REQUEST FOR PROPOSALS
EMPLOYEE BENEFIT PROGRAMS
OKALOOSA COUNTY
BOARD OF COUNTY COMMISSIONERS

RFP #: RM 44-12

RFP DUE: JULY 25, 2012 @ 4:00 P.M.

THE INTENT OF THIS RFP IS TO OBTAIN PROPOSALS FOR PROVIDING DENTAL, LIFE, AD & D and LONG TERM DISABILITY PROGRAMS

REQUEST FOR PROPOSAL TO PROVIDE EMPLOYEE BENEFIT PROGRAMS

The Okaloosa County Board of County Commissioners, under the provisions of Section 287.055, Florida Statutes, and Board policy request proposals from professional firms to provide Dental, Life, AD & D and Long Term Disability programs.

Firms desiring consideration should provide an original and six (6) copies of their statement of proposal. Copies of the RFP may be obtained from the Okaloosa County Purchasing Department, 850-689-5960 or by downloading them from our website at www.co.okaloosa.fl.us (Departments, Purchasing, Vendor Registration & Opportunities).

Proposals must be delivered to the Okaloosa County Purchasing Department at the address listed below no later than **4:00 p.m. (CST), July 25**, 2012 in order to be considered.

All proposals must be in sealed envelopes reflecting on the outside **"Proposal to provide an Employee Benefit Program"**.

All proposals should be addressed as follows:

Okaloosa County Purchasing Department
Attn: Richard Brannon
602-C North Pearl St.
Crestview FL 32536

Richard L. Brannon
Purchasing Director

Date

BOARD OF COUNTY COMMISSIONERS
OKALOOSA COUNTY

Don R. Amunds
Chairman

GENERAL

POLICY/CONTRACT EFFECTIVE DATE, TERMS – All coverage and contracts are to be effective October 1, 2012.

EXTENT OF COVERAGE, OPTIONS – The County requests proposals for Long Term Disability, Life, AD & D and Dental insurance comparable to the current programs. Also, we seek options and alternatives to the present programs. Proposers should provide cost breakdown for each program option and coverage proposed. The County specifically reserves its right to select the coverage, options, programs or combinations of proposals that best meets our objectives.

ACCOMMODATION TO MODIFICATION OF NORMAL COVERAGE – Some desires expressed in this request may require modifications of existing policy forms to serve the County's best interests. In some cases, manuscript endorsements to the policy may be required.

Whenever such modifications may require a substantially greater premium than coverage without the modifications, the amount of additional premium for the modifications should be disclosed so the County will have an option to purchase the modifications or not.

The County prefers that all desired modifications and liberalization clauses be provided with little or no additional premium.

Please keep in mind these desired modifications are not demands, but proposals which indicate flexibility to accommodate the County's coverage desires are preferred.

SAMPLE POLICIES, ENDORSEMENTS & DISCLOSURE OF RESTRICTIONS – Recognizing that coverage varies among insurers, the County requests that sample forms and endorsements be provided with proposals for a fair analysis of coverage as well as price.

To the extent exclusions and restrictions are intended by proposers, they should be stated in the proposals because they will not be allowed subsequently.

The County desires documentation of rates to verify subsequent charges in premium, including premium audits. Records of rates/premiums charged at inception are needed for such verification.

POLICY/CONTRACT DELIVERY – Proposers are expected to deliver insurance policies, forms, endorsements and other related documentation of coverage and services as proposed and as accepted by the County.

If policies, forms, endorsements and other documentation of coverage and services are not delivered as proposed and as accepted by the County no less coverage or services will later be accepted.

The County shall not be obligated to follow-up to obtain documentation of proposed items not included or incomplete in delivered policies, contracts, forms or endorsements. If the County does not follow-up, or if the County follows up only on a limited basis, and if the proposer does not fulfill its obligation to deliver documentation of coverage, services or other terms proposed, it shall not be construed as the County's accepting anything less than proposed, and accepted by the County.

EVALUATION OF PROPOSALS – In the County's evaluation of proposals the following items shall be considered:

COST	A major consideration in evaluating proposals, but not the only consideration.
COVERAGE	The amount and breadth of coverage and extent of restrictions or exclusions.
SERVICE	The capabilities and experience record of services provided by agents and insurers. This may be a minor importance for some coverage or major importance for others. Services include amending policies & contracts for changes, premium billings, loss control/safety and claims services.
STABILITY	Financial stability of the insurer, self-insurance fund or other provider of coverage.
PROVIDERS	Proposers must include a list of providers with their proposal

The order in which these items have been listed does not necessarily reflect their order of importance.

It is possible that the County in its judgment may consider a proposal unacceptable solely because one of these key items is unsatisfactory. For example, a proposal may be considered unacceptable solely on the basis of unsatisfactory cost, or unacceptable solely on the basis of unsatisfactory coverage.

NON-WARRANTY OF SPECIFICATIONS – Due care and diligence has been exercised in the preparation of this RFP and all information contained herein is believed to be substantially correct. However, the responsibility for determining the full extent of the exposures to risk and verification of all information herein shall rest solely with the proposers. Neither the County nor its representatives shall be responsible for any error or omission in this RFP, nor the failure on the part of the proposer to determine the full extent of the exposures.

TERMINATION/RENEWAL/INCREASE NOTICE – The County shall be given at least 120 days notice of cancellation or non-renewal of insurance, administration and other related contracts and prefers at least 120 days notice of any increase in rates, premiums, administration fees, excess insurance costs, attachment points, or other change in coverage.

If a proposer cannot provide 120 days notice of the exact amount of a rate increase, the proposer is expected to give a reasonable estimate of the increase 120 days prior to its effective date.

If the final indication of renewal increase is provided less than 120 days prior to the effective date, and if the amount of increase is unacceptable to the County, the proposer will be expected to modify trends factors and other calculations to allow for a favorable month to month renewal increase compromise if competitive proposals must again be solicited.

If the County shall be required to provide advance notice to the proposer of cancellation or non-renewal, the required notice should not exceed 15 days.

Proposers are expected to agree that receipt of a request for proposals from the County for the benefits and/or services provided does not automatically mean that the County wishes to terminate the current benefits and/or services provided. Any notification required by the current vendors shall be satisfied by the dissemination of this request for proposals.

Changes in cost shall occur no more frequently than on an annual basis, unless directly related to changes in benefits approved by the County at least 60 days prior to effective date of change.

AGENT OF RECORD – (THIS INFORMATION PERTAINS TO ALL TYPES OF COVERAGE OFFERED)

- Please list name & address of Servicing Agent.
- Please list Servicing Agent and duties.
- Please list education level and special certifications held by Servicing Agent.
- Please list support staff and duties.
- Please enclose or attach as exhibit a copy of current Errors & Omissions policy.
- Please enclose or attach as exhibit a copy of your Drug Free Workplace policy.
- Please acknowledge compliance with privacy laws as stated in the Health Insurance Portability Act.
- Please list website of Servicing Agent.
- Please disclose remuneration to be paid to Servicing Agent to include commission, bonus and rewards. Please explain if and or why non-standard remuneration is to be paid to servicing agent.
- Please acknowledge agreement to audit any and all agreed remuneration payments to Servicing Agent.
- Please list 5 current references. Also, please list 3 terminated references.
- Okaloosa County reserves the right to make an alternate selection to fill this position.

INFORMATION FOR GROUPS TO PROVIDE WITH BID PACKAGE:

LIFE & DISABILITY:

- Copy of current certificate of coverage
- Name of current carrier
- Detailed census including salary and title

- Are products voluntary or employer paid?
- Do you currently enroll via census, application or web?
- Special plan provisions to be noted, i.e. classes, management, pilots, etc.
- Office locations.
- Any value added benefits provided with current benefits.
- Has there been any recent life waiver of premium request filed? If so, expected date of return to work? (Life & disability bids only). For Dental would need to list COBRA participation.
- Are there any employees currently receiving disability benefits and or do you expect any claims to be ongoing at renewal date?
- Most recent claims experience.
- Any additional information you may think would be helpful.

DENTAL:

- Copy of current certificate of coverage.
- Current commissions paid.
- Claims experience.
- Detailed census including zip code.

PREMIUM/SERVICE FEE PAYMENT BILLINGS – The County expects to pay insurance premiums and service fees on a monthly basis with no additional charge for interest. If this is unacceptable, the proposer should state its most favorable terms.

PLAN CONTRIBUTION – The County pays the full cost of employee Long Term Disability, Basic Life, AD & D and Dental insurance. The employees pay for family dental and optional life, AD & D and additional LTD coverage through payroll deduction.

PARTICIPANT ELIGIBILITY – Refer to the current plan documents for eligibility rules. All proposals must comply with these requirements. Retirees are eligible to continue their life & dental benefit participation under Florida Statute 112.0801.

ACTIVELY @ WORK WAIVER – All proposals shall waive any actively at work requirement. We will not accept wording that eliminates coverage for persons partially disabled, on medical, maternity, family or other leave who have fulfilled their waiting period under the present plan, but are absent on the first day that coverage becomes effective.

OPEN ENROLLMENT - We require an open enrollment for the 30 days prior to the October 1, 2012 effective date. Employees and their dependents can enroll in the program or terminate participation for the standard changes in lifestyle reasons.

PARTICIPANT ENROLLMENT – The Cafeteria Plan year is October 1, 2012 through September 30, 2013. The enrollment is scheduled from August 1, 2012 through September 1, 2012. Please furnish your most realistic estimate of the least number of calendar days required to enroll our group.

ENROLLMENT VERSUS CENSUS GROUP MIX – The County desires that if the number of enrollees is less than the plan members indicated in the census data, but if the age/sex mixes are not materially different, that the proposal be honored as submitted.

If our enrollment produces a substantially different mix of age and sex, we request immediate comment from the successful proposer as to whether or not proposed rates, premiums, mother cost factors, attachment points, and plan design will be affected.

INSURER QUALIFICATIONS – Proposals are expected from financially sound insurers, authorized to do business in Florida. Best's ratings, where applicable, should be furnished for each insurer being proposed.

Insurers should explain the full range of their services available to the County and should state their experience, expertise and data processing capability. Background information should be furnished on personnel that will service the group.

SUBCONTRACTING – Where proposers do not have the "in house" capability to perform work desired in the Request for Proposals, subcontracting may be permitted with prior knowledge and approval of the County. We must be assured and agree that any proposed subcontractor(s) can perform the work to the desired quality and in a timely manner. Therefore, the name of any intended subcontractor(s) should be identified in the proposal.

SUCCESSFUL PROPOSER HOLD HARMLESS/PAY ON BEHALF – It is expected that the successful proposer of Long Term Disability, Life, AD & D and Dental benefits and services will agree to hold harmless and pay on behalf of the County any liability and/or legal costs arising out of any claims and litigation related to the services, and benefits provided. This includes any actions that may arise from allegations regarding determination of appropriateness or inappropriateness of dental care or any acts, errors or omissions related to the coverage or service provided.

AUTHORIZED OFFER – The person submitting the proposal should indicate the extent of authorization by the insurer, PPO or self-insurance administrator to make a valid offer in the proposal summary that may be accepted by the County to form a valid and binding contract.

If the person submitting the proposal is not authorized to submit a proposal that can be bound by our acceptance, such person should also obtain the signature of an authorized representative of the insurer or other proposer, that may result in a bound contract upon the County's acceptance.

Proposals should be typed or written in ink, signatures should be manually signed in ink, and any corrections should be typed or in ink and initialed.

NO COLLUSION CLAUSE – By responding to this RFP, the proposer certifies the proposer has not divulged to, discussed or compared his/her competitive proposal with other proposers and has not colluded with any other proposers or parties to this competitive proposal whatsoever. Also, the proposer certifies, and in the case of a joint competitive proposal each party hereto certifies as to its own organization, that in connection with the competitive proposal:

Any prices and/or cost data submitted have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices and/or cost data, with any other proposer or with any competitor;

Any prices and/or cost data quoted for this competitive proposal have not been knowingly disclosed by the competitive proposer and will not knowingly be disclosed by the proposer, directly or indirectly to any other proposer or to any competitor, prior to the scheduled award to the contract;

No attempt has been made or will be made by the proposer to induce any other person or firm to submit or not submit a competitive proposal for the purpose of restricting competition;

The only person or persons interested in this competitive proposal, principal, or principals is/are names therein and that no person other than therein mentioned had any interest in this competitive proposal or in the Agreement to be entered into.

CURRENT BENEFIT PROGRAM – The Appendix contains Plan Documents for the current Long Term Disability, Life, AD & D and Dental programs. Available Loss Runs are included also.

Proposers should rely on this material for details on our current program.

All proposals must clearly identify all benefits that deviate from the existing program.

DESIRED LIFE & AD & D PROGRAM & LTD – The County wishes to retain the current basic life and AD & D coverage of $25,000. At present, employees can purchase up to $500,000 supplemental life coverage. Spouse & child coverage is available under the supplemental life program. At present, employees can purchase $25,000 for spouse and $10,000 for dependent optional life coverage. Vendors are encouraged to propose supplemental life coverage with higher limits. Long Term disability is currently provided as 50% of salary replacement for up to 5 years with a Buy up Option.

DESIRED DENTAL PROGRAM – The County wishes to maintain a comparable program to the existing plan. While alternative plans will be considered, such alternatives must cap the County's exposure at a stated maximum cost.

MEDICAL SPECIFICATIONS

1. The County requires any successor insurance carrier to protect current participants by waiving any "actively-at-work" provision and by covering treatments in progress on a "no loss/no gain" basis.

2. It is stipulated that the County will require convenient access to providers in all areas of the County. In order to achieve this, the County may select a combination of vendors offering competing managed care programs.

3. The County is requesting proposals that meet or exceed our current coverage and/or alternative programs that might better meet our objectives.

SELECTION CRITERIA – The County will review all proposals on the basis of the following criteria:

FINANCIAL/COST CONTAINMENT FEATURES

- Cost Competitiveness.
- Willingness to offer performance guarantees.
- Utilization management program.

PROGRAM ADMINISTRATION

- Dedicated claims processors or single contact for resolving claims issues.
- Performance statistics (e.g., turnaround time, financial accuracy, etc.).
- Periodic management reports and recommendations.
- Availability of electronic Loss Runs quarterly or on request.
- Frequency and depth of internal audits.

PROVIDER NETWORKS

- Location of Providers.
- Adequate # and mix of providers.
- Availability of network providers out of Okaloosa County.
- Training in network procedures given to providers' staff.
- Credentials of network providers.
- Stability of Network – Turnover.
- Willingness to expand network.
- Experience in administering network based programs.

QUALITY ISSUES

- Adequate internal & external audits.
- Patient satisfaction as measured by independent surveys.
- Basis of compensation to providers.
- Utilization Review (staffing, response time, standards of necessity).
- Client references.
- Professionalism & completeness of proposal & presentation.

CUSTOMER SERVICE

- Telephone service (e.g., toll free number, hours of operation, call abandonment rate, average speed to answer).
- Appeal and grievance process (i.e., openness, medical objectivity, accessibility).
- Local customer service representative availability.
- Simplified claims processing.
- Clarity & simplicity of enrollment materials.
- Direct mailings to employees or provider lists and information.
- Electronic billing procedures.
- Dispute resolution process.

LIFE INSURANCE SPECIFICATIONS

1. The County requires any successor insurance carrier to protect current participants by waiving any "actively-at-work" provisions.
2. Proposers agree to accept all current supplemental life coverage at present limits.
3. The County requests alternative proposals:
    - Supplemental Life to $500,000.
    - Broader optional Dependent Life coverage.
4. County requests open enrollment.

LIFE INSURANCE – BID QUESTIONS

COMPANY PROFILE

- Please list full name & address.
- Please list Web address.
- Please list financial ratings.
- Please list names, addresses and credentials of all corporate employees that will be responsible for administration & daily support.
- Please list 5 references of similar sized current clients. Also, please list 3 references that terminated coverage.
- Please list most recent retention rates, i.e. renewal persistence.

ELIGIBILITY

- Please list complete definition of eligibility.
- Please describe the actively at work provision at initial plan enrollment.
- Please describe the actively at work provision after initial enrollment, i.e. procedure for filing waiver of premium notice when employee is on extended leave of absence.
- Describe when coverage ends.
- Please provide guidelines for proof of insurability for employee. Also for spouse and dependent when applicable.
- Please provide definition of a dependent.
- Will you offer coverage for retirees? Please describe eligibility definition for retirees.
- Are you willing to accept a census enrollment? If so, please provide desired format.
- Describe Waiver of Premium policy.

BASIC TERM LIFE & AD & D BENEFITS

- State Term Life coverage amount to be quoted and rated.
- State Accidental Death & Dismemberment coverage amount and rates. Please include detailed information for Dismemberment coverage, i.e. payment amount for loss.
- Please list reduction amounts and age of reductions.
- Please fully disclose retiree coverage amounts, rates and reductions, if any.
- Please describe timeline of claims payment.

OPTIONAL VOLUNTARY LIFE BENEFITS

- Will you fully "takeover" current enrollment including voluntary coverage with no medical statements required?
- Please list maximum and minimum voluntary coverage available for employee, spouse and dependent (child).
- Please provide a copy of the medical statement (Proof of Insurability) required when applying for additional coverage in excess of guaranteed issue.
- List coverage amount for children from birth, including guidelines and limitations.
- Please list schedule of voluntary life coverage reductions.
- Please discuss open enrollment.

PORTABILTY/CONVERSION

- Please describe the portability provisions for employee, spouse and dependents.
- Please describe the conversion provisions for employee, spouse and dependents.

RATING

- Please list rating multiyear guarantees.

LONG TERM DISABILITY – BID QUESTIONS

SELECTION CRITERIA – The County will review Long Term Disability insurance proposals on the basis of the following:

- Cost competitiveness.
- Ability to offer rate guarantees for up to 3 years.
- Dedicated claims processors or single contact for resolving claim issues.
- Availability of electronic Loss Runs quarterly or on request.
- Electronic billing procedures.
- Dispute resolution process.

COMPANY PROFILE

- Please list full name & address.

- Please list Web address.
- Please list financial ratings.
- Please list names, addresses and credentials of all corporate employees that will be responsible for administration and daily support.
- Please list 5 references or similar sized current clients. Also, please list 3 references that terminated coverage.
- Please list most recent retention rates, i.e. renewal persistence.

ELIGIBILITY

- Please list complete definition of eligibility.
- Please describe in detail own occupation provisions of the definition of eligibility.
- Please describe provisions if employee is partially disabled.
- Describe definition of monthly earnings.
- Please describe the actively at work provision at initial plan enrollment.
- Please describe the actively at work provision after initial enrollment, i.e. procedure for filing notice when employee is on extended leave of absence.
- Describe when coverage begins and ends.
- Describe policy for employees that are on layoff.
- Please provide guidelines for Proof of Insurability for employee.
- Are you willing to accept a census enrollment? If so, please provide desired format.
- Please confirm elimination period as requested.
- Are you willing to accept those who are currently receiving LTD.
- Please discuss open enrollment.

LTD BENEFITS

- Please list Monthly Benefit Minimum & Maximum for Managers and All Other Employees.
- Please list Maximum period of payment schedule.
- Please describe rehabilitation & return to work provisions.
- Please describe dependent care benefit if any.
- Please describe total benefit cap provision.

- Please provide options for W-2 preparation.
- Explain procedure for claims filing including information required to file claims, provide a copy of claim forms.
- Please describe timeline of claims payment, i.e. maximum payment period.
- Describe Waiver of Premium policy.
- Please list required information to be reported to carrier and frequency of required reporting.
- Explain underwriting participation guidelines.
- Explain billing & reconciliation guidelines.
- Describe procedures for coverage while employee is on an authorized leave of absence including Family & Medical Leave of Absence.
- Explain when disabled employee qualifies for additional benefits, i.e. integration or offset of Social Security Disability, etc.
- Please list payments that will not offset disability payments.
- List any and all illnesses or disabilities that will have any limitation of payment or duration of payments.
- List any disabilities that are excluded from coverage.
- Describe definition of Pre-existing conditions, for initial eligibility, late entrant.
- Please describe policy for recurrent disabilities.
- Describe survivor benefits.
- Please outline continuity of coverage provisions.
- Please describe return to work assistance program, including worksite modification and education provisions.
- Please list any other services unique to your proposal.
- Please describe appeals process and procedures.
- Provide a copy of the claim forms.

RATING

- Please list rating including multi-year guarantees

DENTAL - BID QUESTIONS

COMPANY PROFILE

- Please list full name and address.
- Please list Web address.
- Please list financial ratings.
- Please list names, addresses and credentials of all corporate employees that will be responsible for administration & daily support.
- Please list 5 references of similar sized current clients. Also, please list 3 references that terminated coverage.
- Please list most recent retention rates, i.e. renewal persistence.

ELIGIBILITY

- Please list complete definition of eligibility including dependents & retirees.
- Please describe the actively at work provision at initial plan enrollment.
- Describe when coverage begins and ends including extension of benefit provision.
- Are you willing to accept a census enrollment? If so, please provide desired format.
- Please describe waiting periods for new hires and late entrant provisions.
- Discuss open enrollment.

DENTAL BENEFITS

- Include detailed benefit summary including standard Limitations & Exclusions.
- Name and web address or web link to Provider Network.
- Do you own your network? If not, please explain what network will be used.
- Explain in detail Open Enrollment provision/requirements including late entrant provisions.
- Explain loss of eligibility definition including eligibility during Lay-off and Leave of Absence.
- Will you provide COBRA services? If so, what is the cost if any?
- List benefits covered for Diagnostic & Preventive treatment including frequency schedule.
- List benefits covered for basic treatment. Explain synthetic and plastic restorative filling coverage including frequency schedule.

- List benefits covered for major treatment. Explain coverage for Crowns & Prosthodontics if covered including frequency schedule.
- Describe the claims payment process including timeliness of claims payment, how to file a paper claim and address.
- Describe when would be appropriate to request a pre-treatment determination estimate and how to request a review.
- Describe the claim appeal process.

LIMITATION – EXPLAIN BELOW ITEMS IN DETAIL FOR LIMITATION, REPAIR OR REPLACEMENT

- Definition for frequency of routine examination and cleanings.
- Limitations for frequency of full mouth x-rays, panoramic x-rays & bitewing x-rays.
- Age limitations for topical application of fluoride.
- Age limitations for sealants.
- Age limitations for space maintainers.
- Limitations for filling replacements including amalgam & synthetic.
- Limitations for periodontal scaling & root planing.
- Crown replacements.
- Payments for dentures. Denture repairs.
- Prosthodontic appliances and/or implants.
- Limitations of "Optional Services".

EXCLUSIONS – PLEASE LIST A COMPLETE LISTING OF EXCLUDED SERVICES

RATING

- Please list rating including multiyear guarantees.

PROPOSAL SUBMITTAL FORMAT – Proposers are asked to use the following format for providing responses to this RFP. Each page shall include the name of the entity making the proposal. For clarity, we specifically ask that you use our numbering system. Compliance will aid the County in evaluating your proposal.

GENERAL

1. Are the following required documents signed and attached?

   Drug—Free Workplace Certification **Yes** _____ **No** _____

Recycled Content Form	**Yes** _____	**No** _____
Conflict of Interest Disclosure Form	**Yes** _____	**No** _____
Local Preference Data Sheet	**Yes** _____	**No** _____
Indemnification & Hold Harmless Agreement	**Yes** _____	**No** _____
Proposal Submittal Format w/Authorized Signatures	**Yes** _____	**No** _____

LIFE INSURANCE ONLY

a. Optional Employee Life rate per $1,000 (list by age band).

Maximum amount of coverage (in increments of $25,000) $ _____.

Will you allow open enrollment during September 2012? Yes _____ No _____

b. Have you enclosed a sample policy including all endorsements & restrictions?

Yes _____ No _____

c. Optional Spouse and Child Life coverage – State limit and rate per month.

Will you allow open enrollment during September 2012? Yes _____ No _____

d. Describe alternative term life plans. Quote cost paid by County and optional cost by employee. List advantages of such a plan. Enclose a sample policy.

e. Do you waive all actively-at-work requirements for all proposals quoted?

Yes _____ No _____

f. Additional Comments & Recommendations:

LTD (LONG TERM DISABILITY)

a. Basic Rate -

b. Buy up Rate -

c. Optional Long Term Disability (paid by employee). Describe program and cost per month.

DENTAL INSURANCE ONLY

a. Rate for program comparable to current plan.

One Dependent _____, Two or More Dependents _____,

or Multiple Dependents _____.

List any/all benefit deviations from the current plan:

a. Discuss open enrollment.

b. Have you enclosed a list of dental care providers and a sample policy including all endorsements & restrictions?

Yes _____ No _____

Name of Proposer _____

1. "NO CONTACT CLAUSE"

The Okaloosa County Board of County Commissioners have established a solicitation silence policy **(No Contact Clause)** that prohibits oral and written communication regarding all formal solicitations for goods and services (formal bids, Request for Proposals, Requests for Qualifications) issued by the Board through the County Purchasing Department.

The period commences when the procurement document is advertised and terminates when the Board of County Commissioners approves an award.

When the solicitation silence period is in effect, no oral or written communication is allowed regarding the solicitation between prospective bidders/proposers and members of the Board of County Commissioners, the County Administrator or members of the Board Approved Review Committee. All questions or requests for information regarding the solicitation **must** be directed to the designated Purchasing Representative listed in the solicitation.

Any information thought to affect the committee or staff recommendation submitted after bids are due, should be directed to the Purchasing Director or his appointed representative. It shall be the Purchasing Director's decision whether to consider this information in the decision process.

Any attempt by a vendor/proposer to influence a member or members of the aforementioned shall be grounds to disqualify the proposer from consideration during the selection process.

All proposers must agree to comply with this policy by signing the following statement and including it with their submittal.

I _____ **representing** _____
Signature **Company Name**

Hereby agree to abide by the County's **"No Contact Clause"** and understand violation of this policy shall result in disqualification of my proposal/submittal.

2. **Applicable Laws & Regulations** – The proposer's attention is directed to the fact that all applicable state laws, county municipal ordinances, orders, rules & regulations of all authorities having jurisdiction over the work shall apply to the proposal throughout, and they will be deemed to be included in the contract the same as though they are written out in full herein.

3. **Indemnification & Hold Harmless** – Each contractor must submit an executed sworn certification that he will comply with the Hold Harmless Clause in accordance with the provisions of Florida Statutes, Section 725.06.

To the fullest extent permitted by law, proposer shall indemnify and hold harmless County, its officers and employees from liabilities, damages, losses, and costs including but not limited to reasonable attorney fees, to the extent caused by the negligence, recklessness, or intentional wrongful conduct of the proposer and other persons employed or utilized by the proposer in the performance of this contract.

4. **Conflict of Interest Disclosure Form -** The award hereunder is subject to the provisions of Chapter 112, Florida Statutes. All respondents must disclose with their proposals the name of any officer, director, or agent who is also a public officer or an employee of the Okaloosa Board of County Commissioners, or any of its agencies.

   Furthermore, all respondents must disclose the name of any County officer or employee who owns, directly or indirectly, an interest of five percent (5%) or more in the firm or any of its branches.

   Furthermore, the official, prior to or at the time of submission of the proposal, must file a statement with the Clerk of Circuit Court of Okaloosa County, if he is an officer or employee of the County, disclosing his or spouse's or child's interest and the nature of the intended business.

   Note: For bidder's convenience, this certification form is enclosed and is made a part of the bid package.

5. **Public Entity Crime Information -** A person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not submit a bid on a contract to provide any goods or services to a public entity, may not submit a bid on a contract with a public entity for the construction or repair of a public building or public work, may not submit bids on leases of real property to a public entity, may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in Section 287.017, for **CATEGORY TWO** for a period of 36 months from the date of being placed on the convicted vendor list.

6. **Investigation of Proposer –** The County may make such investigations, as it deems necessary to determine the stability of the contractor to perform the work and that there is no conflict of interest as it relates to the projects. The contractor shall furnish to the Owner any additional information and financial data for this purpose as the County may request.

7. **Contract Documents** – The contract documents provided by the successful proposer will consist of the proposal documents, technical specifications, the plans, the contractor's proposal and bonds; addenda issued prior to execution of the agreement, other documents specifically incorporated by reference in the contract documents, modifications issued after executive of the agreement. A modification is:

   1. A written amendment to the contract signed by both parties;

   2. A change order;

8. **Hierarchy of Contract Documents** – In the event conflicts, inconsistencies, discrepancies, or ambiguities between the contract documents arise, unless otherwise provided, the controlling instrument shall be determined by the descending order of the contract documents as follows:

   1. Modification issued after the execution of the agreement.

   2. Addenda issued after the proposal was advertised to potential proposers.

   3. Special provisions.

4. Technical special provisions.

9. **Conditional & Incomplete Proposals** – The Board of County Commissioners specifically reserves the right to reject any conditional proposal and will normally reject those that make it impossible to determine the trust amount of the proposal.

10. **Reorganization & Bankruptcy Proceedings** – Proposals will not be considered from vendors who are currently involved in official financial reorganization of bankruptcy.

11. **Right to Waive and Reject:**

A. The Board, in its absolute discretion, may reject any proposal of a proposer that has failed, in the opinion of the Board, to complete or perform an Okaloosa County contracted project in a timely fashion or has failed in any other way, in the opinion of the Board, to perform a prior contract in a satisfactory manner, and has directed the Okaloosa County Purchasing Director to emphasize this condition to potential proposers.

B. There is no obligation on the part of the County to award the proposal to the lowest proposer, and the County reserves the right to award the proposal to proposer submitting a responsive proposal with a resulting negotiated agreement which is most advantageous and in the best interest of Okaloosa county, and to reject any and all proposals or to waive any irregularity or technicality in proposals received. Okaloosa County shall be the sole judge of the proposal and the resulting negotiated agreement that is in its best interest and its decision shall be final.

C. The Board of County Commissioners reserves the right to waive any informalities or reject any and all proposals, in whole or part, to utilize any applicable state contracts in lieu of or in addition to this proposal and to accept the proposal that in its judgment will best serve the interest of the County.

D. The Board of County Commissioners specifically reserves the right to reject any conditional proposal and will normally reject those which made it impossible to determine the true amount of the proposal.

12. **Disqualification of Proposers -** Any of the following reasons may be considered as sufficient for the disqualification of a proposer and the rejection of his proposal or proposals:

A. More than one proposal for the same work from an individual, firm or corporation under the same or different name.

B. Evidence that the proposer has a financial interest in the firm of another proposer for the same work.

C. Evidence of collusion among proposers. Participants in such collusion will receive no recognition as proposers for any future work of the County until such participant shall have been reinstated as a qualified proposer.

D. Uncompleted work which in the judgment of the County might hinder or prevent the prompt completion of additional work if awarded.

E. Failure to pay or satisfactorily settle all bills due for labor and material on former contracts in force at the time of advertisement of proposals.

F. Default under previous contract.

13. Preparation of Proposals – Proposals must be submitted upon the prescribed forms provided herein. All blank spaces must be filled in as noted in ink or type in both words and number with the amount extended and totaled. No changes shall be made in phraseology of the form or in the items mentioned therein. In case of any discrepancy between the written amount and the figures, the written amounts shall govern. Any proposals may be rejected which contains any omissions, erasures, alterations, irregularities of any kind, or items not called for or which shall in any manner fail to conform to the conditions or published notice inviting proposals.

14. Discrimination - An entity or affiliate who has been placed on the discriminatory vendor list may not submit a bid on a contract to provide goods or services to a public entity, may not submit a bid on a contract with a public entity for the construction or repair of a public building or public work, may not submit bids on leases of real property to a public entity, may not award or perform work as a contractor, supplier, subcontractor, or consultant under contract with any public entity, and may not transact business with any public entity.

15. Regulation & Ordinances – The proposer is required to be familiar with all Federal, State and Local Laws, Ordinances, Code rules and regulations that may in any way effect the work. Ignorance on the part of the proposer shall in no way relieve proposer from responsibility.

16. Prohibition Against Contingent Fees – Florida Statute 287.6.a. requires the following statement, duly signed and notarized, be included in each submittal:

"The respondent warrants that he or she has not employed or retained any company or person, other than a bona fide employee working solely for the respondent to solicit or secure this agreement and that he or she has not paid or agreed to pay any person, company, corporation, individual or firm, other than a bone fide employee working solely for the respondent, any fee, commission or percentage, gift or other consideration contingent upon or resulting from award or making of this agreement."

17. Financial Background Information – Proposers shall include the following financial information in their submittal:

a. At least (1) bank reference and three (3) trade references.

The County reserves the right to conduct a credit check on any entit(ies) submitting proposal under this RFP process and by submitting a proposal said proposer agrees and consents to such.

18. Protection of Resident Workers – The Okaloosa County Board of County Commissioners actively supports the Immigration & Nationality Act (INA) which includes provisions addressing employment eligibility, employment verification, and nondiscrimination. Under the INA, employers may hire only persons who may legally work in the United States, (i.e., citizens and nationals of the U.S.) and aliens authorized to work in the U. S. The employer

must verify the identity and employment eligibility of anyone to be hired, which includes completing the Employment Eligibility Verification. The contractor shall establish appropriate procedures and controls so no services or products under the contract documents will be performed or manufactured by any worker who is not legally eligible to perform such services or employment. Okaloosa County reserves the right to request documentation showing compliance with the requirement.

Proposers doing construction business with Okaloosa County are required to use the Federal Government Department of Homeland Security's website and use the E-Verify Employment Eligibility & Verification System to confirm eligibility of all employees to work in the United States.

19. The Board of County Commissioners of Okaloosa County in its absolute discretion may reject any response of a firm that has failed, in the opinion of the Board to complete or perform an Okaloosa County contracted project in a timely and acceptable fashion, and has directed the Okaloosa County Purchasing Director to emphasize this condition to potential firms.

20. **Evaluation & Selection** – A Selection Review Committee appointed by the Board of County Commissioners (the Board may elect to serve as the Review Committee) will evaluate all submittals received.

A. Review of all responses received will proceed as follows:

1. The Selection Committee will review all documents submitted.

2. The committee's ranking of prospective firms shall be based on the evaluation criteria listed on the attached ranking sheet as provided in the submittal.

3. Upon ranking and formulating a short list of top ranked proposals, that list will be presented to the Board of County Commissioners. The Board will determine if presentations are required. If presentations are required, they will be made to the Board members in a special called meeting.

   The Board will make the final selection.

B. Negotiations between the selection committee, or the committee designee, and the top firm (or firms) ranking highest on the Board approved short list will proceed as follows:

1. Negotiations will be held with the first firm(s) on the priority list, depending on how proposals are submitted.

2. If no tentative agreement can be reached with the first firm, then negotiations will commence with the next firm on the short list, if so directed by the Board.

3. If no tentative agreement is reached with the top ranked firm, then the committee shall return to the Board to report such and recommend that a new short list be established from among the other responses received. If

for any reason said procedure is not feasible, the committee shall seek direction from the Board as to how to proceed further.

4. Okaloosa County reserves the right to negotiate contracts with one or more firms for the services described herein.

C. Presentation of the tentative contract agreement by the selection committee to the Board for approval. The Executive Summary shall inform the Board as to the terms, conditions, and costs associated with the contract.

D. Upon approval of the contract agreement by the Board, a formal written contract agreement will be executed prior to commencement of the work associated with the contract.

E. Selection will be on the basis of professional qualifications and experience as previously set forth.

1. The selection review committee and the Board of County Commissioners will evaluate and rank all responses meeting the requirements herein and enter into formal negotiations with selected firms. Firms will be notified of dates and times of any interviews once final selection has been made. **(Presentations may be required)**.

21. Submittal Opening – Names of firms that submit a response on or before the deadline specified herein shall be available to the public once the submittal deadline has passed. It is the firm's responsibility to assure that their response is delivered at the proper time and place. Offers by telegram, facsimile or telephone are **NOT** acceptable.

Note: Crestview, Florida is **"not a next day guaranteed delivery location"** by delivery services.

INSURANCE REQUIREMENTS

Contractor's Insurance

A. The **CONTRACTOR** shall not commence any work in connection with this Agreement until he has obtained all required insurance and such insurance has been approved by the Okaloosa County Risk Manager.

B. All insurance policies shall be with insurers licensed to do business in the State of Florida, and any insuring company is required to have a minimum rating of A, Class X in the Best Key Rating Guide published A. M. Best & Co., Inc.

C. All insurance shall include the interest of all entities names in and its respective agents, consultants, servants and employees of each and all other interests as may be reasonably required by Okaloosa County as Additional Insured. The coverage afforded the Additional Insured under this policy shall be primary insurance. If the Additional Insured have other insurance that is applicable to the loss, such other insurance shall be on an excess or contingent basis. The amount of the company's liability under this policy shall not be reduced by the existence of such other insurance.

D. The County of Okaloosa shall be listed as Additional Insured by policy endorsement on all insurance contracts applicable to this Agreement except Workers' Compensation and Professional Liability.

E. The County of Okaloosa shall be furnished proof of coverage by certificates of insurance (COI) and endorsements for every applicable insurance contract required by this Agreement. The COI's and policy endorsements must be delivered to the County Representative not less than ten (10) days prior to the commencement of any and all contractual agreements between the County of Okaloosa and the **CONTRACTOR**.

F. The County shall retain the right to reject all insurance contracts that do not meet the requirement of this Agreement. Further, the County reserves the right to change these insurance requirements with 60-day notice to the **CONTRACTOR**.

G. The insurance definition of Insured or Additional Insured shall include Subcontractor, Sub-subcontractor, and any associated or subsidiary companies of the **CONTRACTOR**, which are involved, and which is a part of the contract.

H. The County reserves the right at any time to require the **CONTRACTOR** to provide certified copies of any insurance policies to document the insurance coverage specified in this Agreement.

I. The designation of **CONTRACTOR** shall include any associated or subsidiary company which is involved and is a part of the contract and such, if any associated or subsidiary company involved in the project must be named in the Workers' Compensation coverage.

J. All policies shall be written so that the County will be notified of cancellation or restrictive amendments at least thirty (30) days prior to the effective date of such

cancellation or amendment. Such notice shall be given directly to the County Representative.

Workers' Compensation Insurance

1. The **CONTRACTOR** shall secure and maintain during the life of this agreement Workers' Compensation insurance for all of his/her employees employed for the project or any site connected with the work, including supervision, administration or management, of this project and in case any work is sublet, with the approval of the County of Okaloosa, the **CONTRACTOR** shall require the Subcontractor similarly to provide Workers' Compensation insurance for all employees employed at the site of the project, and such evidence of insurance shall be furnished the County of Okaloosa not less than ten (10) days prior to the commencement of any and all subcontractual agreements which have been approved by the County of Okaloosa.

2. Such insurance shall comply with the Florida Workers' Compensation Law.

3. No class of employee, including the **CONTRACTOR** himself/herself, shall be excluded from the Workers' Compensation insurance coverage. The Workers' Compensation insurance shall also include Employer's Liability coverage.

Business Automobile and Commercial General Liability Insurance

1. The **CONTRACTOR** shall maintain Business Automobile Liability insurance coverage throughout the life of this Agreement. The insurance shall include Owned, Non-owned & Hired Motor Vehicle coverage.

2. The **CONTRACTOR** shall carry other Commercial General Liability insurance against all other Bodily Injury, Property Damage and Personal and Advertising Injury exposures. The coverage shall include both On-and Off-Premises Operations, Contractual Liability, Broad Form Property Damage, and Professional Liability.

3. All liability insurance (other than Professional Liability) shall be written on an occurrence basis and shall not be written on a claim-made basis. If the insurance is issued with an aggregate limit of liability, the aggregate limit of liability shall apply only to the locations included in this Agreement. If, as the result of any claims or other reasons, the available limits of insurance reduce to less than those stated in the Limits of Liability, the **CONTRACTOR** shall notify the County representative in writing. The **CONTRACTOR** shall purchase additional liability insurance to maintain the requirements established in this Agreement. Umbrella or Excess Liability insurance can be purchased to meet the Limits of Liability specified in this Agreement.

4. Commercial General Liability coverage shall be endorsed to include the following:

    1.) Premises – Operation Liability
    2.) Occurrence Bodily Injury and Property Damage Liability

3.) Independent Contractor's Liability
4.) Completed Operations and Products Liability

5. **CONTRACTOR** shall agree to keep in continuous force Commercial General Liability coverage including Completed Operations and Products Liability for two (2) years beyond acceptance of project.

Limits of Liability

The insurance required shall be written for not less than the following, or greater if required by law and shall include Employer's liability with limits as prescribed in this contract:

		LIMIT
A.	Worker's Compensation	
	1.) State	Statutory
	2.) Employer's Liability	$1,000,000 each accident
B.	Business Automobile & Commercial General Liability Insurance	$1,000,000 each occurrence (A combined single limit)
C.	Personal and Advertising Injury	$250,000

Notice of Claims or Litigation

The **CONTRACTOR** agrees to report any incident or claim that results from performance of this Agreement. The County representative shall receive written notice in the form of a detailed written report describing the incident or claim within ten (10) days of the **CONTRACTOR**'s knowledge. In the event such incident or claim involves injury and/or property damage to a third party, verbal notification shall be given the same day the **CONTRACTOR** becomes aware of the incident or claim followed by a written detailed report within ten (10) days of verbal notification.

Indemnification & Hold Harmless

To the fullest extent permitted by law, **CONTRACTOR** shall indemnify and hold harmless COUNTY, its officers and employees from liabilities, damages, losses, and costs including but not limited to reasonable attorney fees, to the extent caused by the negligence, recklessness, or intentional wrongful conduct of the **CONTRACTOR** and other persons employed or utilized by the **CONTRACTOR** in the performance of this contract.

Certificate of Insurance

A. Certificates of insurance, in duplicate, indicating the job site and evidencing all required coverage must be submitted to and approved by Okaloosa County prior to the commencement of any of the work. The certificate holder(s) shall be as follows:

Okaloosa County
602-C North Pearl Street
Crestview, Florida 32536

B. All policies shall expressly require 30 days written notice to Okaloosa County at the

address set out above, or the cancellations of material alterations of such policies, and the Certificates of Insurance, shall so provide.

C. All certificates shall be subject to Okaloosa County's approval of adequacy of protection and the satisfactory character of the Insurer. County reserves the right to approve or reject all deductible/SIR above $10,000.

D. The Certificates of Insurance shall disclose any and all deductibles or self-insured retentions (SIRs). County requests that all deductibles or SIRs be no greater than $10,000. However, **CONTRACTORS** having insurance with higher deductibles may submit a bid without penalty reflecting the pricing for their deductible provided that **CONTRACTOR** also submits a brief company financial statement.

E. All deductibles or SIRs, whether approved by Okaloosa County or not, shall be the **CONTRACTOR**'s full responsibility. In particular, the **CONTRACTOR** shall afford full coverage as specified herein to entities listed as Additional Insured.

F. In no way will the entities listed as Additional Insured be responsible for, pay for, be damaged by, or limited to coverage required by this schedule due to the existence of a deductible or SIR. Specific written approval from Okaloosa County will only be provided upon demonstration that the **CONTRACTOR** has the financial capability and funds necessary to cover the responsibilities incurred as a result of the deductible or SIR.

G. In the event of failure of the **CONTRACTOR** to furnish and maintain said insurance and to furnish satisfactory evidence thereof, Okaloosa County shall have the right (but not the obligation) to take out and maintain insurance on the project. All costs for the coverage will be paid by **CONTRACTOR** upon presentation of a bill.

General Terms

Any type of insurance or increase of limits of liability not described above which the **CONTRACTOR** required for its own protection or on account of statute shall be its own responsibility and at its own expense.

The carrying of the insurance described shall in no way be interpreted as relieving the **CONTRACTOR** of any responsibility under this contract.

Should the **CONTRACTOR** engage a subcontractor or sub-subcontractor, the same conditions will apply under this agreement to each subcontractor and sub-subcontractor.

The **CONTRACTOR** hereby waives all rights of subrogation against Okaloosa County and its consultants and other indemnities of the **CONTRACTOR** under all the foregoing policies of insurance.

Umbrella Insurance

The **CONTRACTOR** shall have the right to meet the liability insurance requirements with the purchase of an umbrella insurance policy. In all instances, the combination of primary and umbrella liability coverage must equal or exceed the minimum liability insurance limits stated in this agreement.

COMPANY DATA

Physical Address & Phone #: _____

_____

_____

Proposer's Company Name: _____

Physical Address: _____

_____

_____

Contact Person (Typed-Printed): _____

Phone #: _____

Cell #: _____

Federal ID or SS #: _____

Proposer's License #: _____

Fax #: _____

Emergency #'s After Hours,
Weekends & Holidays: _____

LIST OF REFERENCES

Refer to Bid Specification

NAME OF CUSTOMER _____
ADDRESS _____
PHONE NUMBER _____
PERSON TO CONTACT _____

NAME OF CUSTOMER _____
ADDRESS _____
PHONE NUMBER _____
PERSON TO CONTACT _____

NAME OF CUSTOMER _____
ADDRESS _____
PHONE NUMBER _____
PERSON TO CONTACT _____

NAME OF CUSTOMER _____
ADDRESS _____
PHONE NUMBER _____
PERSON TO CONTACT _____

NAME OF CUSTOMER _____
ADDRESS _____
PHONE NUMBER _____
PERSON TO CONTACT _____

ADDENDUM ACKNOWLEDGEMENT

The bidder acknowledges that he/she has received the following addendum:

ADDENDUM NO._____ DATED_____

ADDENDUM NO._____ DATED_____

ADDENDUM NO._____ DATED_____

ADDENDUM NO._____ DATED_____

ADDENDUM NO._____ DATED_____

Bidder Firm Name: _____

Address: _____

_____

Title: _____

Phone #: _____

FAX No.: _____

CONFLICT OF INTEREST DISCLOSURE FORM

For purposes of determining any possible conflict of interest, all bidders/proposers, must disclose if any Okaloosa Board of County Commissioner, employee(s), elected officials(s), or if any of its agencies is also an owner, corporate officer, agency, employee, etc., of their business.

Indicate either "yes" (a county employee, elected official, or agency is also associated with your business), or "no". If yes, give person(s) name(s) and position(s) with your business.

YES_____ NO_____

NAME(S) **POSITION(S)**

_____

_____

_____

_____

FIRM NAME: _____

BY (PRINTED): _____

BY (SIGNATURE): _____

TITLE: _____

ADDRESS: _____

_____

PHONE NO. _____

E-MAIL _____

DRUG-FREE WORKPLACE CERTIFICATION

THE BELOW SIGNED BIDDER CERTIFIES that it has implemented a drug-free workplace program. In order to have a drug-free workplace program, a business shall:

1. Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.

2. Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.

3. Give each employee engaged in providing the commodities or contractual services that are under quote a copy of the statement specified in subsection 1.

4. In the statement specified in subsection 1, notify the employees that, as a condition of working on the commodities or contractual services that are under quote, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of Chapter 893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.

5. Impose a sanction on, or require the satisfactory participation in, drug abuse assistance or rehabilitation program if such is available in employee's community, by any employee who is convicted.

6. Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

As the person authorized to sign this statement, I certify that this firm complies fully with the above requirements.

DATE: _____

COMPANY: _____

ADDRESS: _____

_____

_____

PHONE NO.: _____

SIGNATURE: _____

NAME: _____
(Typed or Printed)

TITLE: _____

E-MAIL: _____

LIST OF REPRESENTATIVES

CONTRACT ADMINISTRATOR:

Susan Barrow, Okaloosa County Risk Management
Okaloosa County Risk Management Dept.
601-A North Pearl St.
Crestview FL 32536
850-689-5977 / 850-689-5973 (F)

CONTRACTOR'S REPRESENTATIVE:

_____

_____

_____

_____

_____

INDEMNIFICATION AND HOLD HARMLESS

To the fullest extent permitted by law, CONTRACTOR shall indemnify and hold harmless COUNTY, its officers and employees from liabilities, damages, losses, and costs including but not limited to reasonable attorney fees, to the extent caused by the negligence, recklessness, or intentional wrongful conduct of the CONTRACTOR and other persons employed or utilized by the CONTRACTOR in the performance of this Agreement.

_____	_____
Bidder's Company Name	Authorized Signature – Manual
_____	_____
Physical Address	Authorized Signature – Typed
_____	_____
Mailing Address	Title
_____	_____
Phone Number	FAX Number
_____	_____
Cellular Number	After-Hours Number(s)

_____

DATE

ANTI-COLLUSION STATEMENT: The below signed bidder has not divulged to, discussed or compared his bid with other bidders and has not colluded with any other bidder or parties to bid whatever. (Note: No premiums, rebates, or gratuities permitted either with, prior to, or after any delivery of materials. Any such violation will result in the cancellation and/or return of material (as applicable) and the removal from bid list(s).

Bidder's Company Name	Authorized Signature – Manual
	Authorized Signature – Typed
Address	Title
Phone #	Fax #
Federal ID # or SS #	E-mail address

RANKING SHEET
EMPLOYEE BENEFIT PROGRAMS

SCORING							
Availability of Local Providers/Coverage (20 Pts)							
Pricing/Cost (25 Pts)							
Understanding of Proposal (15 Pts)							
Financial Stability (20 Pts)							
Service Record & Reputation (20 Pts)							
TOTAL POINTS - 100							

PERSON COMPLETING FORM:

NAME: _____

DEPT: _____

DATE: _____

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OKALOOSA COUNTY BOCC

GROUP POLICY 640884
EXPERIENCE REPORT

DENTAL INSURANCE

	10/01/2010 THROUGH 09/30/2011	10/01/2000 THROUGH 09/30/2011
EARNED PREMIUMS	$642,435	$5,377,745
PAID CLAIMS	481,178	4,166,181
CHANGE IN IBNR RESERVES	-2,806	28,335
TOTAL INCURRED CLAIMS	478,372	4,194,516
LESS COMMISSIONS	6,187	60,015
PREMIUM TAX	11,243	94,111
OTHER EXPENSE AND RISK CHARGES	107,717	931,437
TOTAL EXPENSE AND RISK CHARGES	125,147	1,085,563
BALANCE	38,916	97,666

YOUR PRODUCER HAS RECEIVED CONTINGENT COMPENSATION BASED ON THE AMOUNT OF PREMIUM YOU PAID. THE CONTINGENT COMPENSATION IS NOT INCLUDED IN THIS REPORT BECAUSE THE STANDARD DOES NOT CHARGE TO YOUR EXPERIENCE THE AMOUNT PAID ON YOUR BEHALF. CONTINGENT COMPENSATION INFORMATION IS AVAILABLE UPON REQUEST.

JHAYER
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900 SW Fifth Avenue
Portland OR 97204
Tel 888.937.4783

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OKALOOSA COUNTY BOCC

GROUP POLICY 640884
EXPERIENCE REPORT

DENTAL INSURANCE

	10/01/2011 THROUGH 12/31/2011	10/01/2000 THROUGH 12/31/2011
EARNED PREMIUMS	$158,753	$5,536,497
PAID CLAIMS	119,914	4,286,094
CHANGE IN IBNR RESERVES	-662	27,673
TOTAL INCURRED CLAIMS	119,252	4,313,767
LESS COMMISSIONS	2,584	62,599
PREMIUM TAX	2,778	96,889
OTHER EXPENSE AND RISK CHARGES	26,906	958,343
TOTAL EXPENSE AND RISK CHARGES	32,268	1,117,831
BALANCE	7,233	104,899

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OKALOOSA COUNTY BOCC

GROUP POLICY 640884
EXPERIENCE REPORT

LONG TERM DISABILITY

	10/01/2010 THROUGH 09/30/2011	10/01/2000 THROUGH 09/30/2011
EARNED PREMIUMS	$77,360	$583,190
PAID CLAIMS	7,507	78,830
CHANGE IN REPORTED RESERVES	-17,200	7,751
CHANGE IN IBNR RESERVES	7,748	37,017
EMPLOYER FICA	127	339
TOTAL INCURRED CLAIMS	-1,818	123,937
LESS COMMISSIONS	4,851	38,147
PREMIUM TAX	1,354	10,207
OTHER EXPENSE AND RISK CHARGES	24,550	203,719
TOTAL EXPENSE AND RISK CHARGES	30,755	252,073
BALANCE	48,424	207,179

YOUR PRODUCER HAS RECEIVED CONTINGENT COMPENSATION BASED ON THE AMOUNT OF PREMIUM YOU PAID. THE CONTINGENT COMPENSATION IS NOT INCLUDED IN THIS REPORT BECAUSE THE STANDARD DOES NOT CHARGE TO YOUR EXPERIENCE THE AMOUNT PAID ON YOUR BEHALF. CONTINGENT COMPENSATION INFORMATION IS AVAILABLE UPON REQUEST.

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OKALOOSA COUNTY BOCC

GROUP POLICY 640884
EXPERIENCE REPORT

LONG TERM DISABILITY

	10/01/2011 THROUGH 12/31/2011	10/01/2000 THROUGH 12/31/2011
EARNED PREMIUMS	$17,870	$601,060
PAID CLAIMS	1,200	80,030
CHANGE IN REPORTED RESERVES	29,524	37,275
CHANGE IN IBNR RESERVES	-239	36,778
EMPLOYER FICA	0	339
TOTAL INCURRED CLAIMS	30,485	154,422
LESS COMMISSIONS	1,791	39,938
PREMIUM TAX	313	10,520
OTHER EXPENSE AND RISK CHARGES	6,070	209,789
TOTAL EXPENSE AND RISK CHARGES	8,174	260,247
BALANCE	-20,789	186,390

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OKALOOSA COUNTY BOCC

GROUP POLICY 640884
EXPERIENCE REPORT

TERM LIFE DEPENDENT LIFE
AD&D INS

	10/01/2010 THROUGH 09/30/2011	10/01/2000 THROUGH 09/30/2011
EARNED PREMIUMS	$305,742	$2,791,522
PAID CLAIMS	400,000	1,975,000
CHANGE IN REPORTED RESERVES	-65,000	500,500
CHANGE IN IBNR RESERVES	10,643	56,298
CONVERSION CHARGES	5,625	46,950
TOTAL INCURRED CLAIMS	351,268	2,578,748
LESS COMMISSIONS	15,101	138,529
PREMIUM TAX	5,351	48,849
OTHER EXPENSE AND RISK CHARGES	37,714	366,315
TOTAL EXPENSE AND RISK CHARGES	58,166	553,693
BALANCE	-103,692	-340,919

YOUR PRODUCER HAS RECEIVED CONTINGENT COMPENSATION BASED ON THE AMOUNT OF PREMIUM YOU PAID. THE CONTINGENT COMPENSATION IS NOT INCLUDED IN THIS REPORT BECAUSE THE STANDARD DOES NOT CHARGE TO YOUR EXPERIENCE THE AMOUNT PAID ON YOUR BEHALF. CONTINGENT COMPENSATION INFORMATION IS AVAILABLE UPON REQUEST.

Need to Request

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OKALOOSA COUNTY BOCC

GROUP POLICY 640884
EXPERIENCE REPORT

TERM LIFE DEPENDENT LIFE
AD&D INS

	10/01/2011 THROUGH 12/31/2011	10/01/2000 THROUGH 12/31/2011
EARNED PREMIUMS	$71,396	$2,862,919
PAID CLAIMS	0	1,975,000
CHANGE IN REPORTED RESERVES	16,250	516,750
CHANGE IN IBNR RESERVES	-1,635	54,663
CONVERSION CHARGES	0	46,950
TOTAL INCURRED CLAIMS	14,615	2,593,363
LESS COMMISSIONS	2,465	140,993
PREMIUM TAX	1,250	50,099
OTHER EXPENSE AND RISK CHARGES	9,251	375,566
TOTAL EXPENSE AND RISK CHARGES	12,966	566,658
BALANCE	43,815	-297,102

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Tel 888.937.4783

POLICY 640884 OKALOOSA COUNTY BOCC FROM 01/2011 THRU 12/2011

CLAIM NUMBER	CLAIMANT NAME	S X	COV	PD	O C	BIRTH	INCUR	APPROV	TERM	CAUSE CODE	P N	BENEFIT	AMOUNT PAID THIS PERIOD	TOTAL PAID THIS CLAIM	RESERVE END OF PERIOD	RESERVE BEG OF PERIOD
C70047		M	TERM			05/1954	01/2011	01/2011	03/2011				25,000.00	25,000.00		
C70047		M	TERM			05/1954	01/2011	01/2011	03/2011				200,000.00	200,000.00		
C74000		M	TERM			02/1950	02/2011	03/2011	03/2011				25,000.00	25,000.00		
C74000		M	TERM			02/1950	02/2011	03/2011	03/2011				100,000.00	100,000.00		
C82115		M	TERM			04/1950	05/2011	06/2011	06/2011				25,000.00	25,000.00		
C82115		M	TERM			04/1950	05/2011	06/2011	06/2011				25,000.00	25,000.00		
								COVERAGE - TERM					400,000.00	400,000.00		
B13674		M	TPD2		8	12/1947	06/2004	11/2004				10,000.00			6,500.00	6,500.00
B13674		M	TPD2		8	12/1947	06/2004	11/2004				75,000.00			48,750.00	48,750.00
B15562		F	TPD2		2	12/1955	04/2004	12/2004				10,000.00			6,500.00	6,500.00
B15562		F	TPD2		2	12/1955	04/2004	12/2004				100,000.00			65,000.00	65,000.00
B88256		M	TPD2		1	03/1956	10/2007	01/2008				25,000.00			16,250.00	16,250.00
B88256		M	TPD2		1	03/1956	10/2007	03/2008				200,000.00			130,000.00	130,000.00
B91071		M	TPD2		8	12/1956	08/2007	02/2008				25,000.00			16,250.00	16,250.00
B93593		M	TPD2		6	05/1957	08/2007	03/2008				25,000.00			16,250.00	16,250.00
B93593		M	TPD2		6	05/1957	08/2007	03/2008				100,000.00			65,000.00	65,000.00
C02755		M	TPD2		8	05/1954	07/2008	11/2008				25,000.00			16,250.00	16,250.00
C06751		F	TPD2		2	08/1957	03/2008	09/2008				150,000.00			97,500.00	97,500.00
C06751		F	TPD2		2	08/1957	03/2008	09/2008				25,000.00			16,250.00	16,250.00
C71049		M	TPD2		0	04/1950	07/2010	02/2011	06/2011							
C71049		M	TPD2		0	04/1950	07/2010	02/2011	06/2011							
C74476		F	TPD2		9	09/1951	09/2010	05/2011	08/2011							
C96837		F	TPD2		2	12/1952	06/2011	12/2011				25,000.00			16,250.00	
								SUBTOTAL PENDING - TPD2								
								SUBTOTAL OTHER - TPD2							516,750.00	500,500.00
								COVERAGE - TPD2							516,750.00	500,500.00
VD1513		C	M	LTD	5	05/1957	08/2007	03/2008		NS		1,531.92	1,200.00	4,810.56	1,687.00	2,686.00
VD6334		L	M	LTD	0	03/1956	10/2007	01/2008		OS		2,064.58	1,200.00	9,431.91	1,687.00	2,686.00
VE9506		R	F	LTD	1	08/1957	03/2008	09/2008		NS		1,612.01	1,200.00	3,900.00	1,697.00	2,678.00
VF4399		J	M	LTD	5	05/1954	07/2008	11/2008		NS		1,708.38	1,200.00	3,600.00	1,681.00	2,638.00
VH8905		D	M	LTD	5	05/1954	07/2009	11/2009	01/2011	NS			100.00	1,200.00		149.00
VL2413		G	M	LTD	2	04/1950	07/2010	01/2011	05/2011	NS		1,658.91	2,306.99	2,306.99		34,853.00
VO5917		D	M	LTD	8	03/1962	06/2011	01/2012		NA	P	1,442.12			26,546.98	
VO9111		S	F	LTD	1	12/1952	06/2011	11/2011		NS		1,282.73			3,976.00	

CLAIM NUMBER	CLAIMANT NAME	S X	COV	PD	O C	BIRTH	INCUR	APPROV	TERM	CAUSE CODE	P N	BENEFIT	AMOUNT PAID THIS PERIOD	TOTAL PAID THIS CLAIM	RESERVE END OF PERIOD	RESERVE BEG OF PERIOD
								SUBTOTAL PENDING - LTD							26,546.98	
								SUBTOTAL OTHER - LTD					7,206.99	25,249.46	10,728.00	45,690.00
								COVERAGE - LTD					7,206.99	25,249.46	37,274.98.	45,690.00
								POLICY - 640884					407,206.99	425,249.46	554,024.98	546,190.00

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

People. Not Just Policies.®

CERTIFICATE

GROUP LIFE INSURANCE

Policyowner:	Okaloosa County Board of County Commissioners
Policy Number:	640884-A
Effective Date:	October 1, 2000

A Group Policy has been issued to the Policyowner. We certify that you will be insured as provided by the terms of the Group Policy. If your coverage is changed by an amendment to the Group Policy, we will provide the Policyowner with a revised Certificate or other notice to be given to you.

This policy includes an Accelerated Benefit. Death benefits will be reduced if an Accelerated Benefit is paid. The receipt of this benefit may be taxable and may affect your eligibility for Medicaid or other government benefits or entitlements. However, if you meet the definition of "terminally ill individual" according to the Internal Revenue Code Section 101, your Accelerated Benefit may be non-taxable. You should consult your personal tax and/or legal advisor before you apply for an Accelerated Benefit.

Possession of this Certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate. If the terms of the Certificate differ from the Group Policy, the terms stated in the Group Policy will govern.

"We", "us" and "our" mean Standard Insurance Company. "You" and "your" mean the Member. All other defined terms appear with the initial letter capitalized. Section headings, and references to them, appear in boldface type.

Ronald E. Timpe
President

GC190-LIFE/S399

Table of Contents

Index of Defined Terms

COVERAGE FEATURES

This section contains many of the features of your group life insurance. Other provisions, including exclusions and limitations, appear in other sections. Please refer to the text of each section for full details. The Table of Contents and the Index of Defined Terms help locate sections and definitions.

GENERAL POLICY INFORMATION

Group Policy Number:	640884-A
Type of Insurance Provided:	
Life Insurance:	Yes
Supplemental Life Insurance:	Not applicable
Dependents Life Insurance:	Yes
Accidental Death And Dismemberment (AD&D) Insurance:	Yes
Policyowner:	Okaloosa County Board of County Commissioners
Employer (s):	Okaloosa County Board of County Commissioners
Group Policy Effective Date:	October 1, 2000
Policy Issued in:	Florida

BECOMING INSURED

To become insured for Life Insurance you must: (a) Be a Member; (b) Complete your Eligibility Waiting Period; and (c) Meet the requirements in **Life Insurance** and **Active Work Provisions**. The requirements for becoming insured for coverages other than Life Insurance are set out in the text.

Definition of Member:

You are a Member if you are:

1. An active employee of the Employer; and
2. Regularly working at least 32 hours each week.

You are not a Member if you are:

1. A temporary or seasonal employee; or
2. A full time member of the armed forces of any country.

Class Definition:

Class 1:	Department directors, county manager and county commissioners
Class 2:	All other Members

Eligibility Waiting Period:	You are eligible on one of the following dates, but not before the Group Policy Effective Date:
Class 1:	If you are a Member on the Group Policy Effective Date, you are eligible on that date. If you become a Member after the Group Policy Effective Date, you are eligible on the date you become a Member.
Class 2:	If you are a Member on the Group Policy Effective Date, you are eligible on the first day of the calendar month following 90 consecutive days as a Member. If you become a Member after the Group Policy Effective Date, you are eligible on the first day of the calendar month following 90 consecutive days as a Member.
Evidence of Insurability:	Required: a. For late application for Contributory insurance. b. For reinstatements if required. c. For Members eligible but not insured under the Prior Plan. However, if you apply for Plan 2 Life Insurance on the Group Policy Effective Date, this requirement will be waived for you up to $100,000 on the Group Policy Effective Date. d. For Dependents eligible but not insure under the Prior Plan. e. For Dependents Life Insurance Benefit for your Spouse in excess of the Guarantee Issue Amount of $25,000. However, if your Spouse was insured under the Prior Plan for an amount up to $50,000 on the day before the Group Policy Effective Date, this requirement will be waived on the Group Policy Effective Date. f. For any increase in your Plan 2 Life Insurance Benefit resulting from a Plan change you elect. g. For any increase in Dependents Life Insurance Benefit resulting from a Plan change you elect. h. For becoming insured for any amount greater than the amount for which you were insured under the Prior Plan, if your insurance under the Prior Plan was limited because you did not provide evidence of insurability or because your evidence of insurability was not approved.

PREMIUM CONTRIBUTIONS

Life and AD&D Insurance:

Plan 1:	Noncontributory
Plan 2:	Contributory

Dependents Life Insurance: Contributory

The cost of insurance may be funded by contributions to an IRC Section 125 Cafeteria Plan.

SCHEDULE OF INSURANCE

SCHEDULE OF LIFE INSURANCE

For you:

Life Insurance Benefit:

You will become insured under Plan 1 if you meet the requirements to become insured under the Group Policy.

If you are insured under Plan 1, you may also become insured under Plan 2 if you meet the requirements to become insured under Plan 2 Life Insurance under the Group Policy. Plan 2 is a Contributory plan requiring premium contributions from Members.

You may be insured under Plan 1 and Plan 2 at any one time.

Plan 1 (basic):	$10,000
Plan 2 (additional):	You may apply for Life Insurance in multiples of $25,000, from $25,000 to $300,000.
The Repatriation Benefit:	The expenses incurred to transport your body to a mortuary near your primary place of residence, but not to exceed $5,000 or 10% of the Life Insurance Benefit, whichever is less.

For your Spouse:

Dependents Life Insurance Benefit:	You may apply for Dependents Life Insurance for your Spouse in multiples of $5,000 from $5,000 to $150,000.

The amount of Dependents Life Insurance for your Spouse may not exceed 50% of the amount of your Life Insurance.

For your Child:

Dependents Life Insurance Benefit:	You may apply for Dependents Life Insurance for your Child in multiples of $1,000 from $1,000 to $10,000.

The amount of Dependents Life Insurance for your Child may not exceed 50% of the amount of your Life Insurance.

SCHEDULE OF AD&D INSURANCE

For you:

AD&D Insurance Benefit:	The amount of your Plan 1 AD&D Insurance Benefit is equal to the amount of your Plan 1 Life Insurance Benefit. The amount payable for certain Losses is less than 100% of the AD&D Insurance Benefit. See AD&D Table Of Losses.

	The amount of your Plan 2 AD&D Insurance Benefit is equal to the amount of your Plan 2 Life Insurance Benefit. The amount payable for certain Losses is less than 100% of the AD&D Insurance Benefit. See AD&D Table Of Losses.
Seat Belt Benefit:	The amount of the Seat Belt Benefit is the lesser of (1) $10,000 or (2) the amount of AD&D Insurance Benefit payable for loss of life.
Career Adjustment Benefit:	The tuition expenses for training incurred by your Spouse within 36 months after the date of your death, exclusive of room and board, but not to exceed $5,000 per year, or the cumulative total of $10,000 or 25% of the AD&D Insurance Benefit, whichever is less.
Child Care Benefit:	The total child care expense incurred by your Spouse within 36 months after the date of your death for all Children under age 13, but not to exceed $5,000 per year, or the cumulative total of $10,000 or 25% of the AD&D Insurance Benefit, whichever is less.
Higher Education Benefit:	The tuition expenses incurred per Child within 4 years after the date of your death at an accredited institution of higher education, exclusive of room and board, but not to exceed $5,000 per year, or the cumulative total of $20,000 or 25% of the AD&D Insurance Benefit, whichever is less.
Line of Duty Benefit	The Lesser of (1) $50,000; or (2) 100% of the amount of the AD&D Insurance Benefit otherwise payable for the Loss.
Occupational Assault Benefit:	The lesser of (1) $25,000; or (2) 50% of the amount of the AD&D Insurance Benefit otherwise payable for the Loss.
Public Transportation Benefit:	The lesser of (1) $200,000; or (2) 100% of the amount of the AD&D Insurance Benefit otherwise payable for the Loss of your life.

AD&D TABLE OF LOSSES

The amount payable is a percentage of the AD&D Insurance Benefit in effect on the date of the accident and is determined by the Loss suffered as shown in the following table:

Loss:		Percentage Payable:
a.	Life	100%
b.	One hand or one foot	50%
c.	Sight in one eye, speech, or hearing in both ears	50%
d.	Two or more of the Losses listed in b. and c. above	100%
e.	Thumb and index finger of the same hand	25% *
f.	Quadriplegia	100%

g.	Hemiplegia	50%
h.	Paraplegia	50%

No more than 100% of your AD&D Insurance will be paid for all Losses resulting from one accident.

* **No AD&D Insurance Benefit will be paid for Loss of thumb and index finger of the same hand if an AD&D Insurance Benefit is payable for the Loss of that entire hand.**

REDUCTIONS IN INSURANCE

If you reach an age shown below, the amount of insurance will be the amount determined from the Schedule of Insurance, multiplied by the appropriate percentage below:

Life and AD&D Insurance:

Age	Percentage
65 through 69	65%
70 through 74	40%
75 through 79	25%
80 or over	15%

OTHER BENEFITS

Waiver Of Premium:	Yes
Accelerated Benefit:	Yes
Insurance Eligible For Portability Of Insurance:	
Life Insurance:	
Plan 1 (basic):	Yes. The maximum amount of Life Insurance you may continue is the lesser of: (1) the amount in effect on the date your employment terminates; or (2) $300,000. The minimum amount of Life Insurance you may continue is $10,000.
Plan 2 (additional)	The maximum amount of Additional Life Insurance you may continue is the lesser of: (1) the amount in effect on the date your employment terminates; or (2) $300,000. The minimum amount of Life Insurance you may continue is $25,000.
Dependents Life Insurance:	
For your Spouse:	The maximum amount of Dependents Life Insurance you may continue is the lesser of: (1) the amount in effect on the date your employment terminates; or (2) $10,000. The minimum amount of Dependents Life Insurance you may continue is $5,000.

For each Child:	The maximum amount of Dependents Insurance you may continue is the lesser of: (1) the amount in effect on the date your employment terminates; or (2) $5,000. The minimum amount of Dependents Life Insurance you may continue is $1,000.

Portability Premium — Age-graded Rates Per Multiple Of $1,000 Per Month

Age of Insured On last October 1	Rate
Under 30	$
30 through 34	
35 through 39	
40 through 44	
45 through 49	
50 through 54	
55 through 59	
60 through 64	
65 through 69	
70 through 74	
75 through 79	
80 through 89	
90 or above	

OTHER PROVISIONS

Limits on Right To Convert if Group Policy terminates or is amended:	
Minimum Time Insured:	5 years
Maximum Conversion Amount:	$10,000
Suicide Exclusion:	Applies to: a. Plan 2 Life Insurance b. Dependents Life Insurance for your Spouse c. AD&D Insurance
Leave Of Absence Period:	60 days
Continuity Of Coverage:	Yes
Annual Earnings based on:	Earnings in effect on your last full day of Active Work.
Earnings Period for Commissions (see **Definitions**):	The preceding 12 calendar months.

LIFE INSURANCE

A. Insuring Clause

If you die while insured for Life Insurance, we will pay benefits according to the terms of the Group Policy after we receive satisfactory Proof Of Loss.

B. Amount Of Life Insurance

See the **Coverage Features** for the Life Insurance schedule.

C. Changes In Life Insurance

1. Increases

You must apply in writing for any elective increase in your Life Insurance.

Subject to the **Active Work Provisions**, an increase in your Life Insurance becomes effective as follows:

a. Increases Subject To Evidence Of Insurability

An increase in your Life Insurance subject to Evidence Of Insurability becomes effective on the date we approve your Evidence Of Insurability.

b. Increases Not Subject To Evidence Of Insurability

An increase in your Life Insurance not subject to Evidence Of Insurability becomes effective on the first day of the calendar month coinciding with or next following the date you apply for an elective increase or the date of change in your classification, age or Annual Earnings.

2. Decreases

A decrease in your Life Insurance because of a change in your classification, age or Annual Earnings becomes effective on the first day of the calendar month coinciding with or next following the date of the change.

Any other decrease in your Life Insurance becomes effective on the first day of the calendar month coinciding with or next following the date the Policyowner or your Employer receives your written request for the decrease.

D. Repatriation Benefit

The amount of the Repatriation Benefit is shown in the **Coverage Features**.

We will pay a Repatriation Benefit if all of the following requirements are met.

1. A Life Insurance Benefit is payable because of your death.
2. You die more than 200 miles from your primary place of residence.
3. Expenses are incurred to transport your body to a mortuary near your primary place of residence.

E. Suicide Exclusion: Life Insurance

The **Coverage Features** states which Life Insurance plan is subject to this suicide exclusion.

If your death results from suicide or other intentionally self-inflicted Injury, while sane or insane, 1 and 2 below apply.

1. The amount payable will exclude the amount of your Life Insurance which is subject to this suicide exclusion and which has not been continuously in effect for at least 2 years on the date

of your death. In computing the 2-year period, we will include time you were insured under the Prior Plan.

2. We will refund all premiums paid for that portion of your Life Insurance which is excluded from payment under this suicide exclusion.

F. When Life Insurance Become Effective

The **Coverage Features** states whether your Life Insurance is Contributory or Noncontributory.

Subject to the **Active Work Provisions**, your Life Insurance becomes effective as follows:

1. Life Insurance subject to Evidence Of Insurability

   Life Insurance subject to Evidence Of Insurability becomes effective on the date we approve your Evidence Of Insurability.

2. Life Insurance not subject to Evidence Of Insurability

   a. Noncontributory Life Insurance

      Noncontributory Life Insurance not subject to Evidence Of Insurability becomes effective on the date you become eligible.

   b. Contributory Life Insurance

      You must apply in writing for Contributory Life Insurance and agree to pay premiums. Contributory Life Insurance not subject to Evidence Of Insurability becomes effective on:

      (i) The date you become eligible if you apply on or before that date.

      (ii) The date you apply if you apply within 31 days after you become eligible.

Late application: Evidence Of Insurability is required if you apply more than 31 days after you become eligible.

3. Takeover Provision

   a. If you were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Group Policy, your Eligibility Waiting Period is waived on the effective date of your Employer's coverage under the Group Policy.

   b. You must submit satisfactory Evidence Of Insurability to become insured for Life Insurance if you were eligible under the Prior Plan for more than 31 days but were not insured.

G. When Life Insurance Ends

Life Insurance ends automatically on the earliest of:

1. The date the last period ends for which you made a premium contribution, if your insurance is Contributory;

2. The date the Group Policy terminates;

3. The date your employment terminates; and

4. The date you cease to be a Member. However, if you cease to be a Member because you are working less than the required minimum number of hours, your Life Insurance will be continued with premium payment during the following periods, unless it ends under 1 through 3 above.

   a. While your Employer is paying you at least the same Annual Earnings paid to you immediately before you ceased to be a Member.

   b. While your ability to work is limited because of Sickness, Injury, or Pregnancy.

c. During the first 60 days of a temporary layoff, strike, lockout, or other general work stoppage caused by a labor dispute between your collective bargaining unit and your Employer.

d. During a leave of absence if continuation of your insurance under the Group Policy is required by a state-mandated family or medical leave act or law.

e. During any other scheduled leave of absence approved by your Employer in advance and in writing and lasting not more than the period shown in the **Coverage Features.**

H. Reinstatement Of Life Insurance

If your Life Insurance ends, you may become insured again as a new Member. However, 1 through 4 below will apply.

1. If your Life Insurance ends because you cease to be a Member, and if you become a Member again within 90 days, the Eligibility Waiting Period will be waived.

2. If your Life Insurance ends because you fail to make a required premium contribution, you must provide Evidence Of Insurability to become insured again.

3. If you exercised your Right To Convert, you must provide Evidence Of Insurability to become insured again.

4. If your Life Insurance ends because you are on a federal or state-mandated family or medical leave of absence, and you become a Member again immediately following the period allowed, your insurance will be reinstated pursuant to the federal or state-mandated family or medical leave act or law.

DEPENDENTS LIFE INSURANCE

A. Insuring Clause

If your Dependent dies while insured for Dependents Life Insurance, we will pay benefits according to the terms of the Group Policy after we receive satisfactory Proof Of Loss.

B. Amount Of Dependents Life Insurance

See the **Coverage Features** for the amount of your Dependents Life Insurance.

C. Changes In Dependents Life Insurance

1. Increases

You must apply in writing for any elective increase in your Dependents Life Insurance.

Subject to the **Active Work Provisions**, an increase in your Dependents Life Insurance becomes effective as follows:

a. Increases Subject To Evidence Of Insurability

An increase in your Dependents Life Insurance subject to Evidence Of Insurability becomes effective on the date we approve that Dependent's Evidence Of Insurability.

b. Increases Not Subject To Evidence Of Insurability

An increase in your Dependents Life Insurance not subject to Evidence Of Insurability becomes effective on the first day of the calendar month coinciding with or next following the date you apply for an elective increase.

An increase in your Dependents Life Insurance because of an increase in your Life Insurance becomes effective on the date your Life Insurance increases.

2. Decreases

A decrease in your Dependents Life Insurance because of a decrease in your Life Insurance becomes effective on the date your Life Insurance decreases.

D. Suicide Exclusion: Dependents Life Insurance

The **Coverage Features** states which Dependents Life Insurance plan is subject to this suicide exclusion.

If a Dependent's death results from suicide or other intentionally self-inflicted Injury, while sane or insane, 1 and 2 below apply.

1. The amount payable will exclude the amount of your Dependents Life Insurance which is subject to this suicide exclusion and which has not been continuously in effect for at least 2 years on the date of Dependent's death. In computing the 2-year period, we will include time your Dependent was insured under the Prior Plan.
2. We will refund all premiums paid for that amount of your Dependents Life Insurance excluded from payment under this suicide exclusion which we determine are attributable to that Dependent.

E. Definitions For Dependents Life Insurance

Dependent means your Spouse or Child. Dependent does not include a person who is a full-time member of the armed forces of any country.

F. Becoming Insured For Dependents Life Insurance

1. Eligibility

You become eligible to insure your Dependents on the later of:

a. The date your Life Insurance becomes effective; and

b. The date you first acquire a Dependent.

A Member may not be insured as both a Member and a Dependent. A Child may not be insured by more than one Member.

2. Effective Date

The **Coverage Features** states whether your Dependents Life Insurance is Contributory or Noncontributory. Subject to the **Active Work Provisions**, your Dependents Life Insurance becomes effective as follows:

a. Dependents Life Insurance Subject To Evidence Of Insurability

Dependents Life Insurance subject to Evidence Of Insurability becomes effective on the later of:

1. The date your Life Insurance becomes effective; and
2. The first day of the calendar month coinciding with or next following the date we approve the Dependent's Evidence Of Insurability.

b. Dependents Life Insurance Not Subject To Evidence Of Insurability

1. Noncontributory Dependents Life Insurance

Noncontributory Dependents Life Insurance not subject to Evidence Of Insurability becomes effective on the later of:

i. The date your Life Insurance becomes effective; and

ii. The date you first acquire a Dependent.

2. Contributory Dependents Life Insurance

You must apply in writing for Contributory Dependents Life Insurance and agree to pay premiums. Contributory Dependents Life Insurance not subject to Evidence Of Insurability becomes effective on the latest of:

i. The date your Life Insurance becomes effective if you apply on or before that date;

ii. The date you become eligible to insure your Dependents if you apply on or before that date; and

iii. The date you apply if you apply within 31 days after you become eligible.

Late Application: Evidence Of Insurability is required for each Dependent if you apply more than 31 days after you become eligible.

c. While your Dependents Life Insurance is in effect, each new Child becomes insured immediately.

d. Takeover Provision

Each Dependent who was eligible under the Prior Plan for more than 31 days but was not insured must submit satisfactory Evidence Of Insurability to become insured for Dependents Life Insurance.

G. When Dependents Life Insurance Ends

Dependents Life Insurance ends automatically on the earliest of:

1. Five months after you die (no premiums will be charged for your Dependents Life Insurance during this time);
2. The date your Life Insurance ends;
3. The date the Group Policy terminates, or the date Dependents Life Insurance terminates under the Group Policy;
4. The date the last period ends for which you made a premium contribution, if your Dependents Life Insurance is Contributory;
5. For your Spouse, the date of your divorce;
6. For any Dependent, the date the Dependent ceases to be a Dependent; and
7. For a Child who is Disabled, 90 days after we mail you a request for proof of Disability, if proof is not given.

(SP & CH) LI.DL.OT.1X

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

A. Insuring Clause

If you have an accident, including accidental exposure to adverse conditions, while insured for

AD&D Insurance, and the accident results in a Loss, we will pay benefits according to the terms of the Group Policy after we receive satisfactory Proof Of Loss.

B. Definition Of Loss For AD&D Insurance

Loss means loss of life, hand, foot, sight, speech, hearing in both ears, thumb and index finger of the same hand and Quadriplegia, Hemiplegia or Paraplegia which meets all of the following requirements:

1. Is caused solely and directly by an accident.
2. Occurs independently of all other causes.
3. Occurs within 365 days of the accident.
4. With respect to Loss of life, is evidenced by a certified copy of the death certificate.
5. With respect to all other Losses, is certified by a Physician in the appropriate specialty as determined by us.

With respect to Loss of life, death will be presumed if you disappear and the disappearance:

1. Is caused solely and directly by an accident that reasonably could have caused Loss of life;
2. Occurs independently of all other causes; and
3. Continued for a period of 365 days after the date of the accident, despite reasonable search efforts.

With respect to a hand or foot, Loss means actual and permanent severance from the body at or above the wrist or ankle joint, whether or not surgically reattached.

With respect to sight, Loss means entire, uncorrectable, and irrecoverable loss of sight.

With respect to speech, Loss means entire, uncorrectable, and irrecoverable loss of audible speech.

With respect to hearing, Loss means entire, uncorrectable, and irrecoverable loss of hearing in both ears.

With respect to thumb and index finger of the same hand, Loss means actual and permanent severance from the body at or above the metacarpophalangeal joints.

With respect to Quadriplegia, Hemiplegia, and Paraplegia, Loss must be permanent, complete, and irreversible.

Quadriplegia means total paralysis of both upper and lower limbs. Hemiplegia means total paralysis of the upper and lower limbs on the same side of the body. Paraplegia means total paralysis of both lower limbs.

C. Amount Payable

See **Coverage Features** for the AD&D Insurance schedule. The amount payable is a percentage of the AD&D Insurance Benefit in effect on the date of the accident and is determined by the Loss suffered. See AD&D Table Of Losses in the **Coverage Features**.

D. Changes In AD&D Insurance

Changes in your AD&D Insurance will become effective on the date your Life Insurance changes.

E. AD&D Insurance Exclusions

No AD&D Insurance benefit is payable if the accident or Loss is caused or contributed to by any of the following:

1. War or act of War. War means declared or undeclared war, whether civil or international, and

any substantial armed conflict between organized forces of a military nature.

2. Suicide or other intentionally self-inflicted Injury, while sane or insane.
3. Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.
4. The voluntary use or consumption of any poison, chemical compound or drug, unless used or consumed according to the directions of a Physician.
5. Sickness or Pregnancy existing at the time of the accident.
6. Heart attack or stroke.
7. Medical or surgical treatment for any of the above.

F. Additional AD&D Benefits

Seat Belt Benefit

The amount of the Seat Belt Benefit is shown in the **Coverage Features**.

We will pay a Seat Belt Benefit if all of the following requirements are met:

1. You die as a result of an Automobile accident for which an AD&D Insurance Benefit is payable for Loss of your Life; and
2. You are wearing and properly utilizing a Seat Belt System at the time of the accident, as evidenced by a police accident report.

Seat Belt System means a properly installed combination lap and shoulder restraint system that meets the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration. Seat Belt System will include a lap belt alone, but only if the Automobile did not have a combination lap and shoulder restraint system when manufactured. Seat Belt System does not include a shoulder restraint alone.

Automobile means a motor vehicle licensed for use on public highways.

Career Adjustment Benefit

The amount of the Career Adjustment Benefit is shown in the **Coverage Features**.

We will pay a Career Adjustment Benefit to your Spouse if all of the following requirements are met:

1. You are insured under the Group Policy.
2. You die as a result of an accident for which an AD&D Insurance Benefit is payable for Loss of your life.
3. Your Spouse is, within 36 months after the date of your death, registered and in attendance at a professional or trades training program for the purpose of obtaining employment or increasing earnings.

No Career Adjustment Benefit will be paid if you have no surviving Spouse.

Child Care Benefit

The amount of the Child Care Benefit is shown in the **Coverage Features**.

We will pay a Child Care Benefit to your Spouse if all of the following requirements are met:

1. You are insured under the Group Policy.

2. You die as a result of an accident for which an AD&D Insurance Benefit is payable for Loss of your life.

3. Your Spouse pays a licensed child care provider who is not a member of your family for child care provided to your Child(ren) under age 13 within 36 months of your death.

4. The child care is necessary in order for your Spouse to work or to obtain training for work or to increase earnings.

No Child Care Benefit will be paid if you have no surviving Spouse.

Higher Education Benefit

The amount of the Higher Education Benefit is shown in the **Coverage Features**.

We will pay a Higher Education Benefit to your Child if all of the following requirements are met:

1. You are insured under the Group Policy.

2. You die as a result of an accident for which an AD&D Insurance Benefit is payable for Loss of your life.

3. Your Child is, within 12 months after the date of your death, registered and in full-time attendance at an accredited institution of higher education beyond high school.

The Higher Education Benefit will be paid annually to each Child who meets the requirements of item 3 above, for a maximum of 4 consecutive years beginning on the date of your death. No Higher Education Benefit will be paid if there is no Child eligible to receive it.

Line Of Duty Benefit

The amount of the Line Of Duty Benefit is shown in the **Coverage Features.**

We will pay a Line Of Duty Benefit if all of the following requirements are met:

1. You are a Public Safety Officer.

2. You suffer a Loss for which an AD&D Insurance Benefit is payable.

3. The Loss is the result of a Line Of Duty Accident.

Public Safety Officer means a Member whose primary job duties include controlling or reducing crime or juvenile delinquency, criminal law enforcement, or fire suppression. Public Safety Officer includes police officers, firefighters, corrections officers, judicial officers, and officially recognized or designated volunteer firefighters, if they otherwise meet the definition of Public Safety Officer.

Line of Duty Accident means an accident, including accidental exposure to adverse weather conditions, that occurs while you are taking any action which by rule, regulation, law, or condition of employment you are obligated or authorized to perform as a Public Safety Officer in the course of controlling or reducing crime or criminal law enforcement, including such action taken in response to an emergency while off duty.

If you are a Public Safety Officer, whose primary job duties are controlling or reducing crime, criminal law enforcement, or fire suppression, Line of Duty Accident includes a Line Of Duty Accident that occurs while you are on duty at social, ceremonial, or athletic functions to which you are assigned or for which you are paid as a Public Safety Officer by your Employer.

Occupational Assault Benefit

The amount of the Occupational Assault Benefit is shown in the **Coverage Features.**

We will pay an Occupational Assault Benefit if all of the following requirements are met:

1. While Actively At Work you suffer a Loss for which an AD&D Insurance Benefit is payable.
2. The Loss is the result of an act of physical violence against you that is punishable by law and is evidenced by a police report.

Public Transportation Benefit

The amount of the Public Transportation Benefit is shown in the **Coverage Features.**

We will pay a Public Transportation Benefit if all of the following requirements are met:

1. You die as a result of an accident for which an AD&D Insurance Benefit is payable for Loss of your life.
2. The accident occurs while you are riding as a fare-paying passenger on Public Transportation.

Public Transportation means a public passenger conveyance operated by a licensed common carrier for the transportation of the general public for a fare and operating on regular passenger routes with a definite schedule of departures and arrivals.

G. Becoming Insured For AD&D Insurance

1. Eligibility

   You become eligible for AD&D Insurance on the date your Life Insurance is effective.

2. Effective Date

   The **Coverage Features** states whether AD&D Insurance is Contributory or Noncontributory. Subject to the **Active Work Provisions**, AD&D Insurance becomes effective as follows:

   a. Noncontributory AD&D Insurance

      Noncontributory AD&D Insurance becomes effective on the date you become eligible.

   b. Contributory AD&D Insurance

      You must apply in writing for Contributory AD&D Insurance and agree to pay premiums. Contributory AD&D Insurance becomes effective on the later of:

      (i) The date you become eligible if you apply on or before that date.

      (ii) The first day of the calendar month coinciding with or next following the date you apply, if you apply after you become eligible.

H. When AD&D Insurance Ends

AD&D Insurance ends automatically on the earlier of:

1. The date your Life Insurance ends.
2. The date your Waiver Of Premium begins.
3. The date AD&D Insurance terminates under the Group Policy.

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ACTIVE WORK PROVISIONS

If you are incapable of Active Work because of Sickness, Injury or Pregnancy on the day before the scheduled effective date of your insurance or an increase in your insurance, your insurance or

increase will not become effective until the day after you complete one full day of Active Work as an eligible Member.

Active Work and Actively At Work mean performing the material duties of your own occupation at your Employer's usual place of business.

You will also meet the Active Work requirement if:

1. You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day;
2. You were Actively At Work on your last scheduled work day before the date of your absence; and
3. You were capable of Active Work on the day before the scheduled effective date of your insurance or increase in your insurance.

LI.AW.OT.1

CONTINUITY OF COVERAGE

A. Waiver Of Active Work Requirement

If you were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Group Policy, you can become insured on the effective date of your Employer's coverage without meeting the Active Work requirement. See **Active Work Provisions**.

B. Payment Of Benefit

The benefits payable before you meet the Active Work requirement will be:

1. The benefits which would have been payable under the terms of the Prior Plan if it had remained in force; reduced by
2. Any benefits payable under the Prior Plan.

LI.CC.OT.1

PORTABILITY OF INSURANCE

A. Portability Of Insurance

You may continue your Insurance for up to 24 months if your employment with your Employer terminates, subject to the following:

1. The amount of any Insurance to be continued must have been continuously in effect for at least 12 consecutive months on the date your employment terminates. In computing the 12 consecutive month period, we will include time insured under the Prior Plan.
2. You must be able to perform with reasonable continuity the material duties of at least one gainful occupation for which you are reasonably fitted by education, training and experience on the date your employment terminates.
3. Termination of your employment is not due to retirement.

   If you do not continue your Life Insurance, you may not continue any other Insurance. Insurance continued under Waiver Of Premium may not be continued under this provision.

   Insurance means your Life Insurance and if you continue your Life Insurance, includes the other insurance eligible for portability under the provision as shown in the **Coverage Features**.

B. Application And Premium Payment

To continue Insurance under this provision you must apply in writing and pay the first Portability Premium to us within 31 days after the date your employment terminates. The Portability Premium Rate is shown in the **Coverage Features**.

C. Amount Of Insurance

The minimum and maximum amounts of Insurance eligible for portability are shown in the **Coverage Features**.

The amount of Insurance you continue under this provision cannot be increased.

The amount of your Insurance will be reduced or terminated according to the terms of the Group Policy in effect on the date your employment terminates.

D. When Insurance Ends

Insurance continued under this provision ends automatically on the earliest of:

1. The date it would otherwise end under the Group Policy.
2. The end of the 24-month period during which your Insurance may be continued under this provision.
3. The date you become insured under any other group life insurance plan.

E. Group Policy Provisions

Except as provided above, Insurance continued under this provision is subject to all other terms of the Group Policy. With respect to any notice you are required to provide to the Policyowner or your Employer under other provisions of the Group Policy, such notice must be provided to us while your Insurance is continued.

LI.PY.OT.1

WAIVER OF PREMIUM

A. Waiver Of Premium Benefit

Insurance will be continued without payment of premiums while you are Totally Disabled if:

1. You become Totally Disabled while insured under the Group Policy and under age 60;
2. You complete your Waiting Period; and
3. You give us satisfactory Proof Of Loss.

However, continuation of insurance without payment of premium is limited to 12 months if you become Totally Disabled on or after age 60.

B. Definitions For Waiver Of Premium

1. Insurance means all your insurance under the Group Policy, except AD&D Insurance and Dependents AD&D Insurance.
2. Totally Disabled means that, as a result of Sickness, accidental Injury, or Pregnancy, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience.
3. Waiting Period means the 180 consecutive day period beginning on the date you become Totally Disabled. Waiver Of Premium begins when you complete the Waiting Period.

C. Premium Payment

Premium payment must continue until the later of:

1. The date you complete your Waiting Period; and
2. The date we approve your claim for Waiver Of Premium.

D. Refund Of Premiums

We will refund up to 12 months of the premiums that were paid for Insurance after the date you become Totally Disabled.

E. Amount Of Insurance

The amount of Insurance continued without payment of premium is the amount in effect on the day before you become Totally Disabled, subject to the following requirements:

1. Insurance will be reduced or terminated according to the Group Policy provisions in effect on the day before you become Totally Disabled.
2. The amount of Supplemental Life Insurance on your Spouse will be the lesser of:
   a. The amount in effect on the day before you become Totally Disabled; and
   b. The amount in effect one year before the date you become Totally Disabled.
3. If you receive an Accelerated Benefit, Insurance will be reduced according to the **Accelerated Benefit** provision.

F. Effect Of Death During The Waiting Period

If you die during the Waiting Period and are otherwise eligible for Waiver Of Premium, the Waiting Period will be waived.

G. Termination Or Amendment Of The Group Policy

Insurance will not be affected by termination or amendment of the Group Policy after you become Totally Disabled.

H. When Waiver Of Premium Ends

Waiver Of Premium ends on the earliest of:

1. The date you cease to be Totally Disabled;
2. Twelve months after the date you become Totally Disabled if you become Totally Disabled on or after age 60.
3. 90 days after the date we mail you a request for additional Proof Of Loss, if it is not given;
4. The date you fail to attend an examination or cooperate with the examiner;
5. With respect to the amount of Insurance which an insured has converted, the effective date of the individual life insurance policy issued to the insured; and
6. The date you reach age 65.

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ACCELERATED BENEFIT

A. Accelerated Benefit

If you qualify for Waiver Of Premium and give us satisfactory proof of having a Qualifying Medical Condition while you are insured under the Group Policy, you may have the right to receive during your lifetime a portion of your Insurance as an Accelerated Benefit. You must have at least $10,000 of Insurance in effect to be eligible.

If your Insurance is scheduled to end within 24 months following the date you apply for the Accelerated Benefit, you will not be eligible for the Accelerated Benefit.

Qualifying Medical Condition means you are terminally ill as a result of an illness or physical condition which is reasonably expected to result in death within 12 months.

We may have you examined at our expense in connection with your claim for an Accelerated Benefit. Any such examination will be conducted by one or more Physicians of our choice.

B. Application For Accelerated Benefit

You must apply for an Accelerated Benefit. To apply you must give us satisfactory Proof Of Loss on our forms. Proof Of Loss must include a statement from a Physician that you have a Qualifying Medical Condition.

C. Amount Of Accelerated Benefit

You may receive an Accelerated Benefit of up to 75% of your Insurance. The maximum Accelerated Benefit is $500,000. The minimum Accelerated Benefit is $5,000 or 10% of your Insurance, whichever is greater.

If the amount of your Insurance is scheduled to reduce within 24 months following the date you apply for the Accelerated Benefit, your Accelerated Benefit will be based on the reduced amount.

The Accelerated Benefit will be paid to you once in your lifetime in a lump sum. If you recover from your Qualifying Medical Condition after receiving an Accelerated Benefit, we will not ask you for a refund.

D. Effect On Insurance And Other Benefits

For any purpose other than premium payment, the amount of your Insurance after payment of the Accelerated Benefit will be the greater of the amounts in (1) and (2) below; however, if you assign your rights under the Group Policy, the amount of your Insurance will be the amount in (2) below.

(1) 10% of the amount of your Insurance as if no Accelerated Benefit had been paid; or

(2) The amount of your Insurance as if no Accelerated Benefit had been paid; minus

The amount of the Accelerated Benefit; minus

An interest charge calculated as follows:

A times B times C divided by 365 = interest charge.

A = The amount of the Accelerated Benefit.

B = The monthly average of our variable policy loan interest rate.

C = The number of days from payment of the Accelerated Benefit to the earlier of (1) the date you die, and (2) the date you have a Right To Convert.

Your AD&D Insurance, if any, is not affected by payment of the Accelerated Benefit.

E. Exclusions

No Accelerated Benefit will be paid if:

1. All or part of your Insurance must be paid to your Child(ren), or your Spouse or former Spouse as part of a court approved divorce decree, separate maintenance agreement, or property settlement agreement.
2. You are married and live in a community property state unless you give us a signed written consent from your Spouse.
3. You have made an assignment of all or part of your Insurance unless you give us a signed written consent from the assignee.
4. You have filed for bankruptcy, unless you give us written approval from the Bankruptcy Court for payment of the Accelerated Benefit.
5. You are required by a government agency to use the Accelerated Benefit to apply for, receive, or continue a government benefit or entitlement.
6. You have previously received an Accelerated Benefit under the Group Policy.

F. Definitions For Accelerated Benefit

Insurance means your Life Insurance Benefit and Supplemental Life Insurance Benefit, if any, under the Group Policy.

LI.AB.OT.1

RIGHT TO CONVERT

A. Right To Convert

You may buy an individual policy of life insurance without Evidence Of Insurability if:

1. Your Insurance ends or is reduced due to a Qualifying Event; and
2. You apply in writing and pay us the first premium during the Conversion Period.

Except as limited under C. Limits On Right To Convert, the maximum amount you have a Right To Convert is the amount of your Insurance which ended.

B. Definitions For Right To Convert

1. Conversion Period means the 31-day period after the date of any Qualifying Event.
2. Insurance means all your insurance under the Group Policy, including insurance continued under Waiver Of Premium, but excluding AD&D Insurance.
3. Qualifying Event means termination or reduction of your Insurance for any reason except:
   a. The Member's failure to make a required premium contribution.
   b. Payment of an Accelerated Benefit.
4. You and your mean any person insured under the Group Policy.

C. Limits On Right To Convert

If your Insurance ends or is reduced because of termination or amendment of the Group Policy, 1 and 2 below will apply.

1. You may not convert Insurance which has been in effect for less than the Minimum Time Insured. See **Coverage Features**.

2. The maximum amount you have a Right To Convert is the lesser of:

   a. The amount of your Insurance which ended, minus any other group life insurance for which you become eligible during the Conversion Period; and

   b. The Maximum Conversion Amount. See **Coverage Features.**

D. The Individual Policy

You may select any form of individual life insurance policy we issue to persons of your age, except:

1. A term insurance policy;
2. A universal life policy;
3. A policy with disability, accidental death, or other additional benefits; or
4. A policy in an amount less than the minimum amount we issue for the form of life insurance you select.

The individual policy of life insurance will become effective on the day after the end of the Conversion Period. We will use our published rates for standard risks to determine the premium.

E. Death During The Conversion Period

If you die during the Conversion Period, we will pay a death benefit equal to the maximum amount you had a Right To Convert, whether or not you applied for an individual policy. The benefit will be paid according to the **Benefit Payment And Beneficiary Provisions**.

LI.RC.OT.1

CLAIMS

A. Filing A Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, the claim may be submitted in a letter to us.

B. Time Limits On Filing Proof Of Loss

Proof Of Loss must be provided within 90 days after the date of the loss. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.

Proof Of Loss for Waiver Of Premium must be provided within 12 months after the end of the Waiting Period. We will require further Proof Of Loss at reasonable intervals, but not more often than once a year after you have been continuously Totally Disabled for two years.

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the Member or Beneficiary lacks legal capacity.

C. Proof Of Loss

Proof Of Loss means written proof that a loss occurred:

1. For which the Group Policy provides benefits;
2. Which is not subject to any exclusions; and
3. Which meets all other conditions for benefits.

Proof Of Loss includes any other information we may reasonably require in support of a claim. Proof Of Loss must be in writing and must be provided at the expense of the claimant. No benefits will be provided until we receive Proof Of Loss.

D. Investigation Of Claim

We may have you examined at our expense at reasonable intervals. Any such examination will be conducted by specialists of our choice.

We may have an autopsy performed at our expense, except where prohibited by law.

E. Time Of Payment

We will pay benefits within 60 days after Proof Of Loss is satisfied.

F. Notice Of Decision On Claim

The claimant will receive a written decision on a claim within a reasonable time after we receive the claim.

If the claimant does not receive our decision within 90 days after we receive the claim, the claimant will have an immediate right to request a review as if the claim had been denied.

If we deny any part of the claim, the claimant will receive a written notice of denial containing:

1. The reasons for our decision;
2. Reference to the parts of the Group Policy on which our decision is based;
3. A description of any additional information needed to support the claim; and
4. Information concerning the claimant's right to a review of our decision.

G. Review Procedure

If all or part of a claim is denied, the claimant must request a review in writing within 60 days after receiving notice of the denial.

The claimant may send us written comments or other items to support the claim, and may review any nonprivileged information that relates to the request for review.

We will review the claim promptly after we receive the request. We will send notice of our decision within 60 days after we receive the request, or within 120 days if special circumstances require an extension. We will state the reasons for our decision and refer to the relevant parts of the Group Policy.

LI.CL.OT.1

ASSIGNMENT

The rights and benefits under the Group Policy cannot be assigned.

LI.AS.FL.1

BENEFIT PAYMENT AND BENEFICIARY PROVISIONS

A. Payment Of Benefits

1. Except as provided in item 6 below, benefits payable because of your death will be paid to the Beneficiary you name. See B through E of this section.
2. AD&D Insurance benefits payable for Losses other than Loss of Life will be paid to the person who suffers the Loss for which benefits are payable. Any such benefits remaining unpaid at that person's death will be paid according to the provisions for payment of a death benefit.

3. The benefits below will be paid to you if you are living.

   a. AD&D Insurance benefits payable because of the death of your Dependent.

   b. Dependents Life Insurance benefits.

   c. Supplemental Life Insurance benefits payable because of the death of your Spouse.

   d. Accelerated Benefits.

4. Dependents Life Insurance benefits and AD&D Insurance benefits payable because of the death of your Dependent which are unpaid at your death will be paid in equal shares to the first surviving class of the classes below.

   a. The children of the Dependent.

   b. The parents of the Dependent.

   c. The brothers and sisters of the Dependent.

   d. Your estate.

5. Supplemental Life Insurance benefits payable because of the death of your Spouse which are unpaid at your death will be paid in equal shares to the first surviving class of the classes below.

   1. The children of your Spouse.

   2. The parents of your Spouse.

   3. The brothers and sisters of your Spouse.

   4. Your estate.

6. Additional Benefits will be paid as follows:

   The Child Care Benefit will be paid to your surviving Spouse. No Child Care Benefit will be paid if you have no Spouse.

   The Career Adjustment Benefit will be paid to your Spouse. No Career Adjustment Benefit will be paid if you have no Spouse.

   The Higher Education Benefit will be paid annually to each eligible Child. No Higher Education Benefit will be paid if there is no Child eligible to receive it.

   The Repatriation Benefit will be paid to the person who incurs the transportation expenses.

B. Naming A Beneficiary

Beneficiary means a person you name to receive death benefits.

You may name one or more Beneficiaries. Two or more surviving Beneficiaries will share equally, unless you specify otherwise. You may name or change Beneficiaries at any time without the consent of a Beneficiary.

Your Beneficiary designation must be the same for Life Insurance and AD&D Insurance death benefits. Your Beneficiary designations for Life Insurance and your Supplemental Life Insurance may be different.

You must name or change Beneficiaries in writing. Your designation:

1. Must be dated and signed by you;

2. Must be delivered to the Policyowner or Employer during your lifetime;

3. Must relate to the insurance provided under the Group Policy; and

4. Will take effect on the date it is delivered to the Policyowner or Employer.

If we approve it, a written designation signed and dated by you under the Prior Plan will be accepted as your Beneficiary designation under the Group Policy.

C. Simultaneous Death Provision

If a Beneficiary dies on the same day you die, or within 15 days thereafter, benefits will be paid as if that Beneficiary had died before you, unless Proof Of Loss with respect to your death is delivered to us before the date of the Beneficiary's death.

D. No Surviving Beneficiary

If you do not name a Beneficiary, or if you are not survived by one, benefits will be paid in equal shares to the first surviving class of the classes below.

1. Your spouse.

2. Your children.

3. Your parents.

4. Your brothers and sisters.

5. Your estate.

E. Methods Of Payment

Recipient means a person who is entitled to benefits under this **Benefit Payment and Beneficiary Provisions** section.

1. Lump Sum

   If the amount payable to a Recipient is less than $10,000, we will pay it in a lump sum.

2. Standard Secure Access Checking Account

   If the amount payable to a Recipient is $10,000 or more, we will deposit it into a Standard Secure Access checking account which:

   a. Bears interest;

   b. Is owned by the Recipient;

   c. Is subject to the terms and conditions of a confirmation certificate which will be given to the Recipient; and

   d. Is fully guaranteed by us.

3. Installments

   Payment to a Recipient may be made in installments if:

   a. The amount payable is $10,000 or more;

   b. The Recipient chooses; and

   c. We agree.

To the extent permitted by law, the amount payable to the Recipient will not be subject to any legal process or to the claims of any creditor or creditor's representative.

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ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Policyowner, we have full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy.

Our authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;
2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it;
3. The right to determine:
   a. Eligibility for insurance;
   b. Entitlement to benefits;
   c. Amount of benefits payable;
   d. Sufficiency and the amount of information we may reasonably require to determine a., b., or c., above.

Subject to the review procedures of the Group Policy, any decision we make in the exercise of our authority is conclusive and binding.

LI.AL.OT.1

TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought until 60 days after we have been given Proof Of Loss. No such action may be brought more than three years after the earlier of:

1. The date we receive Proof Of Loss; and
2. The time within which Proof Of Loss is required to be given.

LI.TL.OT.1

INCONTESTABILITY PROVISIONS

A. Incontestability Of Insurance

Any statement made to obtain insurance is a representation and not a warranty.

No misrepresentation will be used to reduce or deny a claim unless:

1. The insurance would not have been approved if we had known the truth; and
2. We have given you or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

We will not use a misrepresentation to reduce or deny a claim after the insured's insurance has been in effect for two years.

B. Incontestability Of Group Policy

Any statement made by the Policyowner or Employer to obtain the Group Policy is a representation and not a warranty.

No misrepresentation by the Policyowner or Employer will be used to deny a claim or to deny the validity of the Group Policy unless:

1. The Group Policy would not have been issued if we had known the truth; and
2. We have given the Policyowner or Employer a copy of a written instrument signed by the Policyowner or Employer which contains the misrepresentation.

The validity of the Group Policy will not be contested after it has been in force for two years, except for nonpayment of premiums.

LI.IN.OT.1

CLERICAL ERROR, AGENCY, AND MISSTATEMENT

A. Clerical Error

Clerical error by the Policyowner, your Employer, or their respective employees or representatives will not:

1. Cause a person to become insured.
2. Invalidate insurance otherwise validly in force.
3. Continue insurance otherwise validly terminated.

B. Agency

The Policyowner and your Employer act on their own behalf as your agent, and not as our agent.

C. Misstatement Of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on:

1. The amount of insurance based on the correct age; and
2. The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

LI.CE.OT.1

DEFINITIONS

AD&D Insurance means accidental death and dismemberment insurance, if any, under the Group Poli[illegible].

An[illegible]al Earnings means your annual rate of earnings from your Employer. Your Annual Earnings will be [illegible]ased on your earnings in effect on your last full day of Active Work unless a different date applies (see the **Coverage Features**).

A. Partners, P.C. Partners, Owner-Employees, Sole Proprietors and S-Corporation Shareholders

If you are a Partner, Owner-Employee, Sole Proprietor or S-Corporation Shareholder, Annual Earnings means your annual compensation from your Employer during the Employer's prior tax year. If you are a P.C. Partner, Annual Earnings means your annual compensation received by your professional corporation from the Policyowner during the Policyowner's prior tax year. Your annual compensation is determined by adding the following amounts as reported on the applicable Schedule K-1, Schedule C, Form W-2 or S-Corporation federal income tax return:

1. Your ordinary income (loss) from trade or business activity(ies).
2. Your guaranteed payments, if you are a Partner.

3. Your net profit from business.

4. Your compensation (as an officer), salary, or wages, if you are an S-Corporation Shareholder.

If you were not a Partner, P.C. Partner, Owner-Employee, Sole Proprietor or S-Corporation Shareholder during the entire prior tax year, your Annual Earnings will be 12 times your average monthly compensation for your period as a Partner, P.C. Partner, Owner-Employee, Sole Proprietor or S-Corporation Shareholder.

B. All Other Members

Annual Earnings includes:

1. Commissions averaged over the Earnings Period shown in the **Coverage Features** or over the period of your employment if less than the Earnings Period.

2. Shift differential pay.

Annual Earnings does not include:

1. Bonuses.

2. Overtime pay.

3. Any other extra compensation.

C. All Members

Annual Earnings includes:

1. Contributions you make through a salary reduction agreement with your Employer to:

   a. An Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), or 457 deferred compensation arrangement; or

   b. An executive nonqualified deferred compensation arrangement.

2. Amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC Section 125 plan.

Annual Earnings does not include your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan.

Child means:

1. Your unmarried child from live birth through age 20 (through age 24 if a registered student in full time attendance at an accredited educational institution); or

2. Your unmarried child who meets either of the following requirements:

   a. The child is insured under the Group Policy and, on and after the date on which insurance would otherwise end because of the Child's age, is continuously Disabled.

   b. The child was insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Group Policy and was Disabled on that day, and is continuously Disabled thereafter.

Child includes any of the following, if they otherwise meet the definition of Child:

   i. Your adopted child; or

   ii. Your stepchild, if living in your home;

Your child is Disabled if your child is:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and
2. Chiefly dependent upon you for support and maintenance, or institutionalized because of mental retardation or physical handicap.

You must give us proof your Child is Disabled on our forms within 31 days after a) the date on which insurance would otherwise end because of the Child's age or b) the effective date of your Employer's coverage under the Group Policy if your child is Disabled on that date. At reasonable intervals thereafter, we may require further proof, and have your Child examined at our expense.

Contributory means you pay all or part of the premium for insurance.

Dependents Life Insurance means dependents life insurance, if any, under the Group Policy.

Eligibility Waiting Period means the period you must be a Member before you become eligible for insurance. See **Coverage Features**.

Evidence Of Insurability means an applicant must:

1. Complete and sign our medical history statement;
2. Sign our form authorizing us to obtain information about the applicant's health;
3. Undergo a physical examination, if required by us, which may include blood testing; and
4. Provide any additional information about the applicant's insurability that we may reasonably require.

Group Policy means the group life insurance policy issued by us to the Policyowner and identified by the Group Policy Number.

Injury means an injury to your body.

Life Insurance means life insurance under the Group Policy.

Noncontributory means the Policyowner or Employer pays the entire premium for insurance.

Physician means a licensed M.D. or D.O., acting within the scope of the license. Physician does not include you or your spouse, or the brother, sister, parent or child of either you or your spouse.

Pregnancy means your pregnancy, childbirth, or related medical conditions, including complications of pregnancy.

Prior Plan means your Employer's group life insurance plan in effect on the day before the effective date of your Employer's coverage under the Group Policy and which is replaced by the Group Policy.

Sickness means your sickness, illness, or disease.

Spouse means a person to whom you are legally married. Spouse does not include a person who is a full-time member of the armed forces of any country.

Supplemental Life Insurance means supplemental life insurance, if any, under the Group Policy.

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ALIC99X

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

People. Not Just Policies.®

CERTIFICATE

GROUP DENTAL INSURANCE

Policyowner:	Okaloosa County Board of County Commissioners
Policy Number:	640884-B
Effective Date:	October 1, 2000

A Group Policy has been issued to the Policyowner. We certify that you will be insured as provided by the terms of the Group Policy. If your coverage is changed by an amendment to the Group Policy, we will provide the Policyowner with a revised Certificate or other notice to be given to you.

Possession of this Certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate.

"We", "us" and "our" mean Standard Insurance Company. "You" and "your", as indicated by their usage, mean the Member, the Dependents, or both. All other defined terms appear with the initial letter capitalized. Section headings, and references to them, appear in boldface type.

Ronald E. Timpe
President

GC190-DENT/S399

Table of Contents

Index of Defined Terms

COVERAGE FEATURES

This section contains many of the features of your dental insurance. Other provisions, including exclusions and limitations, appear in other sections. Please refer to the text of each section for full details. The Table of Contents and the Index of Defined Terms help locate sections and definitions.

GENERAL POLICY INFORMATION

Group Policy Number:	640884-B
Policyowner:	Okaloosa County Board of County Commissioners
Employer(s):	Okaloosa County Board of County Commissioners
Group Policy Effective Date:	October 1, 2000
Policy Issued in:	Florida

BECOMING INSURED AS A MEMBER

To become insured you must: (a) Be a Member; (b) Complete your Eligibility Waiting Period; and (c) Meet the requirements in **When Insurance Becomes Effective.** Other information is found in **Late Enrollment Penalty** and **Reinstatement.**

Definition of Member:	You are a Member if you are: 1. An active employee of the Employer; 2. Regularly working at least 30 hours each week; and 3. A citizen or resident of the United States or Canada. You are not a Member if you are: 1. A temporary or seasonal employee; or 2. A full time member of the armed forces of any country.
Class Definition:	None
Eligibility Waiting Period:	You are eligible on one of the following dates, but not before the Group Policy Effective Date: If you are a Member on the Group Policy Effective Date, you are eligible on the first day of the calendar month following 90 consecutive days as a Member. If you become a Member after the Group Policy Effective Date, you are eligible on the first day of the calendar month following 90 consecutive days as a Member.
Late Enrollment Penalty:	The Late Enrollment Penalty applies only to Contributory Insurance.

PREMIUM CONTRIBUTIONS BY MEMBERS

Members:	Noncontributory
Dependents:	Contributory

OTHER PROVISIONS

Dependents Coverage:	Yes
Coverage for Dependents covered under another group dental plan:	Yes
COBRA Continuation:	Yes. The COBRA continuation rate is a percentage of the contribution rate currently in effect on each due date. The contribution rate may change after you cease to be Actively At Work. The percentage is as follows: 18 Month Continuation - 102% 29 Month Continuation - 102% during the first 18 months, 150% during the next 11 months 36 month Continuation - 102%
Orthodontic Dental Benefits:	Yes, for a Child whose first active orthodontic appliance is placed while the Child has Insurance and is under age 19.
Benefit Extension Period under Prior Plan:	The first 31 days following the effective date of your Insurance.
Prosthetics Limitation Period:	36 months, if your Insurance becomes effective on the Group Policy Effective Date. 36 months, if your Insurance becomes effective after the Group Policy Effective Date.

BENEFIT WAITING PERIOD

Major Dental Expenses:	None
Orthodontic Dental Expenses:	None

See **Dental Benefit**, D. Benefit Waiting Period for more information.

SCHEDULE OF DENTAL BENEFITS

Dental Expenses	Dental Benefit Percentage
Preventive Dental Expenses:	100%
Basic Dental Expenses:	80%
Major Dental Expenses:	50%
Orthodontic Dental Expenses:	50%

Deductible Amount:

The Deductible Amount for each Insured Person for all expenses other than Preventive and Orthodontic Dental Expenses is: $50

The Deductible Amount is satisfied for a family of 3 or more Insured Persons when Incurred Basic and Major Dental Expenses equal 3 times the Deductible Amount. Only the Deductible Amount of each Insured Person's Basic and Major Dental Expenses is applied to satisfy the family Deductible Amount.

Dental Expenses Incurred under the Prior Plan will count toward the Deductible Amount for the first Benefit Year under the Group Policy if Incurred during that Benefit Year.

There is no Deductible Amount for Preventive or Orthodontic Dental Expenses.

Maximum Amounts:

All Dental Benefits other than Orthodontic Dental Benefits:	$1,200 per Benefit Year for each Insured Person
Orthodontic Dental Benefits:	$1,000 lifetime maximum for each insured Child

The **Coordination Of Benefits** section applies if an Insured Person has dental coverage under more than one Plan.

Benefit Year:	The period from January 1, 2000 to the following January 1 and each successive 12 month period while the Group Policy remains in effect.
Policy Year:	The period from October 1, 2000 to October 1, 2001 and each successive 12 month period while the Group Policy remains in effect.

INTRODUCTION

A. Insuring Clause

We will pay Dental Benefits according to the terms of the Group Policy for Dental Expenses Incurred by you while you are insured under the Group Policy, after we receive satisfactory Proof Of Loss satisfactory to us.

B. Free Choice Of Dental Professional

You may select a Dental Professional of your choice.

The Dental Professional you select is responsible for the quality of dental care you receive. We are not responsible for any injuries you may suffer while receiving dental care.

C. Predetermination Of Dental Benefit

If your Dental Professional gives us a Treatment Plan, we will tell you and your Dental Professional the amount of Dental Benefit we will pay. We recommend your Dental Professional give us a Treatment Plan when dental services and supplies may result in Dental Expenses of $250 or more.

Treatment Plan means the Dental Professional's report which lists the dental services and supplies recommended and the charge for each item. We may request additional information.

DENTAL BENEFIT

A. Dental Benefit

The Dental Benefit is a percentage of the Reasonable and Customary Charge for those dental services and supplies which are listed in **Dental Expenses**. The percentage that applies is stated in the **Coverage Features**.

B. Deductible Amount

Deductible Amount means the Reasonable and Customary Charge for Dental Expenses you must Incur during the Benefit Year before we will pay a Dental Benefit.

The Deductible Amount is stated in the **Coverage Features**.

C. Maximum Amount of Dental Benefit

The Dental Benefit we will pay is subject to a Maximum Amount. The Maximum Amounts are stated in the **Coverage Features**.

D. Benefit Waiting Period

The **Coverage Features** states the length of the Benefit Waiting Period and which Dental Expenses are subject to a Benefit Waiting Period.

Your Insurance must be in effect continuously for the length of the Benefit Waiting Period stated in the **Coverage Features** before Dental Expenses subject to the Benefit Waiting Period will be covered. Dental Expenses subject to a Benefit Waiting Period will not be applied toward Deductible Amount if Incurred during the Benefit Waiting Period.

If your Insurance is subject to the Late Enrollment Penalty, that provision will be applied instead of the Benefit Waiting Period.

DENTAL EXPENSES

Dental Expenses means the charges for the dental services and supplies provided by your Dental Professional and listed below.

A. Preventive Dental Expenses

Preventive Dental Expenses means charges for the following services and supplies:

1. Prophylaxis, but only once in any 5-month period.
2. Oral Evaluations of the mouth and teeth, but only once in any 5-month period.
3. Fluoride treatments for a Child under age 14, but only once in any 6-month period.
4. The following Dental X-rays:
   a. One set of full mouth or panoramic X-rays in any 60-month period.
   b. 4 bitewing X-rays in any 12-month period.
   c. Periapical X-rays.
   d. One set of occlusal X-rays in any 2-year period.
5. Bacteriologic cultures and examination of oral tissue excised for biopsy.
6. Emergency palliative treatment or evaluation, but only twice in any 12 month period.
7. Space maintainers designed to preserve the space between teeth caused by the premature loss of a primary tooth. Orthodontic space maintainers are not included.
8. Application of sealants for a Child under age 17, but only once in any 3-year period and for posterior teeth only.

B. Basic Dental Expenses

Basic Dental Expenses means charges for the following services and supplies:

1. Endodontic treatment, including pulpotomy, apicoectomy, retrograde filling, and root canal therapy.

   Charges for root canal therapy for which the pulp chamber was opened before the effective date of your Insurance will not be covered during the Benefit Extension Period shown in the **Coverage Features**, if you were insured under the Prior Plan on the day before the effective date of your Insurance.
2. Simple, non-surgical extraction of one or more teeth.
3. Charges for pulp capping or pulp vitality tests.
4. Oral surgery and postoperative treatment as follows:
   a. Surgical extraction of one or more teeth.
   b. Extraction of the tooth root.
   c. Alveolectomy, alveoplasty and frenectomy.
   d. Excision of hyperplastic tissue or oral tissue for biopsy or exostosis.
   e. Reimplantation or transplant of a natural tooth.
   f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst.

g. General anesthetics, analgesics, and intravenous sedation when given as part of an oral surgery listed in this subsection.

5. Periodontal services as follows:

   a. Periodontal maintenance therapy, but only once in any 2 1/2-month period.

   b. Root scaling and root planing, but only once per quadrant of the mouth in any 5-month period.

   c. Occlusal adjustment, but only if performed in conjunction with covered periodontal surgery.

   d. Full mouth debridement, but only once in any 3 year period.

   e. Gingivectomy, gingival curettage, and mucogingival surgery (other than crown lengthening).

   f. Osseous surgery including flap entry and closure.

   g. Pedicle or free soft tissue grafts.

   h. Bone grafts, either single or multiple.

   i. Provisional splinting, either intracoronal or extracoronal.

   j. Excision of pericoronal gingiva.

6. Study models, but only once in any 3-year period.

7. Pin retention of fillings.

8. Fillings using amalgam, silicate, acrylic, synthetic porcelain, and resins or composite filling material to restore teeth broken down by decay or injury.

   Fillings performed on posterior teeth using resins or composite filling material will be paid as fillings using amalgam.

   Fillings performed on the following surfaces of anterior teeth will be paid as single-surface fillings: Mesiolingual; distolingual; mesiobuccal; and distobuccal.

9. Recementing inlays, onlays and crowns.

10. Recementing bridges.

11. Repairs to full and partial dentures and bridges, but only once in any 2-year period. No Dental Benefit will be paid for repair costs that exceed 20% of the replacement cost.

12. Antibiotic injections given by the treating Dental Professional.

13. Dental consultations, but not more than twice in any 12-month period.

C. Major Dental Expenses

Major Dental Expenses means charges for the following services and supplies:

1. Occlusal guards (night guards) for treatment of bruxism, but only once in any 5 year period.

2. Restorative services and supplies as follows:

   a. Gold or porcelain inlays, onlays, veneers and crowns but only when the tooth, because of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling material.

      Charges for the above restorative services, for a tooth which was prepared before the effective date of your Insurance, will not be covered during the Benefit Extension Period shown in the **Coverage Features**, if you were insured under the Prior Plan on the day before the effective date of your Insurance.

b. Stainless steel crowns.

c. Post and core on non-vital teeth.

3. Prosthetic services and supplies as follows:

   a. Initial placement of fixed bridgework (including acid-etch metal bridges), full or partial dentures, or the addition of a tooth to existing partial dentures, but only if the placement or addition includes replacement of a natural tooth lost or extracted.

      i. While you are insured under the Group Policy.

      ii. While you were insured under the Prior Plan and that insurance continued in effect until the day before the effective date of your Insurance.

      This limitation will not apply after your Insurance has been continuously in effect for the length of the Prosthetics Limitation Period shown in the **Coverage Features**. This limitation will not apply to a Child adopted while the Member is insured under the Group Policy.

      Charges for the above prosthetic services for a tooth which was prepared before the effective date of your Insurance will not be covered during the Benefit Extension Period shown in the **Coverage Features**, if you were insured under the Prior Plan.

   b. Relining or rebasing of existing removable full or partial dentures, but only if it has been at least one year since the denture was placed. Charges for these services are covered only once in any 2-year period.

4. Replacement of permanent devices as follows:

   a. Replacement of an existing inlay, onlay, veneer or permanent crown but only if it has been at least 5 years since the restoration was initially placed or last replaced.

   b. Replacement of full or partial dentures or fixed bridgework which cannot be made serviceable, but only if it has been at least 5 years since the denture or bridgework was initially placed or last replaced. However, this limitation will not apply if replacement is made necessary by the loss or extraction of one or more natural teeth.

      i. While your Insurance is in effect; or

      ii. While you were insured under the Prior Plan and that insurance is continuously in effect until you become insured under the Group Policy.

   No Dental Benefit will be paid for any duplicate prosthetic appliance or the replacement of any lost, missing, or stolen prosthetic appliance.

5. Replacement of Temporary Devices, as follows:

   Replacement of a temporary crown, interim prosthetic device, temporary denture, temporary stayplate or a flipper with a permanent device is covered, but only if the temporary device has been in place for less than 12 months. However, the Dental Benefit payable for the permanent device will be reduced by any Dental Benefit we paid for placement or replacement of the Temporary Device.

   A temporary device that has been in place for more than 12 months will be considered a permanent device for purposes of replacement.

D. Orthodontic Dental Expenses

The **Coverage Features** states who is covered for Orthodontic Dental Expenses and whether a Benefit Waiting Period applies.

Orthodontic Dental Expenses means charges for the following services and supplies:

1. Cephalometric film.
2. Removable, fixed or cemented appliance for tooth guidance or for interceptive orthodontic treatment, including impressions, installation and all adjustments within 6 months of installation.
3. Comprehensive (full-banded) orthodontic treatment of transitional or permanent teeth.

No Dental Benefit will be paid for Orthodontic Dental Expenses Incurred after the date Insurance ends.

Takeover Provision: If the first active orthodontic appliance was placed before the effective date of your Insurance, Dental Benefits will be paid for Orthodontic Dental Expenses if:

a. You were insured under the Prior Plan on the day before the effective date of your Insurance;

b. You Incur Orthodontic Dental Expenses after that date;

c. You are continuously insured under the Group Policy from the effective date of your Insurance through the date Orthodontic Dental Expenses are Incurred; and

d. Orthodontic dental benefits would have been payable under the Prior Plan, if it had remained in force.

However, the lifetime Maximum Amount for Orthodontic Dental Benefits under the Group Policy will be reduced by all payments for orthodontic treatment made under the Employer's group dental benefit program.

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EXCLUSIONS

No Dental Benefit will be paid for the following charges:

1. Charges for services or supplies other than the Dental Expenses listed in the Group Policy.
2. Charges for office visits.
3. Charges which exceed the Reasonable and Customary Charge for the services or supplies provided.
4. Charges which exceed the Reasonable and Customary Charge for the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.
5. Charges which exceed the Reasonable And Customary Charge that would have been charged had all required dental services and supplies been provided by the same Dental Professional, if you (a) change Dental Professionals while receiving treatment; or (b) receive care from more than one Dental Professional for one dental procedure.
6. Charges for services or supplies for which no charge would be made in the absence of insurance or for which you are not obligated to pay.
7. Charges for services or supplies which do not have a reasonably favorable prognosis or which are not necessary according to generally accepted standards of dental practice.
8. Charges for services or supplies that are not generally accepted by the dental profession or are experimental or investigational.
9. Charges for services or supplies that are primarily for cosmetic purposes.
10. Charges for Periodontal Splints, except provisional splinting covered under the Group Policy.

11. Charges for appliances or restorations to increase vertical dimension, to restore an occlusion, or for gnathologic recordings.

12. Charges for services or supplies related to diagnosis or treatment of temporomandibular joint disorder or craniomandibular disorder.

13. Charges for: implants; precision attachments or semi-precision attachments; acid etch (other than acid etch metal bridge retainers); drugs; bite regulation; bite analysis; treatment of fractures; orthognathic surgery; instruction in dental plaque control or dental hygienics; or nutritional counseling.

14. Charges for services or supplies for which you are entitled to benefits under any workers' compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an Injury or Sickness arising out of or in the course of any employment for wage or profit.

15. Charges for Dental Expenses for which benefits are payable under any medical expense plan or under any liability policy including, but not limited to, an automobile policy or a homeowner's policy.

16. Charges for services or supplies received as a result of any dental condition caused or contributed to by War or any act of War. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

17. Charges for maxillo-facial surgery, myofuctional therapy, cleft palate treatment, or treatment of micrognathia or macrognathia.

18. Charges for lingually placed direct bonded appliances and arch wires.

COORDINATION OF BENEFITS

This section applies if an Insured Person has dental coverage under more than one Plan. All Dental Benefits are subject to this section.

A. Definitions For This Section

1. Plan means the Group Policy and any of the following dental plans providing benefits for dental services or supplies:

   a. Any group insurance policy.

   b. Any group prepayment arrangement.

   c. Any labor/management trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

   d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does not include a state plan under Medicaid (Title XVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

   e. Any other group-type coverage which is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

   Each contract or other arrangement for coverage under a through e above is a separate Plan. Also, if an arrangement has two parts and the coordination of benefits rules apply only to one of the two, each of the parts is a separate Plan.

2. Plan does not include the following:

   a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual Health Maintenance Organizations or other prepayment service, group practice plans.

   b. Coverages covering grammar school, high school and college students for accidents only, including athletic injuries.

   c. An indemnity-type policy, excess insurance policy as defined in Florida Statutes Section 627.635, a policy with coverage limited to specific illnesses or accidents, or a Medicare supplement policy.

3. Allowable Expense means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering you. When a Plan provides services rather than cash benefits, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had claim been made for them.

4. Claim Determination Period means a Benefit Year, but does not include any time when you were not insured under the Group Policy.

B. Order Of Benefits: Which Plan Pays First

If payment under the Group Policy must be made first, that payment will not be reduced because of this section.

If a Plan does not have a coordination of benefits provision, that Plan must provide benefits first.

If a Plan also has a coordination of benefits provision, 1 through 5 below will apply.

1. The benefits of a Plan which covers a person as an employee, member or subscriber are determined before those of a Plan which covers the person as a dependent.

2. If a Dependent Child is covered by different parents under separate Plans, the benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined first. If both parents have the same birthday, the benefits of the Plan which covered a parent longer are determined first.

   If the other Plan has the gender rule, the other Plan will determine the order of benefits.

3. If a Dependent Child is covered by divorced or separated parents under two or more Plans, benefits for that Child will be determined in the following order:

   a. The Plan of the parent with custody.

   b. The Plan of the spouse of the parent with custody.

   c. The Plan of the parent not having custody.

   However, if the specific terms of a court decree establish a parent's responsibility to provide coverage, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period during which benefits are paid or provided before the entity has that actual knowledge.

4. The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, this rule will be ignored.

5. If the rules above do not establish the order of benefits, the benefits of a Plan that has covered a person for a longer period will be determined first.

C. Effect On Benefits When Other Plan Pays First

If all or any part of a Dental Expense for which you claim Dental Benefits is an Allowable Expense under any other Plan, then Dental Benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the Allowable Expense.

However, the amount by which Dental Benefits have been reduced during the Claim Determination Period will be used by us to pay Allowable Expenses not otherwise paid which were Incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims that have been submitted in the current Claim Determination Period.

If Dental Benefits are reduced as described above, each benefit will be reduced proportionately. The total amount paid will be charged toward the Maximum Amounts.

D. Right To Receive And Release Information

We may without your consent and notice to you:

1. Release any information with respect to your coverage and benefits under the Group Policy; and
2. Obtain from any other insurance company, organization, or person any information with respect to your coverage and benefits under another Plan.

You must provide us with any information necessary to coordinate benefits.

E. Facility Of Payment

Whenever payments which should have been made by us according to this section have been made under another Plan, we may pay the other Plan the amount we should have paid you. Any such payment will be a Dental Benefit and we will be fully discharged from liability to the extent of that payment.

WHEN MEMBER'S INSURANCE BECOMES EFFECTIVE

The **Coverage Features** states whether the Member's Insurance is Contributory or Noncontributory.

A. Noncontributory Insurance

Your Noncontributory Insurance becomes effective on the date you become eligible.

B. Contributory Insurance

You must apply in writing for Contributory Insurance and agree to pay premiums. Your Contributory Insurance becomes effective on the later of:

1. The date you become eligible, if you apply on or before that date.
2. The date you apply.

However, your Contributory Insurance will be subject to the Late Enrollment Penalty if:

1. The **Coverage Features** states that there is a Late Enrollment Penalty; and
2. You were eligible for insurance under the Prior Plan for more than 31 days but were not insured; or

3. You apply for Insurance more than 31 days after you become eligible. However the Late Enrollment Penalty will not apply if on the date you become eligible for Insurance you are insured under another employer's group dental benefit program, and thereafter, your coverage under that program ends because you are no longer eligible and you apply for Insurance within 31 days after your coverage under that program ends.

C. Takeover Provision

If you were insured under the Prior Plan on the day before the Group Policy Effective Date, your Eligibility Waiting Period is waived on the Group Policy Effective Date.

In computing the Deductible Amount, we will include any portion of the deductible amount for that Benefit Year satisfied while insured under the Prior Plan.

The Prosthetics Limitation Period will be reduced by any period of continuous coverage under the Prior Plan that ends on the day before your Insurance is effective.

BECOMING INSURED AS A DEPENDENT

A. Definition Of Dependent

Dependent means the Member's Spouse or Child. Dependent does not include a full-time member of the armed forces of any country.

Spouse means the person to whom the Member is legally married and from whom the Member is not legally separated.

Child means:

1. The Member's child from live birth through the last day of the calendar year in which the child reaches age 25, who is dependent upon the Member for support, and who is either:
   a. A registered student in full or part-time attendance at an accredited educational institution; or
   b. Living in the Member's home.
2. The Member's unmarried child who meets either of the following requirements:
   a. The child is Insured under the Group Policy and, on and after the date on which Insurance would otherwise end because of the Child's age, is continuously Disabled.
   b. The child was insured under the Prior Plan on the day before the effective date of the Member's Employer coverage under the Group Policy and was Disabled on that day, and is continuously Disabled thereafter.

   Child includes any of the following, if they otherwise meet the definition of Child:
   i. The Member's adopted child from time of placement, or earlier, if required by your state insurance code;
   ii. The Member's stepchild if living in the Member's home; and
   iii. A child living in the Member's home and for whom the Member is the court appointed legal guardian.

   Disabled and Disability for this definition mean that the Member's child is:
   1. Continuously incapable of self-sustaining employment because of mental retardation or or physical handicap; and
   2. Chiefly dependent upon the Member for support and maintenance, or institutionalized because of mental retardation or physical handicap.

Proof of Disability must be given on our forms. At reasonable intervals thereafter, we may require further proof of Disability, and have the Child examined at our expense.

B. Eligibility For Insurance

You are eligible for Insurance if you are a Dependent of an insured Member, unless:

1. You are eligible for Insurance as a Member; or
2. You are covered under another group dental plan, and the **Coverage Features** states that such Dependents are not eligible.

C. When Insurance for Dependents Becomes Effective

The **Coverage Features** states whether Insurance for Dependents is Contributory or Noncontributory.

1. Noncontributory Insurance

   Noncontributory Dependents Insurance becomes effective on the date you become eligible.

2. Contributory Insurance

   The Member must apply in writing for Contributory Dependents Insurance and agree to pay premiums. Your Insurance becomes effective on the later of:

   a. The date you become eligible.

   b. The date the Member enrolls you.

   However, your Contributory Insurance will be subject to the Late Enrollment Penalty if:

   i. The **Coverage Features** states that the Late Enrollment Penalty applies; and

   ii. The Member was eligible to enroll you under the Prior Plan for more than 31 days but chose not to enroll you; or

   iii. The Member applies for your Insurance more than 31 days after the date you become eligible. However, the Late Enrollment Penalty will not apply, if on the date you become eligible for Insurance, you are insured under another employer's group dental benefit program, and thereafter, your coverage under that program ends because you are no longer eligible and the Member applies for Insurance for you within 31 days after your coverage under that program ends.

3. Insurance For Newborn And Adopted Children

   A newborn Child is automatically insured from the moment of birth. An adopted Child is automatically insured from the time of placement, or earlier if required by your state insurance code. If your Insurance is Contributory, but the Member does not have Insurance for Dependents, the Member must apply for Insurance within 31 days after the date Insurance under this provision is effective. If the Member does not apply, Insurance for the newborn or adopted Child will end automatically after that 31 day period.

LATE ENROLLMENT PENALTY

If your Insurance is subject to the Late Enrollment Penalty, you will only be covered for Preventive Dental Expenses during the first 12 months after your Insurance becomes effective. You will only be covered for Preventive and Basic Dental Expenses during the second 12 months your Insurance is in effect. Thereafter, you will be covered for Preventive, Basic, Major and Orthodontic Dental Expenses.

WHEN INSURANCE ENDS

Insurance ends automatically on the earliest of:

1. The date the last period ends for which a premium contribution was made for your Insurance.
2. The date the Group Policy terminates.
3. The date the Member's employment terminates.
4. The last day of the calendar month in which you cease to be a Member. However, if you cease to be a Member because you are working less than the required minimum number of hours, your Insurance will be continued with payment of premium during the following periods unless it ends under 1 through 3 above.
   a. Through the last day of the calendar month for which your Employer pays you the same amount paid to you immediately before you ceased to be a Member.
   b. From the date you are unable to be Actively At Work because of Sickness, Injury or Pregnancy, until the earlier of: 1) the last day of the calendar month in which your employment is terminated by you or your Employer; and 2) the end of 6 months.
   c. During a leave of absence if continuation of your Insurance under the Group Policy is required by the federal or state mandated family or medical leave act or law.
   d. During any other leave of absence approved by your Employer, but not beyond the end of the calendar month following the calendar month in which the leave of absence begins.
5. For Any Dependent:
   a. The last day of the calendar month in which you cease to be a Dependent.
   b. The date the Member's Insurance ends, except as otherwise provided.
   c. The date you become covered under any other group dental plan, if the **Coverage Features** states that Dependents covered under another group dental plan are not eligible for Insurance.
   d. For a Child who is Disabled, 90 days after we mail the Member a request for proof of Disability, if proof is not given.
   e. For a Spouse, the date of your divorce.

REINSTATEMENT

If your Insurance ends, you may become insured again as a new Member or Dependent, subject to the following:

1. If Insurance ends because you cease to be a Member, and if you become a Member again within 90 days, a new Eligibility Waiting Period, new Late Enrollment Penalty, and a new Benefit Waiting Period will not apply, except as provided below. However, the Member and each Dependent must serve the remainder of any Eligibility Waiting Period, Late Enrollment Penalty, or Benefit Waiting Period that applied when Insurance ended.
2. If the Member applies more than 31 days after becoming eligible again, the Member and each Dependent will be subject to a new Late Enrollment Penalty, and a new Benefit Waiting Period.
3. If Insurance ends because the Member fails to make a required premium contribution, the Member and each Dependent will be subject to a new Late Enrollment Penalty.
4. If Insurance ends because the Member is on a federal or a state mandated family or medical leave, and the Member becomes eligible for Insurance again immediately following the period allowed,

your Insurance will be reinstated pursuant to the federal or state mandated family or medical leave act or law.

EXTENSION OF BENEFITS

We will extend Dental Benefits to cover dental services and supplies for dental procedures other than routine examinations, prophylaxis, x-rays, sealants or orthodontic services which the Insured person receives within 90 days after the date Insurance ends for any reason other than the Member's voluntary termination of coverage. The extension will apply only if:

1. The dental services or supplies were recommended in writing and the course of treatment commenced before the date Insurance ended.
2. Dental Benefits would have been paid had Insurance continued.
3. The dental services or supplies are not covered under a succeeding group insurance plan.

CONTINUATION AFTER DEATH OF MEMBER

Insurance for a Dependent will continue without payment of premium for 60 days after the death of the Member.

Insurance will not continue for a Dependent whose Insurance would end for any reason other than the death of the Member.

COBRA CONTINUATION

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after Insurance ends because of a Qualifying Event.

A. Definitions For This Section

Qualified Beneficiary means an Insured Person.

A Qualifying Event occurs when:

1. The Member dies;
2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer;
3. The Member's work hours fall below the minimum number required to be a Member;
4. The Member becomes divorced or legally separated from a Spouse;
5. The Member becomes entitled to receive Medicare benefits under Title XVIII of the Social Security Act;
6. The Child of a Member ceases to be a Dependent; or
7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed.

B. Electing COBRA Continuation

Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:

1. The date on which Insurance would otherwise end; and

2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.

C. Notice Requirements

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.

2. The Qualified Beneficiary must notify the Plan Administrator in writing within 60 days of Qualifying Event 4 or 6 above.

3. Each Qualified Beneficiary who, within the first 60 days of COBRA continuation due to Qualifying Event 2 or 3 above, is determined by the Social Security Administration to be disabled under Title II or XVI of the Social Security Act at the time of Qualifying Event 2 or 3 above must notify the Plan Administrator in writing within 60 days after the date disability is determined. If the Qualified Beneficiary ceases to be disabled, the Qualified Beneficiary must notify the Plan Administrator in writing within 30 days of the final determination date.

4. The Employer must give the Plan Administrator written notice within 30 days of Qualifying Event 1, 2, 3, 5, or 7.

5. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

D. Premium Requirements

Insurance continued under this provision will be retroactive to the date Insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. See **Coverage Features** for the COBRA Continuation Premium Rate.

E. COBRA Continuation Periods

1. 18-Month COBRA Continuation

Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3 above.

2. 29-Month COBRA Continuation

Each Qualified Beneficiary who within the first 60 days of COBRA continuation due to Qualifying Event 2 or 3 above, is determined by the Social Security Administration to be disabled under Title II or XVI of the Social Security Act at the time of Qualifying Event 2 or 3 above, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

If you are a Dependent, you may continue Insurance for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6.

Note: The total period of COBRA continuation available in 1 through 3 above will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

F. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;
2. 31 days after the date the last period ends for which a required premium payment was made;
3. The last day of the COBRA continuation period.
4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVIII of the Social Security Act;
5. The first date on which the Qualified Beneficiary is: (a) covered under another group dental policy and (b) not subject to any preexisting condition limitation in that policy.

CLAIMS

A. Filing A Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, the claim may be submitted in a letter to us. The letter should describe the Dental Expenses for which the claim is made.

B. Time Limits On Filing Proof Of Loss

Proof Of Loss must be provided within 90 days after the Incurred Date of the Dental Expenses. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period. If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while you lack legal capacity.

C. Proof Of Loss

Proof Of Loss means written proof that you have Incurred Dental Expenses for which Dental Benefits are payable. Proof Of Loss must be provided at your expense. No Dental Benefit will be paid until Proof Of Loss is satisfied.

D. Documentation Of Proof Of Loss

At your expense, you must submit completed claim statements, your signed authorization for us to obtain information, and any other items we may reasonably require in support of your claim.

E. Investigation Of Claim

We may investigate your claim at any time.

At our expense, we may have a Dental Professional of our choice examine you and review X-rays.

We may deny or suspend payment of Dental Benefits if you or your Dental Professional fails to cooperate with a review or examination by the Dental Professional of our choice.

F. Payment Of Dental Benefits

We will pay all Dental Benefits directly to you immediately after Proof Of Loss is satisfied.

You may authorize us in writing to make payment to the Dental Professional providing the services or supplies.

G. Right To Recover Overpayment

If we make a payment, and you are not entitled to all or a part of that payment, we may recover the payment from you or the Dental Professional. We may deduct the overpayment from future Dental Benefits.

H. Notice Of Decision On Claim

You will receive a written decision on your claim within a reasonable time after we receive your claim.

If you do not receive our decision within 90 days after we receive your claim, you will have an immediate right to request a review as if your claim had been denied.

If we deny any part of your claim, you will receive a written notice of denial containing:

1. The reasons for our decision;
2. Reference to the parts of the Group Policy on which our decision is based;
3. A description of any additional information needed to support your claim; and
4. Information concerning your right to a review of our decision.

I. Review Procedure

If all or part of a claim is denied, you may request a review. You must request a review in writing within 60 days after you receive notice of the denial.

When you request a review, you may send us written comments or other items to support your claim. You may review any non-privileged information that relates to your request for review.

We will review your claim promptly after we receive your request. We will send you a notice of our decision within 60 days after we receive your request, or within 120 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant parts of the Group Policy.

ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Policyowner, we have full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy.

Our authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;
2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it;
3. The right to determine:
   a. Eligibility for Insurance;
   b. Entitlement to benefits;
   c. Amount of benefits payable;
   d. Sufficiency and the amount of information we may reasonably require to determine a, b, or c above.

Subject to the review procedures of the Group Policy, any decision we make in the exercise of our authority is conclusive and binding.

TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought until 60 days after you have given us Proof Of Loss. No such action may be brought after expiration of the applicable statute of limitations from the earlier of:

1. The date we receive Proof Of Loss; and
2. The end of the period within which Proof Of Loss is required to be given.

INCONTESTABILITY PROVISIONS

A. Incontestability Of Insurance

Any statement made to obtain or to increase Insurance is a representation and not a warranty.

No misrepresentation will be used to reduce or deny a claim unless:

1. The Insurance would not have been approved if we had known the truth; and
2. We have given you or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

After Insurance has been in effect for two years during the lifetime of the Insured Person, we will not use a misrepresentation to reduce or deny a claim, unless it was a fraudulent misrepresentation.

B. Incontestability Of Group Policy

Any statement made by the Policyowner or Employer to obtain the Group Policy is a representation and not a warranty.

No misrepresentation by the Policyowner or Employer will be used to deny a claim or to deny the validity of the Group Policy unless:

1. The Group Policy would not have been issued if we had known the truth; and
2. We have given the Policyowner or Employer a copy of a written instrument signed by the Policyowner or Employer which contains the misrepresentation.

The validity of the Group Policy will not be contested after it has been in force for two years, except for nonpayment of premiums or fraudulent misrepresentations.

CLERICAL ERROR AND MISSTATEMENT

A. Clerical Error

Clerical error by the Policyowner or Employer will not:

1. Cause a person to become insured;
2. Invalidate Insurance otherwise validly in force; or
3. Continue Insurance otherwise validly terminated.

B. The Policyowner and your Employer act on their own behalf as your agent, and not as our agent.

C. Misstatement Of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on:

1. The amount of Insurance based on the correct age; and

2. The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

TERMINATION OR AMENDMENT OF THE GROUP POLICY

The Group Policy may be terminated by us or the Policyowner according to its terms. It will terminate automatically for nonpayment of premium. The Policyowner may terminate the Group Policy in whole, and may terminate Insurance for any class or group of Members, at any time by giving us written notice.

Benefits under the Group Policy are limited to its terms, including any valid amendment. No change or amendment will be valid unless it is approved in writing by one of our executive officers and given to the Policyowner for attachment to the Group Policy. If the terms of the Certificate differ from the Group Policy, the terms stated in the Group Policy will govern. The Policyowner, your Employer and their respective employees or representatives have no right or authority to change or amend the Group Policy or to waive any of its terms or provisions without our signed written approval.

We may change the Group Policy in whole or in part when any change or clarification in law or governmental regulation affects our obligations under the Group Policy, or with the Policyowner's consent.

Any such change or amendment of the Group Policy may apply to current or future Members or to any separate classes or groups thereof.

DEFINITIONS

Active Work and Actively At Work mean performing the material duties of your own occupation at your Employer's usual place of business.

Contributory means Insurance is elective and Members pay all or part of the premium for Insurance.

Dental Professional means any of the following who is acting within the scope of the license:

1. A doctor of dental medicine (D.M.D.);
2. A doctor of dental surgery (D.D.S.);
3. A dental hygienist; or
4. A denturist.

Dental Professional does not include: the Member; or the spouse, brother, sister, parent or child of either the Member or the Member's Dependent.

Eligibility Waiting Period means the period you must be a Member before you become eligible for Insurance. See **Coverage Features**.

Employer means an employer (including approved affiliates and subsidiaries) for which coverage under the Group Policy is approved in writing by us.

Group Policy means the group dental insurance policy issued by us to the Policyowner and identified by the Group Policy Number.

Incur, Incurs, Incurred and Incurred Date mean, with respect to a Dental Expense, the date the services or supplies are provided to you, except:

1. Bridgework, a crown, or onlay work is incurred on the date the tooth or teeth are prepared;
2. Placement or modification of a full or partial denture is incurred on the date the impression is made; and;

3. Root canal therapy is incurred on the date the pulp chamber is opened.

Injury means an injury to your body.

Insurance means insurance under the Group Policy.

Insured Person means the Member or any Dependent who is insured under the Group Policy.

Noncontributory means (a) Insurance is nonelective and the Policyowner or Employer pay the entire premium for Insurance; or (b) the Policyowner or Employer require all eligible Members to have Insurance and to pay all or part of the premium for Insurance.

Periodontal Splint means any appliance designed to retain teeth in position, and includes multiple abutments for fixed bridgework.

Plan Administrator means the person designated by the Employer to maintain the coverage under the Group Policy.

Pregnancy means your pregnancy, childbirth or related medical conditions, including complications of pregnancy.

Prior Plan means your Employer's group dental plan in effect on the day before the effective date of your Employer's coverage under the Group Policy and which is replaced by the Group Policy.

Reasonable and Customary Charge means the lesser of:

1. The Dental Professional's usual charge for the same services or supplies in the absence of dental insurance coverage; and
2. The charge customarily billed to private patients for the same or similar dental services or supplies by Dental Professionals with similar training and experience in the same Geographically Significant Area. Geographically Significant Area means an area which we determine is large enough to provide a representative base of charges for the same or similar dental services or supplies.

The Reasonable and Customary Charge is determined every six months. The Reasonable and Customary Charge is based upon national and regional claims statistics which compile billed fees that Dental Professionals customarily charge for dental services and supplies.

Sickness means your sickness, illness, or disease.

DENC98

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
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People. Not Just Policies.®

CERTIFICATE

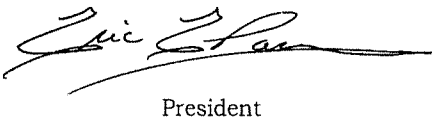
GROUP LONG TERM DISABILITY INSURANCE

Policyholder:	Okaloosa County Board of County Commissioners
Policy Number:	640884-C
Effective Date:	October 1, 2003

The Group Policy has been issued to the Policyholder. We certify that you will be insured as provided by the terms of your Employer's coverage under the Group Policy. If the terms of this Certificate differ from the terms of your Employer's coverage under the Group Policy, the latter will govern. If your coverage is changed by an amendment to the Group Policy, we will provide the Employer with a revised Certificate or other notice to be given to you.

Possession of this Certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate.

"You" and "your" mean the Member. "We", "us" and "our" mean Standard Life Insurance Company. Other defined terms appear with the initial letters capitalized. Section headings, and references to them, appear in boldface type.



President

GC190-LTD/S399

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COVERAGE FEATURES

This section contains many of the features of your long term disability (LTD) insurance. Other provisions, including exclusions, limitations, and Deductible Income, appear in other sections. Please refer to the text of each section for full details. The Table of Contents and the Index of Defined Terms help locate sections and definitions.

GENERAL POLICY INFORMATION

Group Policy Number:	640884-C
Policyholder:	Okaloosa County Board of County Commissioners
Employer(s):	Okaloosa County Board of County Commissioners
Group Policy Effective Date:	October 1, 2003
Policy Issued in:	Florida

Member means:

1. A regular employee of the Employer;
2. Actively At Work at least 32 hours each week (for purposes of the Member definition, Actively At Work will include regularly scheduled days off, holidays, or vacation days, so long as the person is capable of Active Work on those days); and
3. A citizen or resident of the United States or Canada.

Member does not include a temporary or seasonal employee, a full-time member of the armed forces of any country, a leased employee, or an independent contractor.

Class Definition:

Class 1: Department Directors, County Manager and County Commissioners

Class 2: All other Members

SCHEDULE OF INSURANCE

Eligibility Waiting Period:	You are eligible on one of the following dates:
Class 1:	If you are a Member on the Group Policy Effective Date, you are eligible on that date. If you become a Member after the Group Policy Effective Date, you are eligible on the date you become a Member.
Class 2:	If you are a Member on the Group Policy Effective Date, you are eligible on the first day of the calendar month coinciding with or next following 90 consecutive days as a Member. If you become a Member after the Group Policy Effective Date, you are eligible on the first day of the calendar month coinciding with or next following 90 consecutive days as a Member.

Eligibility Waiting Period means the period you must be a Member before you become eligible for insurance.

Own Occupation Period:	The first 12 months for which LTD Benefits are paid.
Any Occupation Period:	From the end of the Own Occupation Period to the end of the Maximum Benefit Period.

LTD Benefit:	Plan 1: 50% of the first $7,000 of your Predisability Earnings, reduced by Deductible Income.
Maximum:	$3,500 before reduction by Deductible Income.
Minimum:	$100
	Plan 2: 60% of the first $8,333 of your Predisability Earnings, reduced by Deductible Income.
Maximum:	$5,000 before reduction by Deductible Income.
Minimum:	$100

You may be insured under either Plan 1 or Plan 2, but not both. You will be insured under Plan 1 unless you are insured under Plan 2. If you cease paying for premiums under Plan 2, you will automatically be insured under Plan 1.

For all Plans:

Benefit Waiting Period:	180 days
Maximum Benefit Period:	Determined by your age when Disability begins, as follows:

Age	Maximum Benefit Period
61 or younger	To age 65, or for 5 years, whichever is shorter.
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year

PREMIUM CONTRIBUTIONS

Plan 1 insurance is:	Noncontributory
Plan 2 insurance is:	Contributory

INSURING CLAUSE

If you become Disabled while insured under the Group Policy, we will pay LTD Benefits according to the terms of the Group Policy after we receive Proof Of Loss satisfactory to us.

LT.IC.OT.1

BECOMING INSURED

To become insured you must be a Member, complete your Eligibility Waiting Period, and meet the requirements in **Active Work Provisions** and **When Your Insurance Becomes Effective**.

You are a Member if you are:

1. A regular employee of the Employer;
2. Actively At Work at least 32 hours each week (for purposes of the Member definition, Actively At Work will include regularly scheduled days off, holidays, or vacation days, so long as you are capable of Active Work on those days); and
3. A citizen or resident of the United States or Canada.

You are not a Member if you are a temporary or seasonal employee, a full-time member of the armed forces of any country, a leased employee, or an independent contractor.

Eligibility Waiting Period means the period you must be a Member before you become eligible for insurance. Your Eligibility Waiting Period is shown in the **Coverage Features.**

(VAR MBR DEF) LT.BI.OT.1

WHEN YOUR INSURANCE BECOMES EFFECTIVE

A. When Insurance Becomes Effective

Subject to the **Active Work Provisions**, your insurance becomes effective as follows:

1. Insurance Subject To Evidence Of Insurability

   Insurance subject to Evidence Of Insurability becomes effective on the date we approve your Evidence Of Insurability.

2. Insurance Not Subject To Evidence of Insurability

   The **Coverage Features** states whether insurance is Contributory or Noncontributory.

   a. Noncontributory Insurance

      Noncontributory insurance not subject to Evidence Of Insurability becomes effective on the date you become eligible.

   b. Contributory Insurance

      You must apply in writing for Contributory insurance and agree to pay premiums. Contributory insurance not subject to Evidence Of Insurability becomes effective on:

      i. The date you become eligible if you apply on or before that date; or

      ii. The date you apply if you apply within 31 days after you become eligible.

      Late application: Evidence Of Insurability is required if you apply more than 31 days after you become eligible.

B. Takeover Provisions

1. If you were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Group Policy, your Eligibility Waiting Period is waived on the effective date of your Employer's coverage under the Group Policy.
2. You must submit satisfactory Evidence Of Insurability to become insured if you were eligible for insurance under the Prior Plan for more than 31 days but were not insured.

C. Evidence Of Insurability Requirement

Evidence Of Insurability satisfactory to us is required:

a. For late application for Contributory insurance.

b. For Members eligible but not insured under the Prior Plan.

c. For reinstatements if required.

Providing Evidence Of Insurability means you must:

1. Complete and sign our medical history statement;
2. Sign our form authorizing us to obtain information about your health;
3. Undergo a physical examination, if required by us, which may include blood testing; and
4. Provide any additional information about your insurability that we may reasonably require.

(VAR EOI) LT.EF.OT.1

ACTIVE WORK PROVISIONS

A. Active Work Requirement

You must be capable of Active Work on the day before the scheduled effective date of your insurance or your insurance will not become effective as scheduled. If you are incapable of Active Work because of Physical Disease, Injury, Pregnancy or Mental Disorder on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day after you complete one full day of Active Work as an eligible Member.

Active Work and Actively At Work mean performing with reasonable continuity the Material Duties of your Own Occupation at your Employer's usual place of business.

B. Changes In Insurance

This Active Work requirement also applies to any increase in your insurance.

LT.AW.OT.1

CONTINUITY OF COVERAGE

A. Waiver Of Active Work Requirement

If you were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Group Policy, you can become insured on the effective date of your Employer's coverage without meeting the Active Work requirement. See **Active Work Provisions**.

The LTD Benefit payable for a period of continuous Disability beginning before you meet the Active Work requirement will be:

1. The monthly benefit which would have been payable under the terms of the Prior Plan if it had remained in force; reduced by
2. Any benefits payable under the Prior Plan.

There is no Minimum LTD Benefit if there is a reduction by benefits payable under the Prior Plan.

B. Effect Of Preexisting Conditions

If your Disability is subject to the Preexisting Condition Exclusion, LTD Benefits will be payable if:

1. You were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Group Policy;
2. You became insured under the Group Policy when your insurance under the Prior Plan ceased;
3. You were continuously insured under the Group Policy from the effective date of your insurance under the Group Policy through the date you became Disabled from the Preexisting Condition; and
4. Benefits would have been payable under the terms of the Prior Plan if it had remained in force, taking into account the preexisting condition exclusion, if any, of the Prior Plan.

For such a Disability, the amount of your LTD Benefit will be the lesser of:

a. The monthly benefit that would have been payable under the terms of the Prior Plan if it had remained in force; or

b. The LTD Benefit payable under the terms of the Group Policy, but without application of the Preexisting Condition Exclusion.

Your LTD Benefits for such a Disability will end on the earlier of the following dates:

a. The date benefits would have ended under the terms of the Prior Plan if it had remained in force; or

b. The date LTD Benefits end under the terms of the Group Policy.

(PX AND AW) LT.CC.OT.1

WHEN YOUR INSURANCE ENDS

Your insurance ends automatically on the earliest of:

1. The date the last period ends for which a premium contribution was made for your insurance.
2. The date the Group Policy terminates.
3. The date your employment terminates.
4. The date you cease to be a Member. However, your insurance will be continued during the following periods when you are absent from Active Work, unless it ends under any of the above.

   a. During the first 90 days of a temporary or indefinite administrative or involuntary leave of absence or sick leave, provided your Employer is paying you at least the same Predisability Earnings paid to you immediately before you ceased to be a Member. A period when you are absent from Active Work as part of a severance or other employment termination agreement is not a leave of absence, even if you are receiving the same Predisability Earnings.

   b. During a leave of absence if continuation of your insurance under the Group Policy is required by a state-mandated family or medical leave act or law.

   c. During any other temporary leave of absence approved by your Employer in advance and in writing and scheduled to last 30 days or less. A period of Disability is not a leave of absence.

LT.EN.OT.1

WAIVER OF PREMIUM

We will waive payment of premium for your insurance while LTD Benefits are payable.

LT.WP.OT.1

REINSTATEMENT OF INSURANCE

If your insurance ends, you may become insured again as a new Member. However, the following will apply:

1. If you cease to be a Member because of a covered Disability, your insurance will end; however, if you become a Member again immediately after LTD Benefits end, the Eligibility Waiting Period will be waived and, with respect to the condition(s) for which LTD Benefits were payable, the Preexisting Condition Exclusion will be applied as if your insurance had remained in effect during that period of Disability.
2. If your insurance ends because you cease to be a Member for any reason other than a covered Disability, and if you become a Member again within 90 days, the Eligibility Waiting Period will be waived.
3. If your insurance ends because you fail to make a required premium contribution, you must provide Evidence Of Insurability to become insured again.
4. If your insurance ends because you are on a federal or state-mandated family or medical leave of absence, and you become a Member again immediately following the period allowed, your insurance will be reinstated pursuant to the federal or state-mandated family or medical leave act or law.
5. The Preexisting Conditions Exclusion will be applied as if insurance had remained in effect in the following instances:
   a. If you become insured again within 90 days.
   b. If required by federal or state-mandated family or medical leave act or law and you become insured again immediately following the period allowed under the family or medical leave act or law.
6. In no event will insurance be retroactive.

LT.RE.OT.1

DEFINITION OF DISABILITY

You are Disabled if you meet the following definitions during the periods they apply:

A. Own Occupation Definition Of Disability.

B. Any Occupation Definition Of Disability.

A. Own Occupation Definition Of Disability

During the Benefit Waiting Period and the Own Occupation Period you are required to be Disabled only from your Own Occupation.

You are Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder:

1. You are unable to perform with reasonable continuity the Material Duties of your Own Occupation; and

2. You suffer a loss of at least 20% in your Indexed Predisability Earnings when working in your Own Occupation.

Note: You are not Disabled merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license.

During the Own Occupation Period you may work in another occupation while you meet the Own Occupation Definition Of Disability. However, you will no longer be Disabled when your Work Earnings from another occupation meet or exceed 80% of your Indexed Predisability Earnings. Your Work Earnings may be Deductible Income. See **Return To Work Provisions** and **Deductible Income**.

Own Occupation means any employment, business, trade, profession, calling or vocation that involves Material Duties of the same general character as the occupation you are regularly performing for your Employer when Disability begins. In determining your Own Occupation, we are not limited to looking at the way you perform your job for your Employer, but we may also look at the way the occupation is generally performed in the national economy. If your Own Occupation involves the rendering of professional services and you are required to have a professional or occupational license in order to work, your Own Occupation is as broad as the scope of your license.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

B. Any Occupation Definition Of Disability

During the Any Occupation Period you are required to be Disabled from all occupations.

You are Disabled from all occupations if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to perform with reasonable continuity the Material Duties of Any Occupation.

Any Occupation means any occupation or employment which you are able to perform, whether due to education, training, or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 60% of your Indexed Predisability Earnings within twelve months following your return to work, regardless of whether you are working in that or any other occupation.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

Your Own Occupation Period and Any Occupation Period are shown in the **Coverage Features**.

(OWN_ANY_WITH 40) LT.DD.OT.1

RETURN TO WORK PROVISIONS

A. Return To Work Responsibility

During the Own Occupation Period no LTD Benefits will be paid for any period when you are able to work in your Own Occupation and able to earn at least 20% of your Indexed Predisability Earnings, but you elect not to work.

During the Any Occupation Period no LTD Benefits will be paid for any period when you are able to work in Any Occupation and able to earn at least 20% of your Indexed Predisability Earnings, but you elect not to work.

B. Return To Work Incentive

You may serve your Benefit Waiting Period while working if you meet the Own Occupation Definition Of Disability.

You are eligible for the Return To Work Incentive on the first day you work after the Benefit Waiting Period if LTD Benefits are payable on that date. The Return To Work Incentive changes 12 months after that date, as follows:

1. During the first 12 months, your Work Earnings will be Deductible Income as determined in a., b. and c:

   a. Determine the amount of your LTD Benefit as if there were no Deductible Income, and add your Work Earnings to that amount.

   b. Determine 100% of your Indexed Predisability Earnings.

   c. If a. is greater than b., the difference will be Deductible Income.

2. After those first 12 months, 50% of your Work Earnings will be Deductible Income.

C. Work Earnings Definition

Work Earnings means your gross monthly earnings from work you perform while Disabled, plus the earnings you could receive if you worked as much as you are able to, considering your Disability, in work that is reasonably available:

a. In your Own Occupation during the Own Occupation Period; and

b. In Any Occupation during the Any Occupation Period.

Work Earnings includes earnings from your Employer, any other employer, or self-employment, and any sick pay, vacation pay, annual or personal leave pay or other salary continuation earned or accrued while working.

Earnings from work you perform will be included in Work Earnings when you have the right to receive them. If you are paid in a lump sum or on a basis other than monthly, we will prorate your Work Earnings over the period of time to which they apply. If no period of time is stated, we will use a reasonable one.

In determining your Work Earnings we:

1. Will use the financial accounting method you use for income tax purposes, if you use that method on a consistent basis.

2. Will not be limited to the taxable income you report to the Internal Revenue Service.

3. May ignore expenses under section 179 of the IRC as a deduction from your gross earnings.

4. May ignore depreciation as a deduction from your gross earnings.

5. May adjust the financial information you give us in order to clearly reflect your Work Earnings.

If we determine that your earnings vary substantially from month to month, we may determine your Work Earnings by averaging your earnings over the most recent three-month period. During the Own Occupation Period you will no longer be Disabled when your average Work Earnings over the last three months exceed 80% of your Indexed Predisability Earnings. During the Any Occupation Period you will no longer be Disabled when your average Work Earnings over the last three months exceed 60% of your Indexed Predisability Earnings.

LT.RW.OT.1

REASONABLE ACCOMMODATION EXPENSE BENEFIT

If you return to work in any occupation for any employer, not including self-employment, as a result of a reasonable accommodation made by such employer, we will pay that employer a Reasonable Accommodation Expense Benefit of up to $25,000, but not to exceed the expenses incurred.

The Reasonable Accommodation Expense Benefit is payable only if the reasonable accommodation is approved by us in writing prior to its implementation.

LT.RA.OT.1

REHABILITATION PLAN PROVISION

While you are Disabled you may qualify to participate in a Rehabilitation Plan. Rehabilitation Plan means a written plan, program or course of vocational training or education that is intended to prepare you to return to work.

To participate in a Rehabilitation Plan you must apply on our forms or in a letter to us. The terms, conditions and objectives of the plan must be accepted by you and approved by us in advance. We have the sole discretion to approve your Rehabilitation Plan.

An approved Rehabilitation Plan may include our payment of some or all of the expenses you incur in connection with the plan, including:

a. Training and education expenses.

b. Family care expenses.

c. Job-related expenses.

d. Job search expenses.

LT.RH.OT.1

TEMPORARY RECOVERY

You may temporarily recover from your Disability and then become Disabled again from the same cause or causes without having to serve a new Benefit Waiting Period. Temporary Recovery means you cease to be Disabled for no longer than the applicable Allowable Period. See **Definition Of Disability**.

A. Allowable Periods

1. During the Benefit Waiting Period: a total of 30 days of recovery.
2. During the Maximum Benefit Period: 180 days for each period of recovery.

B. Effect Of Temporary Recovery

If your Temporary Recovery does not exceed the Allowable Periods, the following will apply.

1. The Predisability Earnings used to determine your LTD Benefit will not change.
2. The period of Temporary Recovery will not count toward your Benefit Waiting Period, your Maximum Benefit Period or your Own Occupation Period.
3. No LTD Benefits will be payable for the period of Temporary Recovery.
4. No LTD Benefits will be payable after benefits become payable to you under any other disability insurance plan under which you become insured during your period of Temporary Recovery.
5. Except as stated above, the provisions of the Group Policy will be applied as if there had been no interruption of your Disability.

LT.TR.OT.1

WHEN LTD BENEFITS END

Your LTD Benefits end automatically on the earliest of:

1. The date you are no longer Disabled.
2. The date your Maximum Benefit Period ends.
3. The date you die.
4. The date benefits become payable under any other LTD plan under which you become insured through employment during a period of Temporary Recovery.
5. The date you fail to provide proof of continued Disability and entitlement to LTD Benefits.

LT.BE.OT.1

PREDISABILITY EARNINGS

Your Predisability Earnings will be based on your earnings in effect on your last full day of Active Work. Any subsequent change in your earnings after that last full day of Active Work will not affect your Predisability Earnings.

Predisability Earnings means your monthly rate of earnings from your Employer, including:

1. Contributions you make through a salary reduction agreement with your Employer to:
   a. An Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), 408(p), or 457 deferred compensation arrangement; or
   b. An executive nonqualified deferred compensation arrangement.
2. Commissions averaged over the preceding 12 months or over the period of your employment if less than 12 months.
3. Shift differential pay.
4. Amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC Section 125 plan.

Predisability Earnings does not include:

1. Bonuses.
2. Overtime pay.
3. Your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan.
4. Any other extra compensation.

If you are paid on an annual contract basis, your monthly rate of earnings is one-twelfth (1/12th) of your annual contract salary.

If you are paid hourly, your monthly rate of earnings is based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per month, but not more than 173 hours. If you do not have regular work hours, your monthly rate of earnings is based on the average number of hours you worked per month during the preceding 12 calendar months (or during your period of employment if less than 12 months), but not more than 173 hours.

(REG WITH COM) LT.PD.OT.1

DEDUCTIBLE INCOME

Subject to **Exceptions To Deductible Income**, Deductible Income means:

1. Sick pay, annual or personal leave pay, severance pay, or other salary continuation, including donated amounts, (but not vacation pay) payable to you by your Employer.
2. Your Work Earnings, as described in the **Return To Work Provisions**.
3. Any amount you receive or are eligible to receive because of your disability, including amounts for partial or total disability, whether permanent, temporary, or vocational, under any of the following:
   a. A workers' compensation law;
   b. The Jones Act;
   c. Maritime Doctrine of Maintenance, Wages, or Cure;
   d. Longshoremen's and Harbor Worker's Act; or
   e. Any similar act or law.
4. Any amount you, your spouse, or your child under age 18 receive or are eligible to receive because of your disability or retirement under:
   a. The Federal Social Security Act;
   b. The Canada Pension Plan;
   c. The Quebec Pension Plan;
   d. The Railroad Retirement Act; or
   e. Any similar plan or act.

   Full offset: Both the primary benefit (the benefit awarded to you) and dependents benefit are Deductible Income.

   Benefits your spouse or a child receives or are eligible to receive because of your disability are Deductible Income regardless of marital status, custody, or place of residence. The term "child" has the meaning given in the applicable plan or act.
5. Any amount you receive or are eligible to receive because of your disability under any state disability income benefit law or similar law.
6. Any amount you receive or are eligible to receive because of your disability under another group insurance coverage.
7. Any disability or retirement benefits you receive or are eligible to receive under your Employer's retirement plan, including a public employee retirement system, a state teacher retirement system, and a plan arranged and maintained by a union or employee association for the benefit of its members. You and your Employer's contributions will be considered as distributed simultaneously throughout your lifetime, regardless of how funds are distributed from the retirement plan.

   If any of these plans has two or more payment options, the option which comes closest to providing you a monthly income for life with no survivors benefit will be Deductible Income, even if you choose a different option.
8. Any earnings or compensation included in Predisability Earnings which you receive or are eligible to receive while LTD Benefits are payable.

9. Any amount you receive or are eligible to receive under any unemployment compensation law or similar act or law.

10. Any amount you receive or are eligible to receive from or on behalf of a third party because of your disability, whether by judgement, settlement or other method. If you notify us before filing suit or settling your claim against such third party, the amount used as Deductible Income will be reduced by a pro rata share of your costs of recovery, including reasonable attorney fees.

11. Any amount you receive by compromise, settlement, or other method as a result of a claim for any of the above, whether disputed or undisputed.

(NO CHOICE_NO OTHR OFFST_PUB_WITH 3RD) LT.DI.OT.1

EXCEPTIONS TO DEDUCTIBLE INCOME

Deductible Income does not include:

1. Any cost of living increase in any Deductible Income other than Work Earnings, if the increase becomes effective while you are Disabled and while you are eligible for the Deductible Income.
2. Reimbursement for hospital, medical, or surgical expense.
3. Reasonable attorneys fees incurred in connection with a claim for Deductible Income.
4. Benefits from any individual disability insurance policy.
5. Early retirement benefits under the Federal Social Security Act which are not actually received.
6. Group credit or mortgage disability insurance benefits.
7. Accelerated death benefits paid under a life insurance policy.
8. Benefits from the following:
   a. Profit sharing plan.
   b. Thrift or savings plan.
   c. Deferred compensation plan.
   d. Plan under IRC Section 401(k), 408(k), 408(p), or 457.
   e. Individual Retirement Account (IRA).
   f. Tax Sheltered Annuity (TSA) under IRC Section 403(b).
   g. Stock ownership plan.
   h. Keogh (HR-10) plan.

(PUB_NO OTHR OFFST) LT.ED.OT.1

RULES FOR DEDUCTIBLE INCOME

A. Monthly Equivalents

Each month we will determine your LTD Benefit using the Deductible Income for the same monthly period, even if you actually receive the Deductible Income in another month.

If you are paid Deductible Income in a lump sum or by a method other than monthly, we will determine your LTD Benefit using a prorated amount. We will use the period of time to which the Deductible Income applies. If no period of time is stated, we will use a reasonable one.

B. Your Duty To Pursue Deductible Income

You must pursue Deductible Income for which you may be eligible. We may ask for written documentation of your pursuit of Deductible Income. You must provide it within 60 days after we mail you our request. Otherwise, we may reduce your LTD Benefits by the amount we estimate you would be eligible to receive upon proper pursuit of the Deductible Income.

C. Pending Deductible Income

We will not deduct pending Deductible Income until it becomes payable. You must notify us of the amount of the Deductible Income when it is approved. You must repay us for the resulting overpayment of your claim.

D. Overpayment Of Claim

We will notify you of the amount of any overpayment of your claim under any group disability insurance policy issued by us. You must immediately repay us. You will not receive any LTD Benefits until we have been repaid in full. In the meantime, any LTD Benefits paid, including the Minimum LTD Benefit, will be applied to reduce the amount of the overpayment. We may charge you interest at the legal rate for any overpayment which is not repaid within 30 days after we first mail you notice of the amount of the overpayment.

LT.RU.OT.1

SUBROGATION

If LTD Benefits are paid or payable to you under the Group Policy as the result of any act or omission of a third party, we will be subrogated to all rights of recovery you may have in respect to such act or omission. You must execute and deliver to us such instruments and papers as may be required and do whatever else is needed to secure such rights. You must avoid doing anything that would prejudice our rights of subrogation.

If you notify us before filing suit or settling your claim against such third party, the amount to which we are subrogated will be reduced by a pro rata share of your costs of recovery, including reasonable attorney fees. If suit or action is filed, we may record a notice of payments of LTD Benefits, and such notice shall constitute a lien on any judgement recovered.

If you or your legal representative fail to bring suit or action promptly against such third party, we may institute such suit or action in our name or in your name. We are entitled to retain from any judgement recovered the amount of LTD Benefits paid or to be paid to you or on your behalf, together with our costs of recovery, including attorney fees. The remainder of such recovery, if any, shall be paid to you or as the court may direct.

LT.SG.OT.1

SURVIVORS DEATH BENEFIT

If you die while LTD Benefits are payable, and on the date you die you have been continuously Disabled for at least 180 days, we will pay a Survivors Death Benefit according to 1 through 4 below.

1. The Survivors Death Benefit is a lump sum equal to 3 times your LTD Benefit without reduction by Deductible Income.
2. The Survivors Death Benefit will first be applied to reduce any overpayment of your claim.
3. The Survivors Death Benefit will be paid at our option to any one or more of the following:
   a. Your surviving spouse;
   b. Your surviving unmarried children, including adopted children, under age 25;
   c. Your surviving spouse's unmarried children, including adopted children, under age 25; or

d. Any person providing the care and support of any person listed in a., b., or c. above.

4. No Survivors Death Benefit will be paid if you are not survived by any person listed in a., b., or c. above.

(MULTPL) LT.SB.FL.1

BENEFITS AFTER INSURANCE ENDS OR IS CHANGED

During each period of continuous Disability, we will pay LTD Benefits according to the terms of the Group Policy in effect on the date you become Disabled. Your right to receive LTD Benefits will not be affected by:

1. Any amendment to the Group Policy that is effective after you become Disabled.
2. Termination of the Group Policy after you become Disabled.

LT.BA.OT.1

EFFECT OF NEW DISABILITY

If a period of Disability is extended by a new cause while LTD Benefits are payable, LTD Benefits will continue while you remain Disabled. However, 1 and 2 apply.

1. LTD Benefits will not continue beyond the end of the original Maximum Benefit Period.
2. The **Disabilities Excluded From Coverage, Disabilities Subject To Limited Pay Periods,** and **Limitations** sections will apply to the new cause of Disability.

LT.ND.OT.1

DISABILITIES EXCLUDED FROM COVERAGE

A. War

You are not covered for a Disability caused or contributed to by War or any act of War. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

B. Intentionally Self-Inflicted Injury

You are not covered for a Disability caused or contributed to by an intentionally self-inflicted Injury, while sane or insane.

C. Preexisting Condition

A separate Preexisting Condition exclusion applies for Plan 1 and Plan 2.

1. Definition

Preexisting Condition means a mental or physical condition whether or not diagnosed or misdiagnosed:

a. For which you have done or for which a reasonably prudent person would have done any of the following:

i. Consulted a physician or other licensed medical professional;

ii. Received medical treatment, services or advice;

iii. Undergone diagnostic procedures, including self-administered procedures;

iv. Taken prescribed drugs or medications;

b. Which, as a result of any medical examination, including routine examination, was discovered or suspected;

with respect to Plan 1, at any time during the 90 day period just before your insurance becomes effective under Plan 1;

with respect to Plan 2, at any time during the 90 day period just before your insurance becomes effective under Plan 2.

2. Exclusion

With respect to Plan 1, you are not covered for a Disability caused or contributed to by a Preexisting Condition or medical or surgical treatment of a Preexisting Condition unless, on the date you become Disabled, you:

a. Have been continuously insured under Plan 1 of the Group Policy for 12 months; and

b. Have been Actively At Work for at least one full day after the end of that 12 months.

With respect to Plan 2, you are not covered for a Disability caused or contributed to by a Preexisting Condition or medical or surgical treatment of a Preexisting Condition unless, on the date you become Disabled, you:

a. Have been continuously insured under Plan 2 of the Group Policy for 12 months; and

b. Have been Actively At Work for at least one full day after the end of that 12 months.

D. Loss Of License Or Certification

You are not covered for a Disability caused or contributed to by the loss of your professional license, occupational license or certification.

E. Violent Or Criminal Conduct

You are not covered for a Disability caused or contributed to by your committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.

(WITH PRUDNT) LT.XD.OT.1X

DISABILITIES SUBJECT TO LIMITED PAY PERIODS

A. Mental Disorders, Substance Abuse and Other Limited Conditions

Payment of LTD Benefits is limited to 12 months during your entire lifetime for a Disability caused or contributed to by any one or more of the following, or medical or surgical treatment of one or more of the following:

1. Mental Disorders;

2. Substance Abuse; or

3. Other Limited Conditions.

However, if you are confined in a Hospital solely because of a Mental Disorder at the end of the 12 months, this limitation will not apply while you are continuously confined.

Mental Disorder means any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome, regardless of cause (including any biological or biochemical disorder or imbalance of the brain) or the presence of physical symptoms. Mental Disorder includes, but is not limited to, bipolar affective disorder, organic brain syndrome, schizophrenia, psychotic illness, manic depressive illness, depression and depressive disorders, anxiety and anxiety disorders.

Substance Abuse means use of alcohol, alcoholism, use of any drug, including hallucinogens, or drug addiction.

Other Limited Conditions means chronic fatigue conditions (such as chronic fatigue syndrome, chronic fatigue immunodeficiency syndrome, post viral syndrome, limbic encephalopathy, Epstein-Barr virus infection, herpesvirus type 6 infection, or myalgic encephalomyelitis), any allergy or sensitivity to chemicals or the environment (such as environmental allergies, sick building syndrome, multiple chemical sensitivity syndrome or chronic toxic encephalopathy), chronic pain conditions (such as fibromyalgia, reflex sympathetic dystrophy or myofascial pain), carpal tunnel or repetitive motion syndrome, temporomandibular joint disorder, craniomandibular joint disorder, arthritis, diseases or disorders of the cervical thoracic, or lumbosacral back and its surrounding soft tissue, and sprains or strains of joints or muscles.

However, Other Limited Conditions does not include neoplastic diseases, neurologic diseases, endocrine diseases, hematologic diseases, asthma, allergy-induced reactive lung disease, tumors, malignancies, or vascular malformations, demyelinating diseases, lupus, rheumatoid or psoriatic arthritis, herniated discs with neurological abnormalities that are documented by electromyogram and computerized tomography or magnetic resonance imaging, scoliosis, radiculopathies that are documented by electromyogram, spondylolisthesis, grade II or higher, myelopathies and myelitis, traumatic spinal cord necrosis, osteoporosis, discitis, Paget's disease.

Hospital means a legally operated hospital providing full-time medical care and treatment under the direction of a full-time staff of licensed physicians. Rest homes, nursing homes, convalescent homes, homes for the aged, and facilities primarily affording custodial, educational, or rehabilitative care are not Hospitals. Hospital does not include any rehabilitative care facility unless the rehabilitative care is for treatment of physical disability and is provided in a licensed hospital which is accredited by the Joint Commission on the Accreditation of Hospitals, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities.

B. Rules For Disabilities Subject To Limited Pay Periods

1. If you are Disabled as a result of a Mental Disorder or any Physical Disease or Injury for which payment of LTD Benefits is subject to a limited pay period, and at the same time are Disabled as a result of a Physical Disease, Injury, or Pregnancy that is not subject to such limitation, LTD Benefits will be payable first for conditions that are subject to the limitation.

2. No LTD Benefits will be payable after the end of the limited pay period, unless on that date you continue to be Disabled as a result of a Physical Disease, Injury, or Pregnancy for which payment of LTD Benefits is not limited.

(WITH MUSC) LT.LP.FL.1

LIMITATIONS

A. Care Of A Physician

You must be under the ongoing care of a Physician in the appropriate specialty as determined by us during the Benefit Waiting Period. No LTD Benefits will be paid for any period of Disability when you are not under the ongoing care of a Physician in the appropriate specialty as determined by us.

B. Return To Work Responsibility

During the Own Occupation Period no LTD Benefits will be paid for any period of Disability when you are able to work in your Own Occupation and able to earn at least 20% of your Indexed Predisability Earnings, but you elect not to work.

During the Any Occupation Period, no LTD Benefits will be paid for any period of Disability when you are able to work in Any Occupation and able to earn at least 20% of your Indexed Predisability Earnings, but elect not to work.

C. Rehabilitation Program

No LTD Benefits will be paid for any period of Disability when you are not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by us unless your Disability prevents you from participating.

D. Foreign Residency

Payment of LTD Benefits is limited to 12 months for each period of continuous Disability while you reside outside of the United States or Canada.

E. Imprisonment

No LTD Benefits will be paid for any period of Disability when you are confined for any reason in a penal or correctional institution.

LT.LM.OT.1

CLAIMS

A. Filing A Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, you may submit your claim in a letter to us. The letter should include the date disability began, and the cause and nature of the disability.

B. Time Limits On Filing Proof Of Loss

You must give us Proof Of Loss within 90 days after the end of the Benefit Waiting Period. If you cannot do so, you must give it to us as soon as reasonably possible, but not later than one year after that 90-day period. If Proof Of Loss is filed outside these time limits, your claim will be denied. These limits will not apply while you lack legal capacity.

C. Proof Of Loss

Proof Of Loss means written proof that you are Disabled and entitled to LTD Benefits. Proof Of Loss must be provided at your expense.

For claims of Disability due to conditions other than Mental Disorders, we may require proof of physical impairment that results from anatomical or physiological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

D. Documentation

Completed claims statements, a signed authorization for us to obtain information, and any other items we may reasonably require in support of a claim must be submitted at your expense. If the required documentation is not provided within 45 days after we mail our request, your claim may be denied.

E. Investigation Of Claim

We may investigate your claim at any time.

At our expense, we may have you examined at reasonable intervals by specialists of our choice. We may deny or suspend LTD Benefits if you fail to attend an examination or cooperate with the examiner.

F. Time Of Payment

We will pay LTD Benefits within 60 days after you satisfy Proof Of Loss.

LTD Benefits will be paid to you at the end of each month you qualify for them. LTD Benefits remaining unpaid at your death will be paid to the person(s) receiving the Survivors Death Benefit. If no Survivors Death Benefit is paid, the unpaid LTD Benefits will be paid to your estate.

G. Notice Of Decision On Claim

We will evaluate your claim promptly after you file it. Within 45 days after we receive your claim we will send you: (a) a written decision on your claim; or (b) a notice that we are extending the period to decide your claim for 30 days. Before the end of this extension period we will send you: (a) a written decision on your claim; or (b) a notice that we are extending the period to decide your claim for an additional 30 days. If an extension is due to your failure to provide information necessary to decide the claim, the extended time period for deciding your claim will not begin until you provide the information or otherwise respond.

If we extend the period to decide your claim, we will notify you of the following: (a) the reasons for the extension; (b) when we expect to decide your claim; (c) an explanation of the standards on which entitlement to benefits is based; (d) the unresolved issues preventing a decision; and (e) any additional information we need to resolve those issues.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.

b. Reference to the parts of the Group Policy on which our decision is based.

c. A description of any additional information needed to support your claim.

d. Information concerning your right to a review of our decision.

H. Review Procedure

If all or part of a claim is denied, you may request a review. You must request a review in writing within 180 days after receiving notice of the denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your request for review. There will be no charge for such copies. You may request the names of medical or vocational experts who provided advice to us about your claim.

The person conducting the review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based on a medical judgement, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original medical judgement and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request. Within 45 days after we receive your request for review we will send you: (a) a written decision on review; or (b) a notice that we are extending the review period for 45 days. If the extension is due to your failure to provide information necessary to decide the claim on review, the extended time period for review of your claim will not begin until you provide the information or otherwise respond.

If we extend the review period, we will notify you of the following: (a) the reasons for the extension; (b) when we expect to decide your claim on review; and (c) any additional information we need to decide your claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may conclude our review of your claim based on the information we have received.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.

b. Reference to the parts of the Group Policy on which our decision is based.

c. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.

I. Assignment

The rights and benefits under the Group Policy are not assignable.

(REV PUB WRDG) LT.CL.FL.2

ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Policyholder or Employer, we have full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy.

Our authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;
2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it;
3. The right to determine:
   a. Eligibility for insurance;
   b. Entitlement to benefits;
   c. The amount of benefits payable; and
   d. The sufficiency and the amount of information we may reasonably require to determine a., b., or c., above.

Subject to the review procedures of the Group Policy, any decision we make in the exercise of our authority is conclusive and binding.

LT.AL.OT.1

TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought until 60 days after you have given us Proof Of Loss. No such action may be brought after expiration of the applicable statute of limitations from the earlier of:

1. The date we receive Proof Of Loss; and
2. The time within which Proof Of Loss is required to be given.

LT.TL.FL.1

INCONTESTABILITY PROVISIONS

A. Incontestability Of Insurance

Any statement made to obtain insurance or to increase insurance is a representation and not a warranty.

No misrepresentation will be used to reduce or deny a claim or contest the validity of insurance unless:

1. The insurance would not have been approved if we had known the truth; and
2. We have given you or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

After insurance has been in effect for two years during the lifetime of the insured, we will not use a misrepresentation to reduce or deny the claim, unless it was a fraudulent misrepresentation.

B. Incontestability Of The Group Policy

Any statement made by the Policyholder or Employer to obtain the Group Policy is a representation and not a warranty.

No misrepresentation by the Policyholder or your Employer will be used to deny a claim or to deny the validity of the Group Policy unless:

1. The Group Policy would not have been issued if we had known the truth; and
2. We have given the Policyholder or Employer a copy of a written instrument signed by the Policyholder or Employer which contains the misrepresentation.

The validity of the Group Policy will not be contested after it has been in force for two years, except for nonpayment of premiums or fraudulent misrepresentations.

LT.IN.OT.1

CLERICAL ERROR, AGENCY, AND MISSTATEMENT

A. Clerical Error

Clerical error by the Policyholder, your Employer, or their respective employees or representatives will not:

1. Cause a person to become insured.
2. Invalidate insurance under the Group Policy otherwise validly in force.
3. Continue insurance under the Group Policy otherwise validly terminated.

B. Agency

The Policyholder and your Employer act on their own behalf as your agent, and not as our agent. The Policyholder and your Employer have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy.

C. Misstatement Of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on:

1. The amount of insurance based on the correct age; and

2. The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

LT.CE.OT.1

TERMINATION OR AMENDMENT OF THE GROUP POLICY

The Group Policy may be terminated by us or the Policyholder according to its terms. It will terminate automatically for nonpayment of premium. The Policyholder may terminate the Group Policy in whole, and may terminate insurance for any class or group of Members, at any time by giving us written notice.

Benefits under the Group Policy are limited to its terms, including any valid amendment. No change or amendment will be valid unless it is approved in writing by one of our executive officers and given to the Policyholder for attachment to the Group Policy. If the terms of the certificate differ from the Group Policy, the terms stated in the Group Policy will govern. The Policyholder, your Employer, and their respective employees or representatives have no right or authority to change or amend the Group Policy or to waive any of its terms or provisions without our signed written approval.

We may change the Group Policy in whole or in part when any change or clarification in law or governmental regulation affects our obligations under the Group Policy, or with the Policyholder's consent.

Any such change or amendment of the Group Policy may apply to current or future Members or to any separate classes or groups of Members.

LT.TA.OT.1

DEFINITIONS

Benefit Waiting Period means the period you must be continuously Disabled before LTD Benefits become payable. No LTD Benefits are payable for the Benefit Waiting Period. See **Coverage Features**.

Contributory means insurance is elective and Members pay all or part of the premium for insurance.

CPI-W means the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. If the CPI-W is discontinued or changed, we may use a comparable index. Where required, we will obtain prior state approval of the new index.

Employer means an employer (including approved affiliates and subsidiaries) for which coverage under the Group Policy is approved in writing by us.

Group Policy means the group LTD insurance policy issued by us to the Policyholder and identified by the Group Policy Number.

Indexed Predisability Earnings means your Predisability Earnings adjusted by the rate of increase in the CPI-W. During your first year of Disability, your Indexed Predisability Earnings are the same as your Predisability Earnings. Thereafter, your Indexed Predisability Earnings are determined on each anniversary of your Disability by increasing the previous year's Indexed Predisability Earnings by the rate of increase in the CPI-W for the prior calendar year. The maximum adjustment in any year is 10%. Your Indexed Predisability Earnings will not decrease, even if the CPI-W decreases.

Injury means an injury to the body.

LTD Benefit means the monthly benefit payable to you under the terms of the Group Policy.

Maximum Benefit Period means the longest period for which LTD Benefits are payable for any one period of continuous Disability, whether from one or more causes. It begins at the end of the Benefit Waiting Period. No LTD Benefits are payable after the end of the Maximum Benefit Period, even if you are still Disabled. See **Coverage Features**.

Noncontributory means (a) insurance is nonelective and the Policyholder or Employer pay the entire premium for insurance; or (b) the Policyholder or Employer require all eligible Members to have insurance and to pay all or part of the premium for insurance.

Physical Disease means a physical disease entity or process that produces structural or functional changes in the body as diagnosed by a Physician.

Physician means a licensed M.D. or D.O., acting within the scope of the license. Physician does not include you or your spouse, or the brother, sister, parent, or child of either you or your spouse.

Pregnancy means your pregnancy, childbirth, or related medical conditions, including complications caused by pregnancy.

Prior Plan means your Employer's group long term disability insurance plan in effect on the day before the effective date of your Employer's participation under the Group Policy and which is replaced by coverage under the Group Policy.

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