in the following pages will apply to you if your Employer has made this coverage available to you at no cost or you have elected the benefit and authorized payroll deduction for the required premium.

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(800) 732-1603 TDD (800) 552-5744
A STOCK INSURANCE COMPANY

**GROUP INSURANCE
CERTIFICATE**

We, the LIFE INSURANCE COMPANY OF NORTH AMERICA, certify that we have issued a Group Policy, FLK-960075, to City of Hallandale Beach.

We certify that we insure all eligible persons, who are enrolled according to the terms of the Policy. Your coverage will begin and end according to the terms set forth in this certificate.

This certificate describes the benefits and basic provisions of your coverage. You should read it with care so you will understand your coverage.

This is not the insurance contract. It does not waive or alter any of the terms of the Policy. If questions arise, the Policy will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

This certificate replaces any and all certificates which may have been issued to you in the past under the Policy.

A handwritten signature in black ink, appearing to read "Gregory H. Wolf". The signature is written in a cursive style with a large, stylized initial "G".

Gregory H. Wolf, President

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SCHEDULE OF BENEFITS

Policy Effective Date: August 1, 2004

Policy Anniversary Date: August 1

Policy Number: FLK-960075

Eligible Class Definition:

All active, Full-time Employees of City of Hallandale Beach regularly working a minimum of 30 hours per week, excluding Police and Fire Department Employees covered under the Police and Fire Pension Plan.

Eligibility Waiting Period

If you were hired on or before the Policy Effective Date: The first of the month on or after 30 days of Active Service

If you were hired after the Policy Effective Date: The first of the month on or after 30 days of Active Service

Benefit Waiting Period

Core Benefit: 90 days

Buy-up Benefit: 90 days

Disability Benefit

Core Benefit: 50%

Buy-up Benefit: 60%

The lesser of the percent of your monthly Covered Earnings listed above, rounded to the nearest dollar, or the Maximum Disability Benefit, reduced by any Other Income Benefits.

"Other Income Benefits" means any benefits listed in the Other Income Benefits provision that you receive on your own behalf or for your dependents, or which your dependents receive because of your entitlement to Other Income Benefits.

Maximum Disability Benefit

Core Benefit: \$1,000 per month

Buy-up Benefit: \$5,000 per month

Minimum Disability Benefit

Core Benefit: The greater of \$100 or 10% of your Monthly Benefit prior to any reductions for Other Income Benefits.

Buy-up Benefit: The greater of \$100 or 10% of your Monthly Benefit prior to any reductions for Other Income Benefits.

Maximum Benefit Period

Age When Disability Begins

Age 62 or under

Age 63

Age 64

Age 65

Age 66

Age 67

Age 68

Age 69 or older

Maximum Benefit Period

The Employee's 65th birthday or the date the 42nd Monthly Benefit is payable, if later.

The date the 36th Monthly Benefit is payable.

The date the 30th Monthly Benefit is payable.

The date the 24th Monthly Benefit is payable.

The date the 21st Monthly Benefit is payable.

The date the 18th Monthly Benefit is payable.

The date the 15th Monthly Benefit is payable.

The date the 12th Monthly Benefit is payable.

TL-004774

WHO IS ELIGIBLE

If you qualify under the Class Definition shown in the Schedule of Benefits you are eligible for coverage under the Policy on the Policy Effective Date, or the day after you complete the Eligibility Waiting Period, if later. The Eligibility Waiting Period is the period of time you must be in Active Service to be eligible for coverage. Your Eligibility Waiting Period will be extended by the number of days you are not in Active Service.

Except as noted in the Reinstatement Provision, if you terminate your coverage and later wish to reapply, or if you are a former Employee who is rehired, you must satisfy a new Eligibility Waiting Period. You are not required to satisfy a new Eligibility Waiting Period if your insurance ends because you no longer qualify under your Class Definition, but you continue to be employed, and within one year you qualify again.

TL-004710

WHEN COVERAGE BEGINS

You will be insured on the date you become eligible, if you are not required to contribute to the cost of this insurance.

If you are required to contribute to the cost of your insurance you may elect to be insured only by authorizing payroll deduction in a form approved by the Employer and us. The effective date of your insurance depends on the date coverage is elected.

If you elect coverage within 31 days after you become eligible, your insurance is effective on the latest of the following dates.

1. The Policy Effective Date.
2. The date you authorized payroll deduction.
3. The date the completed enrollment form is received by the Employer or us.

If your enrollment form is received more than 31 days after you are eligible for insurance, you must satisfy the Insurability Requirement before your insurance is effective. If approved, your insurance is effective on the date we agree in writing to insure you.

If you are not in Active Service on the date your insurance would otherwise be effective, it will be effective on the date you return to any occupation for your Employer on a Full-time basis.

TL-004712

WHEN COVERAGE ENDS

Your insurance ends on the earliest of the dates below.

1. The date you are eligible for coverage under a plan intended to replace this coverage.
2. The date the Policy is terminated.
3. The date you no longer qualify under your Class Definition.
4. The day after the period for which premiums are paid.
5. The date you are no longer in Active Service.

TL-004714

WHEN COVERAGE CONTINUES

Your Disability Insurance will continue if your Active Service ends because of a Disability for which benefits under the Policy are or may become payable. Your premiums will be waived while Disability Benefits are payable. If you do not return to Active Service, this insurance ends when your Disability ends or when benefits are no longer payable, whichever occurs first.

If your Active Service ends because you take an Employer approved unpaid leave of absence, we will continue your insurance as follows if the required premium is paid.

1. for up to 12 weeks for a family medical leave of absence

If your insurance continues and you become Disabled during the leave of absence, Disability Benefits will not begin until you satisfy your Benefit Waiting Period, or the date you are scheduled to return to Active Service, if later.

TL- 004716a (FL)

DESCRIPTION OF BENEFITS WHAT IS COVERED

Disability Benefits

If you become Disabled, as we define the term in the Definitions section, while you are covered under the Policy, we will pay you Disability Benefits. After you are Disabled, you must satisfy the Benefit Waiting Period and be under the Appropriate Care of a Physician. Also, we ask you to provide us with satisfactory proof of your Disability, at your expense, before benefits will be paid.

We will require continued proof of your Disability for benefits to continue.

Benefit Waiting Period

The Benefit Waiting Period is the period of time you must be continuously Disabled before Disability Benefits may be payable. Your Benefit Waiting Period is shown in the Schedule of Benefits.

We will not require you to satisfy the Benefit Waiting Period if benefits were payable to you under a Prior Plan on the Policy Effective Date and you return to Active Service within 6 months after this date. Your return to Active Service must be for more than 14 consecutive days but less than 6 months. Your later period of Disability must be caused by the same or related causes for your Benefit Waiting Period to be waived.

Trial Work Days

Under this plan, you can attempt to return to Active Service without having to start a new Benefit Waiting Period if you cannot continue working, provided you have not worked for more than the specified number of days. A period of Disability is continuous even if you can return to Active Service for up to 15 days during the Benefit Waiting Period. Your Benefit Waiting Period will not be extended by the number of days you returned to Active Service during this period.

Termination of Your Disability Benefits

Your Disability Benefits will end on the earliest of the dates listed below.

1. The date you earn more than the percentage of your Indexed Covered Earnings which is used to determine if you are Disabled
2. The date we determine you are no longer Disabled
3. The date the Maximum Benefit Period ends
4. The date you die
5. The date you refuse to participate in rehabilitation efforts as required by us
6. The date you are no longer receiving Appropriate Care

Successive Periods of Disability

Once you are eligible to receive Disability Benefits under the Policy, separate periods of Disability resulting from the same or related causes are a continuous period of Disability unless you return to Active Service for more than 6 consecutive months.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes, or your later Disability occurs after your coverage under the Policy ends.

The Successive Periods of Disability provision will not apply if you are eligible for coverage under a plan that replaces the Policy.

Mental Illness, Alcoholism and Drug Abuse Limitation

We will pay Disability Benefits on a limited basis during your lifetime for a Disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly Disability Benefits have been paid, no further benefits will be payable for any of the following conditions.

1. Alcoholism
2. Anxiety disorders
3. Delusional (paranoid) disorders
4. Depressive disorders
5. Drug addiction or abuse
6. Eating disorders
7. Mental illness
8. Somatoform disorders (psychosomatic illness)

If, before reaching the lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against the lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above.

Pre-Existing Condition Limitation

We will not pay Disability Benefits if your Disability is caused or contributed to by, or results from, a Pre-Existing Condition. A "pre-existing condition" is any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a physician within 3 months before your most recent effective date of insurance.

The Pre-Existing Condition Limitation will apply to any added benefits or increases in benefits. It will not apply to a period of Disability that begins after you are in Active Service for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefits.

We will not apply the Pre-Existing Condition Limitation to your Disability if you were covered under your Employer's Prior Plan and satisfied the pre-existing condition of that plan. This is true only for the amount of benefit covered under that prior plan. If you were covered under your Employer's Prior Plan, but did not fully satisfy the pre-existing condition limitation of that plan, we will credit you for any time you did satisfy. If you are now covered for benefits in excess of your Prior Plan coverage, the Pre-Existing Condition Limitation will apply to the excess amount.

Time will not be credited toward this limitation for any day you are not actively at work due to your Injury or Sickness. We will extend the limitation by the number of days you are not actively at work due to your Injury or Sickness.

Disability Benefit Calculation

Your Disability Benefit for any month Disability Benefits are payable to you is shown in the Schedule of Benefits. We base our calculation of Disability Benefits on a 30 day period. Benefits will be prorated if payable for any period less than a month.

Work Incentive Benefit

For the first 24 months you return to work your Disability Benefit is as defined in the Schedule of Benefits. If, for any month during this period, the sum of your Disability Benefit, your current earnings and any additional Other Income Benefits exceed 100% of your Indexed Covered Earnings, your Disability Benefit will be reduced by the excess amount.

After 24 months, your Disability Benefit is as shown in the Schedule of Benefits, reduced by 50% of your current earnings received during any month you return to work. If the sum of your Disability Benefit, your current earnings and any additional Other Income Benefits exceed 80% of your monthly Indexed Covered Earnings, your Disability Benefit will be reduced by the excess amount.

No Disability Benefits will be paid if we determine you are able to work under a Transitional Work Arrangement or other modified work arrangement, and you refuse to do so.

Current earnings include any wage or salary you earn for work performed while Disability Benefits are payable. If you are working for another employer on a regular basis when your Disability begins, your current earnings will include any increase in the amount you earn from this work during the period for which Disability Benefits are payable.

We will, from time to time, review your status and will require satisfactory proof of earnings and continued Disability.

Other Income Benefits

While you are Disabled, you may be eligible to receive benefits from other income sources. If so, we may reduce the Disability Benefits payable to you under the Policy by the amount of these Other Income Benefits. The extent to which Other Income Benefits will reduce your Disability Benefits is shown in the Amounts of Insurance section of the Schedule of Benefits.

Other Income Benefits include:

1. any amounts you or your dependents, if applicable, receive (or are assumed to receive*) under:
 - a. the Canada and Quebec Pension Plans;
 - b. the Railroad Retirement Act;
 - c. any local, state, provincial or federal government disability or retirement plan or law as it pertains to your Employer;
 - d. any sick leave or salary continuation plan of your Employer;
 - e. any work loss provision in mandatory "No-Fault" auto insurance.
2. any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive*) either on your behalf or for your dependents; or, if applicable, which your dependents receive (or are assumed to receive*) because of your entitlement to such benefits.
3. any retirement plan benefits funded by your Employer. "Retirement plan" means any defined benefit or defined contribution plan sponsored or funded by your Employer. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any Employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401(k) plan.
4. any proceeds payable under any franchise or group insurance or similar plan. If there is other insurance that applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, we will pay our pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.

5. any amounts you or your dependents, if applicable, receive (or are assumed to receive*) under any Workers' Compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.
6. any amounts paid on account of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.
7. any wage or salary for work performed. If Work Incentive Benefits apply to you, we will only reduce your Disability Benefits to the extent provided under your Work Incentive Benefit.

Dependents include any person who receives (or is assumed to receive*) benefits under any applicable law on account of your entitlement to benefits.

*See the Assumed Receipt of Benefits provision.

Increases in Other Income Benefits

After we make the first deduction for any Other Income Benefit (except wage or salary), we will not reduce your Disability Benefits further during that period of Disability due to any cost of living increase in the Other Income Benefit.

Lump Sum Payments

Other Income Benefits or earnings that are paid in a lump sum will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated monthly over a five-year period.

If no specific allocation of a lump sum payment is made, we will assume the total payment is an Other Income Benefit.

Assumed Receipt of Benefits

We will assume you or your dependents, if applicable, are receiving Other Income Benefits if you may be eligible for them. We will estimate the amount of these assumed benefits on the basis of what you may be eligible to receive and reduce your Disability Benefits as if you actually received them.

Except for any wage or salary for work performed while Disability Benefits are payable, we will not assume your receipt of Other Income Benefits if you give us proof of the following events.

1. Application was made for these benefits.
2. Reimbursement Agreement is signed by you.
3. Any and all appeals were made for these benefits, or we have determined further appeals will not be successful.
4. Payments were denied.

We will not assume you have received, nor will we reduce your Disability Benefits by, any elective, actuarially reduced, or early retirement benefits under such laws until you actually receive them.

Social Security Assistance

We will, at our own discretion, assist you in applying for Social Security Disability Income (SSDI) benefits. Disability Benefits will not be reduced by your assumed receipt of SSDI benefits while you participate in the Social Security Assistance Program.

We may require you to file an appeal if we believe a reversal of a prior decision is possible. If you refuse to participate in, or cooperate with, the Social Security Assistance Program, we will assume receipt of SSDI benefits until you give us proof that you have exhausted all the administrative remedies available to you.

Minimum Benefit

We will pay the Minimum Benefit regardless of any reductions made for Other Income Benefits. However, if there is an overpayment due, this benefit may be reduced to recover the overpayment.

Recovery of Overpayment

If we overpay your benefits, we have the right to recover the amount overpaid by either requesting you to pay the overpaid amount in a lump sum or by reducing any amounts payable to you by the amount due. If there is an overpayment due when you die, we will reduce any benefits payable under the Policy to recover the overpayment.

TL-004771

ADDITIONAL BENEFITS

Rehabilitation During A Period of Disability

If you are Disabled and we determine that you are a suitable candidate for rehabilitation, you may participate in a Rehabilitation Plan. We must agree on the terms and conditions of the Rehabilitation Plan.

We may require you to participate in a rehabilitation assessment, at our expense, and/or Rehabilitation Plan. We will work with you, your Employer, your Physician and others as appropriate, to develop a Rehabilitation Plan. If you refuse to participate in the rehabilitation efforts, Disability Benefits will not be payable.

The Rehabilitation Plan may, at our discretion, allow for payment of your medical expense, education expense, moving expense, accommodation expense or family care expense while you participate in the program.

A "Rehabilitation Plan" is a written agreement between you and us in which we agree to provide, arrange or authorize vocational or physical rehabilitation services.

TL-005105

Survivor Benefit

We will pay a Survivor Benefit if you die while Disability Benefits are payable and at least 3 Monthly Benefits have been payable to you for a continuous period of Disability. The Survivor Benefit will equal the last Disability Benefit, prior to any reductions due to wage or profit, payable to you for work performed while Disabled. A single lump sum payment equal to 3 monthly Survivor Benefits will be payable. In no event will the amount of the Survivor Benefit exceed \$1,000.

We will pay the Survivor Benefit to your Spouse. If you do not have a Spouse, we will pay your surviving Children in equal shares. If you do not have a Spouse or any Children, we will pay your estate.

"Spouse" means your lawful spouse. "Children" means your unmarried children under age 21 who are chiefly dependent upon you for support and maintenance. The term includes a stepchild living with you at the time of your death.

TL-005107

WHAT IS NOT COVERED

We will not pay any Disability Benefits for a Disability that results, directly or indirectly, from:

1. suicide, attempted suicide, or whenever you injure yourself on purpose.
2. war or any act of war, whether or not declared.
3. an Injury or Sickness that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. An Injury or Sickness that occurs while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days.
4. active participation in a riot.
5. commission of a felony.
6. revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless due solely to Injury or Sickness otherwise covered by the Policy.

We will not pay Disability Benefits for any period of Disability during which you:

7. are incarcerated in a penal or corrections institution.
8. are not receiving Appropriate Care.
9. fail to cooperate with us in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit due.
10. refuse to participate in rehabilitation efforts as required by us.
11. refuse to participate in a Transitional Work Arrangement or other modified work arrangement.

“Transitional Work Arrangement” means any work offered to you by the Employer, or an affiliated company while you are Disabled and which may be your own occupation or any occupation. The term includes but is not limited to reassigned duties, work site modification, flexible work arrangements, job adaptation, or special equipment.

TL-004772FL

CLAIM PROVISIONS

Notice of Claim

Written notice of claim, or notice by any other electronic/telephonic means authorized by us, must be given to us within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by us, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Philadelphia, Pennsylvania or to our agent. Notice should include the Employer's name, the Policy Number and the claimant's name and address.

Claim Forms

When we receive notice of claim, we will send claim forms for filing proof of loss. If we do not send claim forms within 15 days after notice is received by us, the proof requirements may be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by us, of the nature and extent of the loss.

Claimant Cooperation Provision

If you fail to cooperate with us in our administration of your claim, we may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data

The Employer is required to cooperate with us in the review of claims and applications for coverage. Any information we provide to the Employer in these areas is confidential and may not be used or released by the Employer if not permitted by applicable laws.

Proof of Loss

You must provide written proof of loss to us, or proof by any other electronic/telephonic means authorized by us, within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by us, must be given not more than one year after the 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is provided outside of these time limits, the claim will be denied. These time limits will not apply due to lack of legal capacity.

Written proof that the loss continues, or proof by any other electronic/telephonic means authorized by us, must be furnished to us at intervals we require. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to us.

Time of Payment

Disability Benefits will be paid at regular intervals of not less frequently than once a month. Any balance, unpaid at the end of any period for which we are liable, will be paid at that time.

To Whom Payable

Disability Benefits will be paid to you. If any person to whom benefits are payable is a minor or, in our opinion is not able to give a valid receipt, such payment will be made to his or her legal guardian. However, if no request for payment has been made by the legal guardian, we may, at our option, make payment to the person or institution appearing to have assumed custody and support.

If you die while any Disability Benefits remain unpaid, we may, at our option, make direct payment to any of your following living relatives: your spouse, your mother, your father, your children, your brothers or sisters; or to the executors or administrators of your estate. We may reduce the amount payable by any indebtedness due.

Payment in the manner described above will release us from all liability for any payment made.

Physical Examination and Autopsy

We may, at our expense, exercise the right to examine any person for whom a claim is pending as often as we may reasonably require. Also, we may, at our expense, require an autopsy unless prohibited by law.

Legal Actions

No legal action may be brought to recover on the Policy within 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by us, is given as required by the Policy. No such action shall be brought after the expiration of the applicable statute of limitations from the time proof of loss is required to be given.

Time Limitations

If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which you live when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship

You have the right to choose any Physician who is practicing legally. We will in no way disturb the Physician/patient relationship.

TL-004724 (FL)

ADMINISTRATIVE PROVISIONS**Premiums**

The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

Your Grace Period

If your required premium is not paid on the Premium Due Date, there is a 31 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

Reinstatement of Insurance

Your coverage may be reinstated if your insurance ends because you are on an Employer approved unpaid leave of absence. Your insurance may be reinstated only if reinstatement occurs within 6 months from the date it ends due to an Employer approved unpaid leave of absence or must be returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).

For your insurance to be reinstated the following conditions must be met.

1. You must qualify under the Class Definition.
2. The required premium must be paid.
3. A written request for reinstatement and a new enrollment form for you must be received by us within 31 days from the date you return to Active Service.

Your reinstated insurance is effective on the date you return to Active Service. If you did not fully satisfy your Eligibility Waiting Period or Pre-Existing Condition Limitation (if any) before your insurance ended due to an unpaid leave of absence, you will receive credit for any time that was satisfied.

TL-004722

GENERAL PROVISIONS**Incontestability**

All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for insurance.

Misstatement of Age

If an Insured's age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

Workers' Compensation Insurance

The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Assignment of Benefits

We will not be affected by the assignment of your certificate until the original assignment or a certified copy of the assignment is filed with us. We will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnished, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

Clerical Error

A person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

TL-004728

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Active Service

If you are an Employee, you are in Active Service on a day which is one of your Employer's scheduled work days if either of the following conditions are met.

1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence.

You are in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Appropriate Care

Appropriate Care means the determination of an accurate and medically supported diagnosis of your Disability by a Physician, or a plan established by a Physician of ongoing medical treatment and care of your Disability that conforms to generally accepted medical standards, including frequency of treatment and care.

Consumer Price Index (CPI-W)

The Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the index is discontinued or changed, another nationally published index that is comparable to the CPI-W will be used.

Covered Earnings

Covered Earnings means your annual wage or salary as reported by the Employer for work performed for the Employer as in effect just prior to the date your Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the July 1 the change, if the Employer gives us written notice of the change and the required premium is paid.

It does not include any amounts received as bonus, commissions, overtime pay or other extra compensation.

Any increase in your Covered Earnings will not be effective during a period of continuous Disability.

Disability/Disabled

For purposes of coverage under the Policy, you are Disabled if, because of Injury or Sickness, you are unable to perform the material and substantial duties of your regular occupation, or solely due to Injury or Sickness, you are unable to earn more than 80% of your Indexed Covered Earnings.

After Disability Benefits have been payable for 24 months, you are Disabled if your Injury or Sickness makes you unable to perform the material and substantial duties of any occupation for which you may reasonably become qualified based on education, training or experience, or solely due to Injury or Sickness, you are unable to earn more than 80% of your Indexed Covered Earnings.

Employee

For eligibility purposes, you are an Employee if you work for the Employer and are in one of the "Classes of Eligible Employees." Otherwise, you are an Employee if you are an employee of the Employer who is insured under the Policy.

Employer

The Policyholder and any affiliates or subsidiaries covered under the Policy. The Employer is acting as your agent for transactions relating to this insurance. You shall not consider any actions of the Employer as actions of the Insurance Company.

Full-time

Full-time means the number of hours set by the Employer as a regular work day for Employees in your eligibility class.

Indexed Covered Earnings

For the first 12 months Monthly Benefits are payable, your Indexed Covered Earnings are equal to your Covered Earnings. After 12 Months Benefits are payable, your Indexed Covered Earnings are your Covered Earnings plus an increase applied on each anniversary of the date Monthly Benefits became payable. The amount of each increase will be the lesser of:

1. 10% of your Indexed Covered Earnings during your preceding year of Disability; or
2. the rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

Injury

Any accidental loss or bodily harm that results directly or independently from all other causes from an Accident.

Insurability Requirement

An eligible person satisfies the Insurability Requirement for an amount of coverage on the day we agree in writing to accept you as insured for that amount. To determine a person's acceptability for coverage, we will require you to provide evidence of good health and may require it be provided at your expense.

Insurance Company

The Insurance Company underwriting the Policy is named on your certificate cover page. References to the Insurance Company have been changed to "we", "our", "ours", and "us" throughout the certificate.

Insured

You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, the required premium is paid and your coverage is in force under the Policy.

Physician

Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include you, your spouse, your immediate family (including parents, children, siblings, or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in your household.

Prior Plan

The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Employer and in effect directly prior to the Policy Effective Date.

Sickness

The term Sickness means a physical or mental illness.

TL-004708 (FL)

IMPORTANT CHANGES FOR STATE REQUIREMENTS

If you reside in one of the following states, please read the important changes below. The provisions of your certificate are modified for residents of the following states. The modifications listed apply only to residents of that state, and only when the underlying provision is included in the certificate.

Louisiana residents:

The percentage of <COV_EARN_TERM> Earnings, if any, that qualifies an insured to meet the definition of Disability/Disabled may not be less than 80%.

Minnesota residents:

The Pre-existing Condition Limitation, if any, may not be longer than 24 months from the insured's most recent effective date of insurance.

Texas residents:

Any provision offsetting or otherwise reducing any benefit by an amount payable under an individual or franchise policy will not apply.

**UNDERWRITTEN BY:
LIFE INSURANCE COMPANY OF NORTH AMERICA
a CIGNA company**

Class 1
08/2004



CIGNA Group Insurance
Life • Accident • Disability

Attachment @

Group Long-term Disability Claims Experience



LTD EXPERIENCE REPORT

Account Name: CITY OF HALLANDALE BEACH
Policy Number: FLK0960075

Start	Finish	Number of Months	Premium	Paid Claims	Total Incurred	Loss Ratio
08/01/2008	07/31/2009	12	\$65,919	\$0	\$0	0.00%
08/01/2009	07/31/2010	12	\$66,745	\$745	\$745	1.12%
08/01/2010	07/31/2011	12	\$66,057	\$0	\$0	0.00%
08/01/2011	07/31/2012	12	\$68,652	\$6,620	\$6,620	9.64%
08/01/2012	03/22/2013	8	\$41,622	\$0	\$15,608	37.50%
Totals:			\$308,996	\$7,365	\$22,973	7.43%

Attachment K

Group EAP Claims Experience

CITY OF HALLANDALE BEACH

Monthly Overview of Services Provided

Plan Year: 10/01/2012 – 09/30/2013

CUSTOMER TOTALS

	<u>Oct</u>	<u>Nov</u>	<u>Dec</u>	<u>Jan</u>	<u>Feb</u>	<u>Mar</u>	<u>Apr</u>	<u>May</u>	<u>Jun</u>	<u>Jul</u>	<u>Aug</u>	<u>Sep</u>	<u>Total</u>
Number of EAP Presentations	1	1	2	1	2	4	0	0	0	0	0	0	11
Web Sessions	1	4	3	5	7	2	0	0	0	0	0	0	22
Total Presentations	2	5	5	6	9	6	0	0	0	0	0	0	33
Source of Presentations													
Self Referral	1	1	0	1	2	4	0	0	0	0	0	0	9
Web	1	4	3	5	7	2	0	0	0	0	0	0	22
Manager/Supr. Referral	0	0	1	0	0	0	0	0	0	0	0	0	1
Mandatory Referral	0	0	0	0	0	0	0	0	0	0	0	0	0
DOT	0	0	0	0	0	0	0	0	0	0	0	0	0
Fitness for Duty	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
Critical Incidents	0	0	0	0	0	0	0	0	0	0	0	0	0
Management Consultations	0	0	1	0	0	0	0	0	0	0	0	0	1
*Crisis Calls	0	0	0	0	0	0	0	0	0	0	0	0	0
*On-Site EAP Contacts	0	0	0	0	0	0	0	0	0	0	0	0	0
*Telephonic Consultations	0	0	0	1	0	0	0	0	0	0	0	0	1
Number of Employees	405	405	405	405	491	491	0	0	0	0	0	0	2,602
Annualized Presentation Rates													
Assistance Program	0.0%	0.0%	5.9%	3.0%	2.4%	4.9%	%	%	%	%	%	%	2.8%
Life Events Program	3.0%	3.0%	0.0%	0.0%	2.4%	4.9%	%	%	%	%	%	%	2.3%
Web Presentations	3.0%	11.9%	8.9%	14.8%	17.1%	4.9%	%	%	%	%	%	%	10.1%
Total	5.9%	14.8%	14.8%	17.8%	22.0%	14.7%	%	%	%	%	%	%	15.2%

* These categories are a sub-set of the "Number of EAP Presentations" and are already reflected in the total.

CITY OF HALLANDALE BEACH

Web Utilization

Period: 01/01/2013 – 03/31/2013

Plan Year: 10/01/2012 – 09/30/2013

Web Usage Summary		
Statistics:	Period	YTD
Number of Sessions	14	22
Average Minutes per Session	9	9
Average Pages per Session	8.93	8.77
Number of Face to Face Online Authorizations Issued	1	1

Web Sessions by Month	
Month	Sessions
Oct	1
Nov	4
Dec	3
Jan	5
Feb	7
Mar	2
Apr	0
May	0
Jun	0
Jul	0
Aug	0
Sep	0

Web Group Usage – Top 5 Groups Accessed				
	Period		YTD	
	Group Hits	Page Hits	Group Hits	Page Hits
Work Life	9	11	11	14
EAP Services Request	5	27	8	48
Benefit Check	4	17	7	30
Article Library	2	4	6	15
Provider Search	3	40	4	45

Web Sessions by Time of Day (CST)		
	Period	YTD
Midnight – 6am	7%	5%
6am – Noon	29%	27%
Noon – 4pm	57%	59%
4pm – 8pm	7%	9%
8pm – Midnight	0%	0%

CITY OF HALLANDALE BEACH

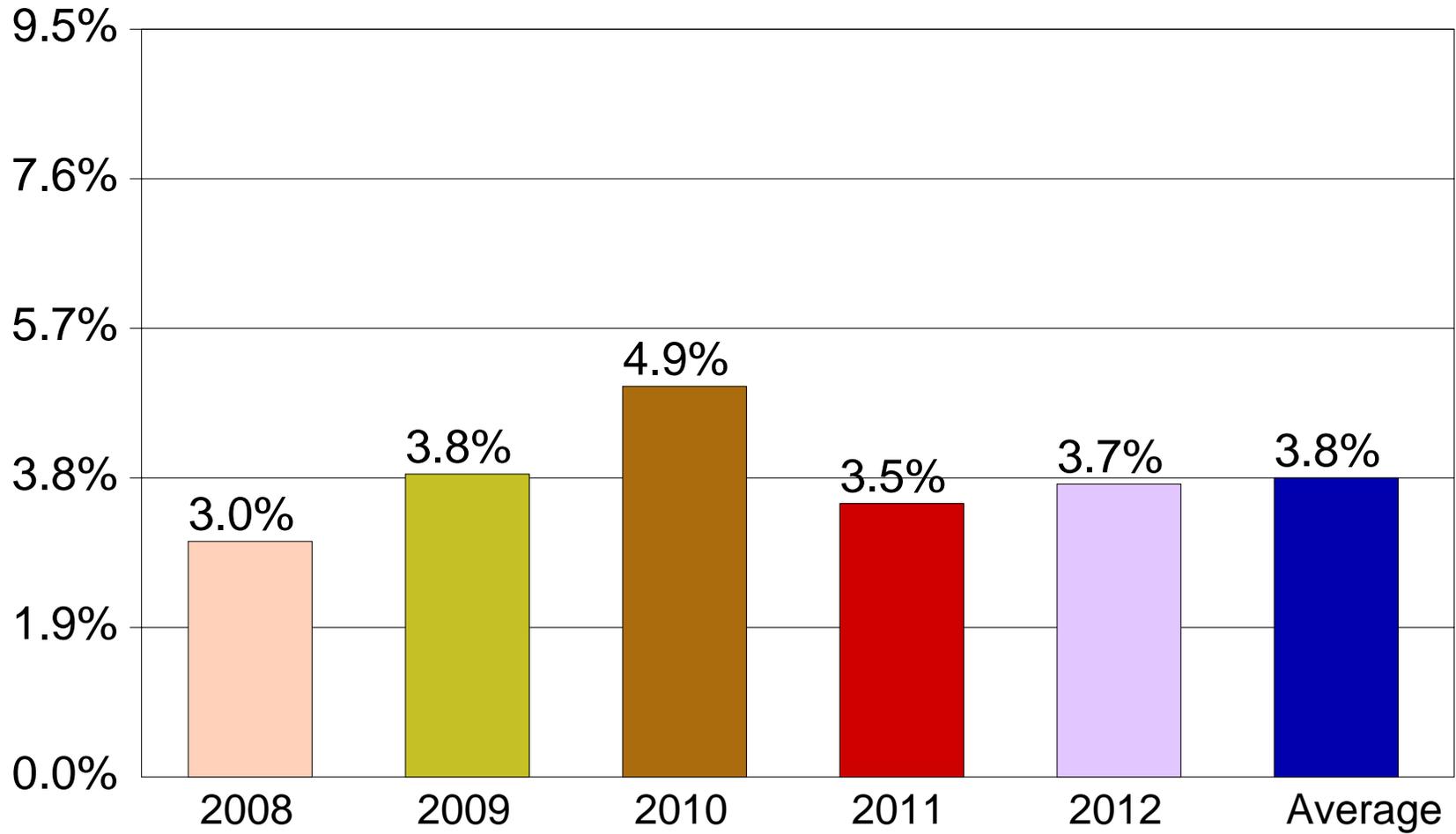
Presentation Profile – Overall
 For the Period: 01/01/2013 – 03/31/2013
 Plan Year: 10/01/2012 – 09/30/2013

CUSTOMER TOTAL

Presenting Problem	Period		YTD	
	Number	Percentage	Number	Percentage
Alcohol Problem	0	0.0%	0	0.0%
Drug Problem	0	0.0%	0	0.0%
Family Concerns	0	0.0%	0	0.0%
Child/Parenting	0	0.0%	0	0.0%
Developmental/Attention Issues	0	0.0%	0	0.0%
Marital/Partner	3	42.9%	3	27.3%
Abuse: Sexual, Physical, Emotional	0	0.0%	0	0.0%
Physical Health	0	0.0%	0	0.0%
Sexual Disorders	0	0.0%	0	0.0%
Depression Concerns	0	0.0%	0	0.0%
Stress/Anxiety	1	14.3%	1	9.1%
Suicidal/Homicidal	0	0.0%	0	0.0%
Grief and Loss Issues	0	0.0%	0	0.0%
Eating Disorder Issues	0	0.0%	0	0.0%
Anger Management	0	0.0%	1	9.1%
Job/Career Issues	0	0.0%	0	0.0%
Workplace Aggression	0	0.0%	0	0.0%
Gambling	0	0.0%	0	0.0%
Information Only	0	0.0%	0	0.0%
Unidentified	0	0.0%	0	0.0%
Management Consultations	0	0.0%	1	9.1%
Relocation Issues	0	0.0%	0	0.0%
Concierge Services	0	0.0%	0	0.0%
Convenience/Personal Services	0	0.0%	0	0.0%
Pet Care	1	14.3%	1	9.1%
Healthy Rewards	0	0.0%	0	0.0%
Education/College	0	0.0%	0	0.0%
Eldercare	0	0.0%	0	0.0%
Childcare	0	0.0%	0	0.0%
Legal	2	28.6%	3	27.3%
Financial	0	0.0%	1	9.1%
	7	100.0%	11	100.0%

CITY OF HALLANDALE BEACH

Historical Overview of EAP Utilization



Attachment K

Questionnaire

Questionnaire

(Complete and Submit with your proposal)

1. List at least five (5) references with a minimum of 400 employees for whom you provide the applicable lines of coverage you are proposing. Include group name, contact name, title and telephone number of reference.

1) _____

2) _____

3) _____

4) _____

5) _____

2. Renewal notification is required 180 days prior to the renewal date for all lines of coverage being proposed. Can you comply with this requirement? If "No", outline your proposed alternative by line of coverage.

Yes _____ No _____

3. What is the length of the rate guarantee proposed for each line of coverage proposed?

Medical: _____

Dental: _____

Vision: _____

Group Basic Life: _____

Group Supplemental Life: _____

Long-term Disability: _____

Employee Assistance Program: _____

4. Confirm that the rates provided are "Net of Commission" for all lines of coverage being proposed.

Yes _____ No _____

5. Has Proposer included copies of all network directories applicable to the medical, dental and vision plans proposed for the City?

Yes _____ No _____

6. Provide a listing of all counties that would be included in the "service area" of the provider networks available under the programs proposed.

7. Confirm that sample copies of the Insurance Certificates of Coverage for the plans proposed are included in your submission.

Yes: _____ No: _____

8. Confirm that Benefit Summaries for all plans proposed are included in your submission.

Yes: _____ No: _____

9. Proposer agrees allow Retirees to continue coverage under the same plan at the same rate as active employees, should they choose to do so.

Yes: _____ No: _____

10. Proposer confirms it has provided coverage options for Retirees, on a comparable level as active employees, who reside outside of the immediate South Florida area.

Yes: _____ No: _____

11. Confirm that all employees enrolled in the group's medical, dental, life and long-term disability plans, who are currently not "actively at work" due to disability, FMLA, or any other reasons, will continue to be covered under the plans implemented for the effective date stated in this RFP. If proposing multiple lines of coverage, be specific by line of coverage.

Yes: _____ No: _____

12. Confirm that all policies, identification cards, and any other correspondence will be mailed directly to the employee.

Yes: _____ No: _____

13. Confirm the proposer has included Geographical Access reports using the criteria stated within the RFP for all lines of coverage being proposed.

Medical: Yes: _____ No: _____ Not Applicable: _____

Dental: Yes: _____ No: _____ Not Applicable: _____

Vision: Yes: _____ No: _____ Not Applicable: _____

14. Describe any performance guarantee programs your company proposes. Please indicate the group name, address, contact person and telephone number of up to three firms in Florida to whom your company has forfeited money because of service problems in the last three years.

15. Please describe your out-of-area coverage for retirees, dependent students or other dependents not residing with the employee (as a result of divorce or other reasons) but covered under their medical, dental or vision plans.

16. Is COBRA administration included in your proposal? (Provide details if yes)

Yes: _____ No: _____

17. What is the name, title and office address of the individual who would have direct daily account responsibility for the program?

Name: _____

Title: _____

Address: _____

Telephone: _____

Fax: _____

Email: _____

Attachment L

Census (Excel Format)

Attached Separately

Attachment M

Price and Benefits Response Forms (Word Format)