Solicitation 565-11734

Actuarial Services for Self-Funded Medical & Pharmacy Plans

Bid Designation: Public

CITY OF FORT LAUDERDALE

City of Fort Lauderdale

Bid 565-11734
Actuarial Services for Self-Funded Medical & Pharmacy Plans

Bid Number	**565-11734**
Bid Title	**Actuarial Services for Self-Funded Medical & Pharmacy Plans**
Bid Start Date	**Mar 30, 2016 6:01:51 PM EDT**
Bid End Date	**Apr 28, 2016 2:00:00 PM EDT**
Question & Answer End Date	**Apr 19, 2016 5:00:00 PM EDT**

Bid Contact **AnnDebra Diaz**
Procurement Specialist II
Procurement
954-828-5949
adiaz@fortlauderdale.gov

Addendum # 1

New Documents	**Copy of employee census 4-2016.xls**

Description

The City of Fort Lauderdale, Florida (City) is seeking qualified, experienced and licensed firm(s) to provide actuarial services for the City's self-funded Medical and Pharmacy Plans for the Department of Human Resources, Employee Benefits Section, in accordance with the terms, conditions, and specifications contained in this Request for Proposals (RFP).
For further information, go to www.bidsync.com

City of Fort Lauderdale
Actuarial Services for Self-Funded
Medical & Pharmacy Plans
RFP # 565-11734

SECTION 1 – INTRODUCTION AND INFORMATION

1.1 Purpose

The City of Fort Lauderdale, Florida (City) is seeking qualified, experienced and licensed firm(s) to provide actuarial services for the City's self-funded Medical and Pharmacy Plans for the Department of Human Resources, Employee Benefits Section, in accordance with the terms, conditions, and specifications contained in this Request for Proposals (RFP).

1.2 Submission Deadline

Sealed proposals shall be delivered during the City's normal business hours in a sealed envelope and addressed to the City of Fort Lauderdale Procurement Services Division, 100 N. Andrews Avenue, #619, Fort Lauderdale, FL 33301 (City Hall) no later than the date and time specified, at which time and place the proposals will be publicly opened and the names of the firms will be read. After the deadline, proposals will not be accepted. Firms are responsible for making certain that their proposal is received at the location specified by the due date and time. The City of Fort Lauderdale is not responsible for delays caused by any mail, package or courier service, including the U.S. mail, or caused by any other occurrence or condition. The City's normal business hours are Monday through Friday, 8:00 a.m. through 5:00 p.m. excluding holidays observed by the City.

1.3 Pre-proposal Conference and Site Visit

There will not be a pre-bid conference or site visit for this Request for Proposal.

1.4 BidSync

The City of Fort Lauderdale uses BidSync (www.bidsync.com) to administer the competitive solicitation process, including but not limited to soliciting proposals, issuing addenda, posting results and issuing notification of an intended decision. There is no charge to register and download the RFP from BidSync. Proposers are strongly encouraged to read the various vendor Guides and Tutorials available in BidSync well in advance of their intention of submitting a proposal to ensure familiarity with the use of BidSync. The City shall not be responsible for a Proposers inability to submit a Proposal by the end date and time for any reason, including issues arising from the use of BidSync.

1.5 Point of Contact

For information concerning procedures for responding to this solicitation, contact Senior Procurement Specialist AnnDebra Diaz at (954) 828-5949 or email at adiaz@fortlauderdale.gov. Such contact shall be for clarification purposes only.

For information concerning technical specifications, please utilize the question / answer feature provided by BidSync at www.bidsync.com. Questions of a material nature must be received prior to the cut-off date specified in the RFP Schedule. Material changes, if any, to the scope of services or bidding procedures will only be transmitted by written addendum. (See addendum section of BidSync Site). Contractor's please note: Proposals shall be submitted as stated in PART IV – Submittal Requirements. No part of your proposal can be submitted via FAX. No variation in price or conditions shall be permitted based upon a claim of ignorance. Submission of a proposal will be considered evidence that the Contractor has familiarized themselves with the nature and extent of the work, and the equipment, materials, and labor required. The entire proposal must be submitted in accordance with all

specifications contained in this solicitation. The questions and answers submitted in BidSync shall become part of any contract that is created from this RFP.

END OF SECTION

SECTION 2 – SPECIAL TERMS AND CONDITIONS

2.1 General Conditions

RFP General Conditions (Form G-107, Rev. 02/15) are included and made a part of this RFP.

2.2 Addenda, Changes, and Interpretations

It is the sole responsibility of each firm to notify the City utilizing the question / answer feature provided by BidSync and request modification or clarification of any ambiguity, conflict, discrepancy, omission or other error discovered in this competitive solicitation. Requests for clarification, modification, interpretation, or changes must be received prior to the Question and Answer (Q & A) Deadline. Requests received after this date may not be addressed. Questions and requests for information that would not materially affect the scope of services to be performed or the solicitation process will be answered within the question / answer feature provided by BidSync and shall be for clarification purposes only. Material changes, if any, to the scope of services or the solicitation process will only be transmitted by official written addendum issued by the City and uploaded to BidSync as a separate addendum to the RFP. Under no circumstances shall an oral explanation given by any City official, officer, staff, or agent be binding upon the City and should be disregarded. All addenda are a part of the competitive solicitation documents and each firm will be bound by such addenda. It is the responsibility of each to read and comprehend all addenda issued.

2.3 Changes and Alterations

Consultant may change or withdraw a Proposal at any time prior to Proposal submission deadline; however, no oral modifications will be allowed. Modifications shall not be allowed following the Proposal deadline.

2.4 Proposer's Costs

The City shall not be liable for any costs incurred by proposers in responding to this RFP.

2.5 Pricing/Delivery

All pricing should be identified on the Cost Proposal page provided in this RFP. No additional costs may be accepted, other than the costs stated on the Cost Proposal page. Failure to use the City's Cost Proposal page and provide costs as requested in this RFP may deem your proposal non-responsive.

Prices proposed shall be valid for at least One-Hundred and Twenty (120) days from time of RFP opening unless otherwise extended and agreed upon by the City and proposer.

2.6 Invoices/Payment

The City will accept invoices no more frequently than once per month. Each invoice shall fully detail the related costs including itemized billed hours, dates of services, hourly rate, service rendered, and shall specify the status of the particular task or project as of the date of the invoice with regard to the accepted schedule for that task or project. Payment will be made within forty-five (45) days after receipt of an invoice acceptable to the City, in accordance with the Florida Local Government Prompt Payment Act. Invoices must be received in a timely manner, for monthly billing, no later than 15 days following the month in which approved services were rendered. If, at any time during the contract, the City shall not approve or accept the Contractor's work product, and agreement cannot be reached between the City and the Contractor to resolve the problem to the City's satisfaction, the City shall negotiate with the Contractor on a payment for the work completed and usable to the City.

2.7 Related Expenses/Travel Expenses

All costs including travel are to be included in your proposal. The City will not accept any additional costs.

2.8 Payment Method

The City of Fort Lauderdale has implemented a Procurement Card (P-Card) program which changes how payments are remitted to its vendors. The City has transitioned from traditional paper checks to payment by credit card via MasterCard or Visa. This allows you as a vendor of the City of Fort Lauderdale to receive your payment fast and safely. No more waiting for checks to be printed and mailed. Payments will be made utilizing the City's P-Card (MasterCard or Visa). Accordingly, firms must presently have the ability to accept credit card payment or take whatever steps necessary to implement acceptance of a credit card before the commencement of a contract. See Contract Payment Method form attached.

2.9 Mistakes

The proposer shall examine this RFP carefully. The submission of a Proposal shall be prima facie evidence that the proposer has full knowledge of the scope, nature, and quality of the work to be performed; the detailed requirements of the specifications; and the conditions under which the work is to be performed. Ignorance of the requirements will not relieve the Proposer from liability and obligations under the Contract.

2.10 Acceptance of Proposals / Minor Irregularities

2.10.1 The City reserves the right to accept or reject any or all proposals, part of proposals, and to waive minor irregularities or variances to specifications contained in proposals which do not make the proposal conditional in nature and minor irregularities in the solicitation process. A minor irregularity shall be a variation from the solicitation that does not affect the price of the contract or does not give a respondent an advantage or benefit not enjoyed by other respondents, does not adversely impact the interests of other firms or, does not affect the fundamental fairness of the solicitation process. The City also reserves the right to reissue a Request for Proposal.

2.10.2 The City reserves the right to disqualify Proposer during any phase of the competitive solicitation process and terminate for cause any resulting contract upon evidence of collusion with intent to defraud or other illegal practices on the part of the Proposer.

2.11 Modification of Services

2.11.1 While this contract is for services provided to the department referenced in this Request for Proposals, the City may require similar work for other City departments. Successful Proposer agrees to take on such work unless such work would not be considered reasonable or become an undue burden to the Successful Proposer.

2.11.2 The City reserves the right to delete any portion of the work at any time without cause, and if such right is exercised by the City, the total fee shall be reduced in the same ratio as the estimated cost of the work deleted bears to the estimated cost of the work originally planned. If work has already been accomplished and approved by the City on any portion of a contract resulting from this RFP, the Successful Proposer shall be paid for the work completed on the basis of the estimated percentage of completion of such portion to the total project cost.

2.11.3 The City may require additional items or services of a similar nature, but not specifically listed in the contract. The Successful Proposer agrees to provide such

items or services, and shall provide the City prices on such additional items or services based upon a formula or method, which is the same or similar to that used in establishing the prices in his proposal. If the price(s) offered are not acceptable to the City, and the situation cannot be resolved to the satisfaction of the City, the City reserves the right to procure those items or services from other vendors, or to cancel the contract upon giving the Successful Proposer thirty (30) days written notice.

2.11.4 If the Successful Proposer and the City agree on modifications or revisions to the task elements, after the City has approved work to begin on a particular task or project, and a budget has been established for that task or project, the Successful Proposer will submit a revised budget to the City for approval prior to proceeding with the work.

2.12 No Exclusive Contract

Proposer agrees and understands that the contract shall not be construed as an exclusive arrangement and further agrees that the City may, at any time, secure similar or identical services from another vendor at the City's sole option.

2.13 Sample Contract Agreement

A sample of the formal agreement template, which may be required to be executed by the awarded vendor can be found at our website http://fortlauderdale.gov/purchasing/AWARDS/CONTRACT_TEMPLATE_SERVICES.pdf. Proposers are encouraged to review the City's sample contract and provide any deviations or provide any changes with their proposal. No changes to contract language will be accepted or contemplated from proposers after the submission deadline.

2.14 Responsiveness

In order to be considered responsive to the solicitation, the firm's proposal shall fully conform in all material respects to the solicitation and all of its requirements, including all form and substance.

2.15 Responsibility

In order to be considered as a responsible firm, firm shall be fully capable to meet all of the requirements of the solicitation and subsequent contract, must possess the full capability, including financial and technical, to perform as contractually required, and must be able to fully document the ability to provide good faith performance.

2.16 Minimum Qualifications

Proposers shall be in the business of providing certified actuarial services and must possess sufficient financial support, equipment and organization to ensure that it can satisfactorily perform the services if awarded a Contract. Proposers must demonstrate that they, or the principals assigned to the project, have successfully provided services with similar magnitude to those specified in the scope of services to at least two public entities similar in size and complexity to the City of Fort Lauderdale or can demonstrate they have the experience with large scale private sector clients and the managerial and financial ability to successfully perform the work.

Proposers shall satisfy each of the following requirements cited below. Failure to do so may result in the proposal being deemed non-responsive.

2.16.1 Proposer or principals shall have at least ten (10) years of certified actuarial services experience. Project manager assigned to the work must have a minimum of ten (10) years' experience in certified actuarial services and have served as project manager on similar projects on a minimum of three previous occasions.

2.16.2 Before awarding a contract, the City reserves the right to require that a Contractor submit such evidence of qualifications as the City may deem necessary. Further, the City may consider any evidence of the financial, technical, and other qualifications and abilities of a firm or principals, including previous experiences of same with the City and performance evaluation for services, in making the award in the best interest of the City.

2.16.3 Firm or principals shall have no record of judgments, pending lawsuits against the City or criminal activities involving moral turpitude and not have any conflicts of interest that have not been waived by the City Commission.

2.16.4 Neither firm nor any principal, officer, or stockholder shall be in arrears or in default of any debt or contract involving the City, (as a party to a contract, or otherwise); nor have failed to perform faithfully on any previous contract with the City.

2.16.5 Firm and those performing the work must be appropriately licensed and registered in the State of Florida.

2.17 Lobbying Activities

Any contractor submitting a response to this solicitation must comply, if applicable, with City of Fort Lauderdale Ordinance No. C-00-27 & Resolution No. 07-101, Lobbying Activities. Copies of Ordinance No. C-00-27 and Resolution No. 07-101 may be obtained from the City Clerk's Office on the 7th Floor of City Hall, 100 N. Andrews Avenue, Fort Lauderdale, Florida. The ordinance may also be viewed on the City's website at: http://www.fortlauderdale.gov/clerk/LobbyistDocs/lobbyist_ordinance.pdf .

2.18 Local Business Preference

2.18.1 Section 2-199.2, Code of Ordinances of the City of Fort Lauderdale, provides for a local business preference. In order to be considered for a local business preference, a proposer must include the Local Business Preference Certification Statement of this RFP, as applicable to the local business preference class claimed at the time of Proposal submittal:

2.18.2 Upon formal request of the City, based on the application of a Local Business Preference the Proposer shall within ten (10) calendar days submit the following documentation to the Local Business Preference Class claimed:

1. Copy of City of Fort Lauderdale current year business tax receipt, or Broward County current year business tax receipt, and

2. List of the names of all employees of the proposer and evidence of employees' residence within the geographic bounds of the City of Fort Lauderdale or Broward County, as the case may be, such as current Florida driver license, residential utility bill (water, electric, telephone, cable television), or other type of similar documentation acceptable to the City.

2.18.3 Failure to comply at time of Proposal submittal shall result in the Proposer being found ineligible for the local business preference.

2.18.4 The complete local business preference ordinance may be found on the City's web site at the following link: http://www.fortlauderdale.gov/home/showdocument?id=6422

2.18.5 Definitions

The term "Business" shall mean a person, firm, corporation or other business entity which is duly licensed and authorized to engage in a particular work in the State of Florida. Business shall be broken down into four (4) types of classes:

1. Class A Business – shall mean any Business that has established and agrees to maintain a permanent place of business located in a non-residential zone and staffed with full-time employees within the limits of the City and shall maintain a staffing level of the prime contractor for the proposed work of at least fifty percent (50%) who are residents of the City.
2. Class B Business – shall mean any Business that has established and agrees to maintain a permanent place of business located in a non-residential zone and staffed with full-time employees within the limits of the City or shall maintain a staffing level of the prime contractor for the proposed work of at least fifty percent (50%) who are residents of the City.
3. Class C Business – shall mean any Business that has established and agrees to maintain a permanent place of business located in a non-residential zone and staffed with full-time employees within the limits of Broward County.
4. Class D Business – shall mean any Business that does not qualify as either a Class A, Class B, or Class C business.

2.19 Protest Procedure

2.19.1 Any Proposer or Bidder who is not recommended for award of a contract and who alleges a failure by the city to follow the city's procurement ordinance or any applicable law may protest to the director of procurement services division (director), by delivering a letter of protest to the director within five (5) days after a notice of intent to award is posted on the city's web site at the following link: http://www.fortlauderdale.gov/purchasing/notices_of_intent.htm

2.19.2 The complete protest ordinance may be found on the city's web site at the following link: http://www.fortlauderdale.gov/purchasing/protestordinance.pdf

2.20 Public Entity Crimes

Contractor, by submitting a proposal attests she/he/it has not been placed on the convicted vendor list. 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 proposal on a contract to provide any goods or services to a public entity, may not submit a proposal on a contract with a public entity for the construction or repair of a public building or public work, may not submit proposals 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, Florida Statutes, for Category Two for a period of 36 months from the date of being placed on the convicted vendor list.

2.21 Subcontractors

2.21.1 If the Contractor proposes to use subcontractors in the course of providing these services to the City, this information shall be a part of the bid response. Such information shall be subject to review, acceptance and approval of the City, prior to any contract award. During the bidding process and after award, the City reserves the right to approve or disapprove of any subcontractor candidate in its best interest and to require Contractor to replace subcontractor with one that meets City approval.

2.21.2 Contractor shall ensure that all of Contractor's subcontractors perform in accordance with the terms and conditions of this Contract. Contractor shall be fully responsible for all of Contractor's subcontractors' performance, and liable for any of Contractor's subcontractors' non-performance and all of Contractor's subcontractors' acts and omissions. Contractor shall defend, at Contractor's expense, counsel being subject to the City's approval or disapproval, and indemnify and hold harmless the City and the City's officers, employees, and agents from and against any claim, lawsuit, third-party action, or judgment, including any award of attorney fees and any award of costs, by or in favor of any Contractor's subcontractors for payment for work performed for the City.

2.21.3 Contractor shall require all of its subcontractors to provide the required insurance coverage as well as any other coverage that the contractor may consider necessary, and any deficiency in the coverage or policy limits of said subcontractors will be the sole responsibility of the contractor.

2.22 Insurance Requirements

2.22.1 The Contractor shall furnish proof of insurance requirements as indicated below. The coverage is to remain in force at all times during the contract period. The following minimum insurance coverage is required. The City is to be added as an "additional insured" with relation to General Liability Insurance. This MUST be written in the description section of the insurance certificate, even if you have a check-off box on your insurance certificate. Any costs for adding the City as "additional insured" will be at the contractor's expense.

2.22.2 The City of Fort Lauderdale shall be given notice 10 days prior to cancellation or modification of any stipulated insurance. The insurance provided shall be endorsed or amended to comply with this notice requirement. In the event that the insurer is unable to accommodate, it shall be the responsibility of the Contractor to provide the proper notice. Such notification will be in writing by registered mail, return receipt requested and addressed to the Procurement Services Division.

2.22.3 The Contractor's insurance must be provided by an A.M. Best's "A-" rated or better insurance company authorized to issue insurance policies in the State of Florida, subject to approval by the City's Risk Manager. Any exclusions or provisions in the insurance maintained by the contractor that precludes coverage for work contemplated in this RFP shall be deemed unacceptable, and shall be considered breach of contract.

Workers' Compensation and Employers' Liability Insurance

Limits: Workers' Compensation – Per Florida Statute 440
Employers' Liability - $500,000

Any firm performing work on behalf of the City of Fort Lauderdale must provide Workers' Compensation insurance. Exceptions and exemptions will be allowed by the City's Risk Manager, if they are in accordance with Florida Statute. For additional information contact the Department of Financial Services, Workers' Compensation Division at (850) 413-1601 or on the web at www.fldfs.com.

Commercial General Liability Insurance

Covering premises-operations, products-completed operations, independent contractors and contractual liability.

Limits: Combined single limit bodily injury/property damage $1,000,000. This coverage must include, but not limited to:

a. Coverage for the liability assumed by the contractor under the indemnity provision of the contract.
b. Coverage for Premises/Operations
c. Products/Completed Operations
d. Broad Form Contractual Liability
e. Independent Contractors

Automobile Liability Insurance

Covering all owned, hired and non-owned automobile equipment.

Limits: Bodily injury	$250,000 each person, $500,000 each occurrence
Property damage	$100,000 each occurrence

Professional Liability (Errors & Omissions)

Consultants
Limits: $2,000,000 per occurrence

2.22.4 A copy of **ANY** current Certificate of Insurance should be included with your proposal.

2.22.5 In the event that you are the successful Proposer, you will be required to provide a certificate naming the City as an "additional insured" for General Liability. Certificate holder should be addressed as follows:

City of Fort Lauderdale
Procurement Services Division
100 N. Andrews Avenue, Room 619
Fort Lauderdale, FL 33301

2.23 Award of Contract

A Contract (the "Agreement") may be awarded by the City Commission. The City reserves the right to execute or not execute, as applicable, a contract with the Proposer(s) that is determined to be in the City's best interests. The City reserves the right to award a contract to more than one Proposer, at the sole and absolute discretion of the in the City.

2.24 Unauthorized Work

The Successful Proposer(s) shall not begin work until a Contract has been awarded by the City Commission and a purchase order or notice to proceed has been issued. Proposer(s) agree and understand that the issuance of a Purchase Order and/or Task Order shall be issued and provided to the Successful Proposer(s) following Commission award; however, receipt of a purchase order and/or task order shall not prevent the Successful Proposer(s) from commencing the work once the City Commission has awarded the contract and notice to proceed is issued.

2.25 Uncontrollable Circumstances ("Force Majeure")

The City and Contractor will be excused from the performance of their respective obligations under this agreement when and to the extent that their performance is delayed or prevented by any circumstances beyond their control including, fire, flood, explosion, strikes or other labor disputes, act of God or public emergency, war, riot, civil commotion, malicious damage, act or omission of any governmental authority, delay or failure or shortage of any type of transportation, equipment, or service from a public utility needed for their performance, provided that:

2.25.1 The non performing party gives the other party prompt written notice describing the particulars of the Force Majeure including, but not limited to, the nature of the occurrence and its expected duration, and continues to furnish timely reports with respect thereto during the period of the Force Majeure;

2.25.2 The excuse of performance is of no greater scope and of no longer duration than is required by the Force Majeure;

2.25.3 No obligations of either party that arose before the Force Majeure causing the excuse of performance are excused as a result of the Force Majeure; and

2.25.4 The non performing party uses its best efforts to remedy its inability to perform.

Notwithstanding the above, performance shall not be excused under this Section for a period in excess of two (2) months, provided that in extenuating circumstances, the City may excuse performance for a longer term. Economic hardship of the Contractor will not constitute Force Majeure. The term of the agreement shall be extended by a period equal to that during which either party's performance is suspended under this Section.

2.26 Canadian Companies

The City may enforce in the United States of America or in Canada or in both countries a judgment entered against the Contractor. The Contractor waives any and all defenses to the City's enforcement in Canada, of a judgment entered by a court in the United States of America. All monetary amounts set forth in this Contract are in United States dollars.

2.27 News Releases/Publicity

News releases, publicity releases, or advertisements relating to this contract or the tasks or projects associated with the project shall not be made without prior City approval.

2.28 Contract Period

The initial contract term shall commence upon date of award by the City, and shall expire December 31, 2017. The City reserves the right to extend the contract for four (4) additional one (1) year periods, providing all terms conditions and specifications remain the same, both

parties agree to the extension, and such extension is approved by the City.

In the event services are scheduled to end because of the expiration of this contract, the Contractor shall continue the service upon the request of the City as authorized by the awarding authority. The extension period shall not extend for more than one hundred twenty (120) days beyond the expiration date of the existing contract. The Contractor shall be compensated for the service at the rate in effect when this extension clause is invoked by the City.

2.29 Cost Adjustments

Prices quoted shall be firm for the initial contract term through December 31, 2017. No cost increases shall be accepted in this initial contract term. Please consider this when providing pricing for this request for proposal.

Thereafter, any extensions which may be approved by the City shall be subject to the following: costs for any extension terms shall be subject to an adjustment only if increases or decreases occur in the industry. Such adjustment shall be based on the latest yearly percentage increase in the All Urban Consumers Price Index (CPI-U) as published by the Bureau of Labor Statistics, U.S. Dep't. of Labor, and shall not exceed five percent (5%).

The yearly increase or decrease in the CPI shall be that latest Index published and available for the calendar year ending 12/31, prior to the end of the contract year then in effect, as compared to the index for the comparable month, one-year prior.

Any requested adjustment shall be fully documented and submitted to the City at least ninety (90) days prior to the contract anniversary date. Any approved cost adjustments shall become effective on the beginning date of the approved contract extension.

The City may, after examination, refuse to accept the adjusted costs if they are not properly documented, or considered to be excessive, or if decreases are considered to be insufficient. In the event the City does not wish to accept the adjusted costs and the matter cannot be resolved to the satisfaction of the City, the Contract will be considered cancelled on the scheduled expiration date.

2.30 Service Test Period

If the Contractor has not previously performed the services to the City, the City reserves the right to require a test period to determine if the Contractor can perform in accordance with the requirements of the contact, and to the City's satisfaction. Such test period can be from thirty to ninety days, and will be conducted under all specifications, terms and conditions contained in the contract. This trial period will then become part of the initial contract period.

A performance evaluation will be conducted prior to the end of the test period and that evaluation will be the basis for the City's decision to continue with the Contractor or to select another Contractor (if applicable).

2.31 Contract Coordinator

The City may designate a Contract Coordinator whose principal duties shall be:

Liaison with Contractor.
Coordinate and approve all work under the contract.
Resolve any disputes.

Assure consistency and quality of Contractor's performance.
Schedule and conduct Contractor performance evaluations and document findings.
Review and approve for payment all invoices for work performed or items delivered.

2.32 Contractor Performance Reviews and Ratings

The City Contract Coordinator may develop a Contractor performance evaluation report. This report shall be used to periodically review and rate the Contractor's performance under the contract with performance rating as follows:

Excellent	Far exceeds requirements.
Good	Exceeds requirements
Fair	Just meets requirements.
Poor	Does not meet all requirements and contractor is subject to penalty provisions under the contact.
Non-compliance	Either continued poor performance after notice or a performance level that does not meet a significant portion of the requirements. This rating makes the Contractor subject to the default or cancellation for cause provisions of the contract.

The report shall also list all discrepancies found during the review period. The Contractor shall be provided with a copy of the report, and may respond in writing if he takes exception to the report or wishes to comment on the report. Contractor performance reviews and subsequent reports will be used in determining the suitability of contract extension.

2.33 Substitution of Personnel

It is the intention of the City that the Contractor's personnel proposed for the contract will be available for the contract term. In the event the Contractor wishes to substitute personnel, he shall propose personnel of equal or higher qualifications and all replacement personnel are subject to City approval. In the event substitute personnel are not satisfactory to the City and the matter cannot be resolved to the satisfaction of the City, the City reserves the right to cancel the Contract for cause. See Section 5.09 General Conditions.

END OF SECTION

SECTION 3 - TECHNICAL SPECIFICATIONS/SCOPE OF SERVICES

3.1 Overview

The City of Fort Lauderdale, Florida (City) is seeking proposals from qualified proposers, herein referred to as the Contractor, to provide actuarial services for the City's Human Resources Department, Risk Management Division, Employee Benefits Section, in accordance with the terms, conditions and specifications contained in this Request for Proposals (RFP).

The City of Fort Lauderdale's group health plan, including pharmacy benefits, has been self-funded since September 1, 2000. Cigna was selected as the Third Party Administrator (TPA) and Pharmacy Benefit Manager (PBM) effective 1/1/12. It includes a specific reinsurance policy also provided by Cigna. The prior health plan administrator was AvMed and the PBM administration was performed by Express Scripts.

The self-funded health (medical and pharmacy) plan is funded jointly by contributions from the City, employees, retirees and COBRA beneficiaries. The benefits are based on a calendar year and the City operates on an October 1 fiscal year. The annual actuary plan certification is based on the fiscal year. Contributions by active employees are collectively bargained based on a defined contribution model that varies by bargaining group. The employees are represented by four labor unions - Teamsters, Federation, IAFF Local 765 and Fraternal Order of Police (FOP) Lodge 31. Police Officers are provided medical and dental coverage exclusively through the FOP.

Attachment 1 includes: a) the 2014-2016 employee and City contributions for the various employee groups, b) FY 2015 Health Revenues vs Expenses, c) FY 2016 Health Revenues vs Expenses through December 2015, d) City of Fort Lauderdale Self-funded Health Plan Overview.

The self-funded plan includes three options: two open access in-network plans and a consumer-driven health plan (CDHP) option that includes a health reimbursement account (HRA) for active employees. Attachment 2 includes the certificates of coverage for each option. The CDHP/HRA plan participation is 47% of the total eligible employees participating in the plan. The CDHP/HRA plan was implemented effective January 1, 2013. Retired employees may continue medical and dental coverage through the retiree group at their expense. However, the City does not include HRA funding for retirees.

The City implemented a near-site Health and Wellness Center in December 2012, administered by Marathon Health, a nationally recognized Health Center Administrator.

3.2 Scope of Services

3.2.1 Prepare annual Actuarial Certification and exhibits as required by Florida Statute 112.08 (rate sufficiency certification) based on the City's fiscal year and annually filed by December 30th. A member of the American Academy of Actuaries or an Associate, Society of Actuaries, must sign the certification.

3.2.2 Upon request, prepare a written actuarial analysis of claim liability for the entire plan (medical and prescription drugs) broken out by employee group and plan option.

3.2.3 Use standard actuarial methods to provide evaluation of entire plan and make recommendations to the City for January 1 rate and benefit renewals 120 days prior to open enrollment each year. Calculate group specific employee and dependent rates and rate equivalents for retirees, COBRA beneficiaries and special groups for the self-funded medical plans.

3.2.4 Prepare forecasts of expected claims, develop overall health and pharmacy trends of the plan experience, estimate Incurred But Not Reported (IBNR) amounts as requested. The actuary shall be responsible for reviewing outstanding reserves and IBNR estimates to assure that the City has established adequate reserves for each of the major types of exposures and estimate of the present value of current reserves for claims.

3.2.5 Analyze historical loss and industry data to calculate future benefit payments in order to evaluate the reasonableness of the stop-loss coverage pricing and make a recommendation on attachment point.

3.2.6 As required, the Contractor must model program costs and be prepared to:

1. Aggregate and sort the data into meaningful analysis categories for the purposes of assessing total program costs and employer and employee contributions.

2. Provide actuarially-based projections for plan design alternatives under variable enrollment assumptions, contribution strategies and benefit design changes.

3. Evaluate the cost impact of changes in plan design and recommend cost-saving options.

4. Calculate self-funded plan reserve liabilities.

5. Project effect of employee contribution changes on participation and renewal costs.

6. Prepare rate tiers for funding and employer contributions.

7. Prepare fees/rate tiers for premiums.

8. Conduct and report migration and/or selection analysis based upon plan design and employer contributions.

10. Attend strategic meetings with senior management as required by the City, to model plan design alternatives, cost impact and to support recommendations.

3.2.7 Assist in the development of the technical component of RFPs for the self-funded health plan to facilitate collection of data/reporting from proposers for analysis.

3.2.8 Assist in the formulation of technical responses to questions, of a financial nature, posed by prospective proposers to be issued via Addenda to RFP.

3.2.9 Analyze and report financial data provided in response to RFPs for the self-funded health plans for accuracy, including performing re-pricing analyses of claims including discounts. Budgetary and Commission processes often dictate that this analysis be performed under tight deadlines. Contractor is required to respond to ad hoc requests for data or analysis and present technical reports to the City Commission and senior management.

3.2.10 Analyze and report health plan and City Health Center claims and utilization for the purpose of identifying return on investment (ROI) for health center operation and the health center's impact on plan spend.

3.2.11 Analyze and report the financial impact of the Affordable Care Act on health plan costs and benefit requirements. Provide guidance on and calculate Transitional Reinsurance program assessment fee. Provide actuarial costing of legislative proposals for mandated benefit programs.

3.2.12 Provide actuarial services which may be necessary as a result of legislative changes.

3.2.13 Contractor must follow HIPAA guidelines and be willing to sign the City's Business Associate Agreement which is attached as Attachment 3.

3.3 Qualifications and Experience

3.3.1 Contractor must be a certified actuary whose primary practice is in the field of health and pharmacy benefits. The contractor must be a current member of the American Academy of Actuaries and an Associate or Fellow of the Society of Actuaries and fully compliant with all continuing education requirements. Documentation of this information must be submitted in the contractor's proposal

The actuarial firm's personnel assigned to this project must have first-hand experience in preparing Actuarial Certification and State exhibits required by Florida Statute 112.08 (rate sufficiency certification) and the evaluation and assessment of the reserving practices of governmental entities of similar size and complexities. Resumes of personnel who will be assigned to this project must be included.

3.3.2. The assigned certified Actuary must have at least 10 years of experience providing self-funded health and pharmacy actuarial services to governmental entities.

3.3.3 The contractor must have the appropriate software to accept the data transfers and perform required services and have the ability to accept electronic data from the health plan TPA, PBM, Benefits Consultant and City Health Center.

3.3.4 The Contractor must be a current Member of the American Academy of Actuaries and Fellow, Society of Actuaries.

END OF SECTION

SECTION 4 – SUBMITTAL REQUIREMENTS

4.1 Instructions

4.1.1 Although proposals are accepted 'hard copy', the City of Fort Lauderdale uses Bidsync (www.bidsync.com) to administer the competitive solicitation process, including but not limited to soliciting proposals, issuing addenda, responding to questions / requests for information. There is no charge to register and download the RFP from Bidsync. Proposers are strongly encouraged to read the various vendor Guides and Tutorials available in Bidsync well in advance of their intention of submitting a proposal to ensure familiarity with the use of Bidsync. The City shall not be responsible for a Proposer's inability to submit a proposal by the end date and time for any reason, including issues arising from the use of Bidsync.

4.1.2 Careful attention must be given to all requested items contained in this RFP. Proposers are invited to submit proposals in accordance with the requirements of this RFP. Please read entire solicitation before submitting a proposal. Proposers must provide a response to each requirement of the RFP. Proposals should be prepared in a concise manner with an emphasis on completeness and clarity. Notes, exceptions, and comments may be rendered on an attachment, provided the same format of this RFP text is followed.

4.1.3 All information submitted by Proposer shall be typewritten or provided as otherwise instructed to in the RFP. Proposers shall use and submit any applicable or required forms provided by the City and attach such to their proposal. Failure to use the forms may cause the proposal to be rejected and deemed non-responsive.

4.1.4 Proposals shall be submitted by an authorized representative of the firm. Proposals must be submitted in the business entities name by the President, Partner, Officer or Representative authorized to contractually bind the business entity. Proposals shall include an attachment evidencing that the individual submitting the proposal, does in fact have the required authority stated herein.

4.1.5 All proposals will become the property of the City. The Proposer's response to the RFP is a public record pursuant to Florida law, which is subject to disclosure by the City under the State of Florida Public Records Law, Florida Statutes Chapter 119.07 ("Public Records Law"). The City shall permit public access to all documents, papers, letters or other material submitted in connection with this RFP and the Contract to be executed for this RFP, subject to the provisions of Chapter 119.07 of the Florida Statutes. Any language contained in the Proposer's response to the RFP purporting to require confidentiality of any portion of the Proposer's response to the RFP, except to the extent that certain information is in the City's opinion is a Trade Secret pursuant to Florida law, shall be void. If a Proposer submits any documents or other information to the City which the Proposer claims is Trade Secret information and exempt from Florida Statutes Chapter 119.07 ("Public Records Laws"), the Proposer shall clearly designate that it is a Trade Secret and that it is asserting that the document or information is exempt. The Proposer must specifically identify the exemption being claimed under Florida Statutes 119.07. The City shall be the final arbiter of whether any information contained in the Proposer's response to the RFP constitutes a Trade Secret. The city's determination of whether an exemption applies shall be final, and the proposer agrees to defend, indemnify, and hold harmless the city and the city's

officers, employees, and agent, against any loss or damages incurred by any person or entity as a result of the city's treatment of records as public records. In the event of Contract award, all documentation produced as part of the Contract shall become the exclusive property of the City.

4.1.6 One (1) original and two (2) copies plus seven (7) electronic (soft) copies of your proposal shall be delivered in a sealed package with the RFP number, due and open date, and RFP title clearly marked on the outside by the due date and time (deadline) to the address specified in Section I, 1.2 – Submission Deadline. It is the sole responsibility of the respondent to ensure their proposal is received on or before the date and time stated, in the specified number of copies and in the format stated herein.

4.1.7 By submitting a response Proposer is confirming that the firm has not been placed on the convicted vendors list as described in Section §287.133 (2) (a) Florida Statues; that the only person(s), company or parties interested in the proposal as principals are named therein; that the proposal is made without collusion with any other person(s), company or parties submitting a proposal; that it is in all respects fair and in good faith, without collusion or fraud; and that the signer of the proposal has full authority to bind the firm.

4.2 Contents of the Proposal

The City deems certain documentation and information important in the determination of responsiveness and for the purpose of evaluating proposals. Proposals should seek to avoid information in excess of that requested, must be concise, and must specifically address the issues of this RFP. The City prefers that proposals be no more than fifty (50) pages double-sided, be bound in a soft cover binder, and utilize recyclable materials as much as practical. Elaborate binders are neither necessary nor desired. Please place the labeled DVD/CD in a paper sleeve. The proposals shall be organized and divided into the sections indicated herein. These are not inclusive of all the information that may be necessary to properly evaluate the proposal and meet the requirements of the scope of work and/or specifications. Additional documents and information should be provided as deemed appropriate by the respondent in proposal to specific requirements stated herein or through the RFP.

4.2.1 Table of Contents

The table of contents should outline in sequential order the major areas of the submittal, including enclosures. All pages should be consecutively numbered and correspond to the Table of Contents.

4.2.2 Executive Summary

Each Offeror must submit an executive summary that identifies the business entity, its background, main office(s), and office location that will service this contract. Identify the officers, principals, supervisory staff and key individuals who will be directly involved with the work and their office locations. The executive summary should also summarize the key elements of the proposal.

4.2.3 Experience and Qualifications

Indicate the firm's number of years of experience in providing the professional services as it relates the work contemplated. Provide details of past projects for agencies of similar size and scope, including information on your firm's ability to meet time and budget requirements. Indicate the firm's initiatives towards its own sustainable business practices that demonstrate a commitment to conservation. Indicate business structure, IE: Corp., Partnership, LLC. Firm should be registered as a legal entity in the

State of Florida; Minority or Woman owned Business (if applicable); Company address, phone number, fax number, E-Mail address, web site, contact person(s), etc. Relative size of the firm, including management, technical and support staff; licenses and any other pertinent information shall be submitted.

4.2.4 Approach to Scope of Work

Provide in concise narrative form, your understanding of the City's needs, goals and objectives as they relate to the project, and your overall approach to accomplishing the project. Give an overview on your proposed vision, ideas and methodology. Describe your proposed approach to the project. As part of the project approach, the proposer shall propose a scheduling methodology (time line) for effectively managing and executing the work in the optimum time. Also provide information on your firm's current workload and how this project will fit into your workload. Describe available facilities, technological capabilities and other available resources you offer for the project.

4.2.5 References

Provide at least three references, preferably government agencies, for projects with similar scope as listed in this RFP. Information should include:

- Client Name, address, contact person telephone and E-mail addresses.
- Description of work.
- Year the project was completed.
- Total cost of the project, estimated and actual.

Note: Do not include City of Fort Lauderdale work or staff as references to demonstrate your capabilities. The Committee is interested in work experience and references other than the City of Fort Lauderdale.

4.2.6 Minority/Women (M/WBE) Participation

If your firm is a certified minority business enterprise as defined by the Florida Small and Minority Business Assistance Act of 1985, provide copies of your certification(s). If your firm is not a certified M/WBE, describe your company's previous efforts, as well as planned efforts in meeting M/WBE procurement goals under Florida Statutes 287.09451.

4.2.7 Subcontractors

Proposer must clearly identify any subcontractors that may be utilized during the term of this contract.

4.2.8 Required Forms

1. **Proposal Certification**
   Complete and attach the Proposal Certification provided herein.

2. **Cost Proposal**
   Provide firm, fixed, costs for all services/products using the form provided in this request for proposal. These firm fixed costs for the project include any costs for travel and miscellaneous expenses. No other costs will be accepted.

3. **Non-Collusion Statement**
   This form is to be completed, if applicable, and inserted in this section.

4. **Local Business Preference (LBP)**
   This form is to be completed, if applicable, and inserted in this section

5. **Contract Payment Method**
   This form must be completed and returned with your proposal. Proposers must presently have the ability to accept these credit cards or take whatever steps necessary to implement acceptance of a card before the start of the contract term, or contract award by the City.

6. **Sample Insurance Certificate**
   Demonstrate your firm's ability to comply with insurance requirements. Provide a previous certificate or other evidence listing the Insurance Companies names for the required coverage and limits.

7. **Business License**
   Evidence that your firm and/or persons performing the work are licensed to do business in the State of Florida

8. **Questionnaire**
   Completion of all questions of Questionnaire, Attachment4 must be returned with your proposal.

END OF SECTION

SECTION 5 – EVALUATION AND AWARD

5.1 Evaluation Procedure

5.1.1 Bid Tabulations/Intent to Award

Notice of Intent to Award Contract/Bid, resulting from the City's formal solicitation process, requiring City Commission action, may be found at http://www.fortlauderdale.gov/purchasing/notices_of_intent.htm. Tabulations of receipt of those parties responding to a formal solicitation may be found at http://www.fortlauderdale.gov/purchasing/bidresults.htm, or any interested party may call the Procurement Office at 954-828-5933.

5.1.2 Evaluation of proposals will be conducted by an Evaluation Committee, consisting of a minimum of three members of City Staff, or other persons selected by the City Manager or designee. All committee members must be present at scheduled evaluation meetings. Proposals shall be evaluated based upon the information and references contained in the responses as submitted.

5.1.3 The Committee may short list no less than three (3) proposals, assuming that three proposals have been received, that it deems best satisfy the weighted criteria set forth herein. The committee may then conduct interviews and/or require oral presentations from the short listed Proposers. The Evaluation Committee shall then re-score and re-rank the short listed firms in accordance with the weighted criteria.

5.1.4 The City may require visits to the Proposer's facilities to inspect record keeping procedures, staff, facilities and equipment as part of the evaluation process.

5.1.5 The final ranking and the Evaluation Committee's recommendation may then be reported to the City Manager for consideration of contract award.

5.2 Evaluation Criteria

5.2.1 The City uses a mathematical formula to determine the scoring for each individual responsive and responsible firm based on the weighted criteria stated herein. Each evaluation committee member will rank each firm by criteria, giving their first ranked firm as number 1, the second ranked firm a number 2, and so on. The City shall average the ranking for each criterion, for all evaluation committee members, and then multiply that average ranking by the weighted criteria identified herein. The lowest average final ranking score will determine the recommendation by the evaluation committee to the City Manager.

5.2.2 Weighted Criteria

ABILITY TO MEET OBJECTIVES	
Understanding of the overall needs of the City for such services, as presented in the narrative proposal and Scope of Services. Understanding of and experience with analyzing the financial impact of an employee wellness center on a self-funded group health plan. This will include problem identification and the proposed method to accomplish the work required.	35%
QUALIFICATIONS	

Experience, qualifications and past performance of the proposing firm, including persons proposed to provide the services, resources and references	35%
Total Project Cost	30%
TOTAL PERCENT AVAILABLE:	100%

5.3 Contract Award

The City reserves the right to award a contract to that Proposer who will best serve the interest of the City. The City reserves the right, based upon its deliberations and in its opinion, to accept or reject any or all proposals. The City also reserves the right to waive minor irregularities or variations of the submittal requirements and RFP process.

END OF SECTION

SECTION 6 - COST PROPOSAL PAGE

Proposer Name: _____

Proposer agrees to supply the services at the prices bid below in accordance with the terms, conditions and specifications contained in this RFP.

Cost to the City: Proposer must quote firm, fixed, costs for all services identified in this request for proposal. These firm fixed costs for the project include any costs for travel and miscellaneous expenses. No other costs will be accepted.

Description	Estimated Annual Quantity		Firm, Fixed Hourly Rate		Total
Actuary	**110 hours**	**x**	**$_____/hr**	**=**	**$_____**

Submitted by:

_____ _____
Name (printed) Signature

_____ _____
Date Title

Attachment 1a) 2014 CITY OF FORT LAUDERDALE HEALTH RATES

IAFF/FIRE (City=$563/mos Medical + $39/mos Dental)	BIWEEKLY MEDICAL RATES			BIWEEKLY DENTAL	MONTHLY		
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	HUMANA DPPO	HMO1	HMO2	CDHP
EMPL ONLY	$ 121.54	$ 100.94	$ 70.04	$ 2.47	$ 263.34	$ 218.70	$ 151.75
EMPL & SPOUSE	$ 248.23	$ 207.03	$ 143.17	$ 5.04	$ 537.83	$ 448.57	$ 310.20
EMPL & CHILD	$ 163.77	$ 136.99	$ 93.73	$ 4.98	$ 354.84	$ 296.81	$ 203.08
EMPL & CHILDREN	$ 223.51	$ 186.43	$ 128.75	$ 4.98	$ 484.27	$ 403.93	$ 278.96
FAMILY	$ 345.05	$ 287.37	$ 198.79	$ 8.51	$ 747.61	$ 622.64	$ 430.71

IAFF/FIRE RETIREES	MONTHLY MEDICAL RATES			MONTHLY DENTAL RATES
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	HUMANA DPPO
EMPL ONLY	$ 835.00	$ 760.00	$ 752.00	$ 29.45
EMPL & SPOUSE	$ 1,713.00	$ 1,587.00	$ 1,542.00	$ 54.38
EMPL & CHILD	$ 1,128.00	$ 1,069.00	$ 1,016.00	$ 48.22
EMPL & CHILDREN	$ 1,546.00	$ 1,453.00	$ 1,392.00	$ 48.22
FAMILY	$ 2,382.00	$ 2,193.00	$ 2,144.00	$ 85.19

TEAMSTERS (City=$655/mos Medical)	BIWEEKLY MEDICAL RATES			BIWEEKLY DENTAL		MONTHLY		
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	Humana DHMO	Humana DPPO	HMO1	HMO2	CDHP
EMPL ONLY	$ 98.88	$ 78.28	$ 47.38	$ 7.02	$ 22.04	$ 214.24	$ 169.61	$ 102.66
EMPL & SPOUSE	$ 200.85	$ 160.68	$ 96.82	$ 12.29	$ 41.29	$ 435.18	$ 348.14	$ 209.78
EMPL & CHILD	$ 132.87	$ 106.09	$ 63.86	$ 14.75	$ 42.45	$ 287.89	$ 229.86	$ 138.36
EMPL & CHILDREN	$ 181.28	$ 144.20	$ 87.55	$ 14.75	$ 42.45	$ 392.77	$ 312.43	$ 189.69
FAMILY	$ 279.13	$ 223.51	$ 131.84	$ 20.67	$ 53.51	$ 604.78	$ 484.27	$ 285.65

MGMT/CONF/ SUPV/PROF/ TEAMSTER RETIREE	MONTHLY MEDICAL RATES			MONTHLY DENTAL RATES	
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	Humana HMO	Humana PPO
EMPL ONLY	$ 835.00	$ 760.00	$ 752.00	$ 15.21	$ 47.75
EMPL & SPOUSE	$ 1,713.00	$ 1,587.00	$ 1,542.00	$ 26.62	$ 89.47
EMPL & CHILD	$ 1,128.00	$ 1,069.00	$ 1,016.00	$ 31.95	$ 91.97
EMPL & CHILDREN	$ 1,546.00	$ 1,453.00	$ 1,392.00	$ 31.95	$ 91.97
FAMILY	$ 2,382.00	$ 2,193.00	$ 2,144.00	$ 44.78	$ 115.93

CONFIDENTIAL (City=$702/mos Medical)	BIWEEKLY MEDICAL RATES			BIWEEKLY DENTAL		MONTHLY		
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	Humana DHMO	Humana DPPO	HMO1	HMO2	CDHP
EMPL ONLY	$ 86.52	$ 66.95	$ 36.05	$ 3.51	$ 11.02	$ 187.46	$ 145.06	$ 78.11
EMPL & SPOUSE	$ 177.16	$ 135.96	$ 74.16	$ 6.15	$ 20.65	$ 383.85	$ 294.58	$ 160.68
EMPL & CHILD	$ 117.42	$ 89.61	$ 49.44	$ 7.38	$ 21.22	$ 254.41	$ 194.16	$ 107.12
EMPL & CHILDREN	$ 159.65	$ 122.57	$ 66.95	$ 7.38	$ 21.22	$ 345.91	$ 265.57	$ 145.06
FAMILY	$ 246.17	$ 188.49	$ 103.00	$ 10.33	$ 26.75	$ 533.37	$ 408.40	$ 223.17

IAFF/FIRE COBRA	MONTHLY MEDICAL RATES			MONTHLY DENTAL RATES
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	HUMANA DPPO
EMPL ONLY	$ 851.70	$ 775.20	$ 767.04	$ 30.35
EMPL & SPOUSE	$ 1,747.26	$ 1,618.74	$ 1,572.84	$ 55.47
EMPL & CHILD	$ 1,150.56	$ 1,090.38	$ 1,036.32	$ 49.19
EMPL & CHILDREN	$ 1,576.92	$ 1,482.06	$ 1,419.84	$ 49.19
FAMILY	$ 2,429.64	$ 2,236.86	$ 2,186.88	$ 86.90

MGMT-PROF-SUPV (City=$702/mos Medical)	BIWEEKLY MEDICAL RATES			BIWEEKLY DENTAL		MONTHLY		
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	Humana DHMO	Humana DPPO	HMO1	HMO2	CDHP
EMPL ONLY	$ 86.52	$ 66.95	$ 36.05	$0.00	$0.00	$ 187.46	$ 145.06	$ 78.11
EMPL & SPOUSE	$ 177.16	$ 135.96	$ 74.16	$0.00	$0.00	$ 383.85	$ 294.58	$ 160.68
EMPL & CHILD	$ 117.42	$ 89.61	$ 49.44	$0.00	$0.00	$ 254.41	$ 194.16	$ 107.12
EMPL & CHILDREN	$ 159.65	$ 122.57	$ 66.95	$0.00	$0.00	$ 345.91	$ 265.57	$ 145.06
FAMILY	$ 246.17	$ 188.49	$ 103.00	$0.00	$0.00	$ 533.37	$ 408.40	$ 223.17

MGMT/CONF/ SUPV/PROF/ TEAMSTER COBRA	MONTHLY MEDICAL RATES			MONTHLY DENTAL RATES	
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	Humana HMO	Humana PPO
EMPL ONLY	$ 851.70	$ 775.20	$ 767.04	$ 15.51	$ 48.71
EMPL & SPOUSE	$ 1,747.26	$ 1,618.74	$ 1,572.84	$ 27.15	$ 91.26
EMPL & CHILD	$ 1,150.56	$ 1,090.38	$ 1,036.32	$ 32.59	$ 93.81
EMPL & CHILDREN	$ 1,576.92	$ 1,482.06	$ 1,419.84	$ 32.59	$ 93.81
FAMILY	$ 2,429.64	$ 2,236.86	$ 2,186.88	$ 45.68	$ 118.25

VISION	ACTIVE BIWEEKLY VISION RATES
EMPL ONLY	$ 2.29
EMPL & SPOUSE	$ 4.38
EMPL & CHILD	$ 4.64
EMPL & CHILDREN	$ 4.64
FAMILY	$ 7.18

	RETIRED MONTHLY MEDICAL RATES
	$ 4.96
	$ 9.49
	$ 10.05
	$ 10.05
	$ 15.56

ADULT CHILD (26 - 30 Yrs Old)	BIWEEKLY MEDICAL RATES			MONTHLY
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	NO DENTAL
ADULT CHILD	$ 97.00	$ 93.00	$ 88.00	
	RETIREE MONTHLY MEDICAL RATES			
	$ 210.17	$ 201.50	$ 190.67	
	COBRA MONTHLY MEDICAL RATES			
	$ 214.37	$ 205.53	$ 194.48	

ALLSTATE VOLUNTARY GAP

Coverages	GAP BIWEEKLY RATES				
	EMPL ONLY	EMPL & SPOUSE	EMPL & CHILD	EMPL & CHILDREN	FAMILY
HMO < 40 YEARS	$ 12.24	$ 22.04	N/A	$ 27.08	$ 36.86
40 to 49 YEARS	$ 16.63	$ 29.95	N/A	$ 30.65	$ 43.95
50 PLUS YEARS	$ 27.76	$ 49.95	N/A	$ 44.99	$ 67.17
CDHP < 40 YEARS	$ 16.83	$ 30.31	N/A	$ 37.33	$ 50.80
40 to 49 YEARS	$ 23.04	$ 41.48	N/A	$ 42.52	$ 60.93
50 PLUS YEARS	$ 37.67	$ 67.79	N/A	$ 61.14	$ 91.24

	GAP MONTHLY RATES				
	EMPL ONLY	EMPL & SPOUSE	EMPL & CHILD	EMPL & CHILDREN	FAMILY
	$ 26.52	$ 47.75	N/A	$ 58.67	$ 79.86
	$ 36.03	$ 64.89	N/A	$ 66.41	$ 95.23
	$ 60.15	$ 108.23	N/A	$ 97.48	$ 145.54
	$ 36.47	$ 65.67	N/A	$ 80.88	$ 110.07
	$ 49.92	$ 89.87	N/A	$ 92.13	$ 132.02
	$ 81.62	$ 146.88	N/A	$ 132.47	$ 197.69

Attachment 1a) 2015 CITY OF FORT LAUDERDALE HEALTH RATES

IAFF/FIRE (City=$563/mos Medical + $39/mos Dental)	BIWEEKLY MEDICAL RATES			BIWEEKLY DENTAL	MONTHLY		
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	HUMANA DPPO	HMO1	HMO2	CDHP
EMPL ONLY	$ 125.79	$ 104.47	$ 72.49	$ 2.47	$ 272.55	$ 226.35	$ 157.06
EMPL & SPOUSE	$ 256.92	$ 214.28	$ 148.18	$ 5.04	$ 556.66	$ 464.27	$ 321.06
EMPL & CHILD	$ 169.50	$ 141.78	$ 97.01	$ 4.98	$ 367.25	$ 307.19	$ 210.19
EMPL & CHILDREN	$ 231.33	$ 192.96	$ 133.26	$ 4.98	$ 501.22	$ 418.08	$ 288.73
FAMILY	$ 357.13	$ 297.43	$ 205.75	$ 8.51	$ 773.78	$ 644.43	$ 445.79

IAFF/FIRE RETIREES	MONTHLY MEDICAL RATES			MONTHLY DENTAL RATES
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	HUMANA DPPO
EMPL ONLY	$ 845.84	$ 769.88	$ 742.72	$ 29.76
EMPL & SPOUSE	$ 1,735.28	$ 1,607.63	$ 1,523.91	$ 54.88
EMPL & CHILD	$ 1,142.67	$ 1,082.89	$ 991.07	$ 48.22
EMPL & CHILDREN	$ 1,566.10	$ 1,471.90	$ 1,371.96	$ 48.22
FAMILY	$ 2,412.96	$ 2,221.50	$ 2,133.74	$ 85.19

TEAMSTERS (City=$660/mos Medical)	BIWEEKLY MEDICAL RATES			BIWEEKLY DENTAL		MONTHLY		
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	Humana DHMO	Humana DPPO	HMO1	HMO2	CDHP
EMPL ONLY	$ 102.34	$ 81.02	$ 49.04	$ 7.02	$ 22.04	$ 221.74	$ 175.54	$ 106.25
EMPL & SPOUSE	$ 207.88	$ 166.30	$ 100.21	$ 12.29	$ 41.29	$ 450.41	$ 360.32	$ 217.12
EMPL & CHILD	$ 137.52	$ 109.80	$ 66.10	$ 14.75	$ 42.45	$ 297.96	$ 237.90	$ 143.22
EMPL & CHILDREN	$ 187.62	$ 149.25	$ 90.61	$ 14.75	$ 42.45	$ 406.51	$ 323.38	$ 196.32
FAMILY	$ 288.90	$ 231.33	$ 136.45	$ 20.67	$ 53.51	$ 625.95	$ 501.22	$ 295.64

MGMT/CONF/ SUPV/PROF/ TEAMSTER RETIREE	MONTHLY MEDICAL RATES			MONTHLY DENTAL RATES	
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	Humana HMO	Humana PPO
EMPL ONLY	$ 845.84	$ 769.88	$ 742.72	$ 15.21	$ 47.75
EMPL & SPOUSE	$ 1,735.28	$ 1,607.63	$ 1,523.91	$ 26.62	$ 89.47
EMPL & CHILD	$ 1,142.67	$ 1,082.89	$ 991.07	$ 31.95	$ 91.97
EMPL & CHILDREN	$ 1,566.10	$ 1,471.90	$ 1,371.96	$ 31.95	$ 91.97
FAMILY	$ 2,412.96	$ 2,221.50	$ 2,133.74	$ 44.78	$ 115.93

CONFIDENTIAL (City=$702/mos Medical)	BIWEEKLY MEDICAL RATES			BIWEEKLY DENTAL		MONTHLY		
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	Humana DHMO	Humana DPPO	HMO1	HMO2	CDHP
EMPL ONLY	$ 89.55	$ 69.29	$ 37.31	$ 3.51	$ 11.02	$ 194.03	$ 150.13	$ 80.84
EMPL & SPOUSE	$ 183.36	$ 140.72	$ 76.76	$ 6.15	$ 20.65	$ 397.28	$ 304.89	$ 166.31
EMPL & CHILD	$ 121.53	$ 92.75	$ 51.17	$ 7.38	$ 21.22	$ 263.32	$ 200.96	$ 110.87
EMPL & CHILDREN	$ 165.24	$ 126.86	$ 69.29	$ 7.38	$ 21.22	$ 358.02	$ 274.86	$ 150.13
FAMILY	$ 254.79	$ 195.09	$ 106.61	$ 10.33	$ 26.75	$ 552.05	$ 422.70	$ 230.99

IAFF/FIRE COBRA	MONTHLY MEDICAL RATES			MONTHLY DENTAL RATES
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	HUMANA DPPO
EMPL ONLY	$ 862.76	$ 785.28	$ 777.02	$ 30.35
EMPL & SPOUSE	$ 1,769.98	$ 1,639.78	$ 1,593.28	$ 55.47
EMPL & CHILD	$ 1,165.53	$ 1,104.54	$ 1,049.79	$ 49.19
EMPL & CHILDREN	$ 1,597.42	$ 1,501.34	$ 1,438.29	$ 49.19
FAMILY	$ 2,461.21	$ 2,265.93	$ 2,215.31	$ 86.90

MGMT-PROF-SUPV (City=$702/mos Medical)	BIWEEKLY MEDICAL RATES			BIWEEKLY DENTAL		MONTHLY		
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	Humana DHMO	Humana DPPO	HMO1	HMO2	CDHP
EMPL ONLY	$ 89.55	$ 69.29	$ 37.31	$0.00	$0.00	$ 194.03	$ 150.13	$ 80.84
EMPL & SPOUSE	$ 183.36	$ 140.72	$ 76.76	$0.00	$0.00	$ 397.28	$ 304.89	$ 166.31
EMPL & CHILD	$ 121.53	$ 92.75	$ 51.17	$0.00	$0.00	$ 263.32	$ 200.96	$ 110.87
EMPL & CHILDREN	$ 165.24	$ 126.86	$ 69.29	$0.00	$0.00	$ 358.02	$ 274.86	$ 150.13
FAMILY	$ 254.79	$ 195.09	$ 106.61	$0.00	$0.00	$ 552.05	$ 422.70	$ 230.99

MGMT/CONF/ SUPV/PROF/ TEAMSTER COBRA	MONTHLY MEDICAL RATES			MONTHLY DENTAL RATES	
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN	Humana HMO	Humana PPO
EMPL ONLY	$ 862.76	$ 785.28	$ 777.02	$ 15.21	$ 47.75
EMPL & SPOUSE	$ 1,769.98	$ 1,639.78	$ 1,593.28	$ 26.62	$ 89.47
EMPL & CHILD	$ 1,165.53	$ 1,104.54	$ 1,049.79	$ 31.95	$ 91.97
EMPL & CHILDREN	$ 1,597.42	$ 1,501.34	$ 1,438.29	$ 31.95	$ 91.97
FAMILY	$ 2,461.21	$ 2,265.93	$ 2,215.31	$ 44.78	$ 115.93

VISION	ACTIVE BIWEEKLY VISION RATES
EMPL ONLY	$ 2.29
EMPL & SPOUSE	$ 4.38
EMPL & CHILD	$ 4.64
EMPL & CHILDREN	$ 4.65
FAMILY	$ 7.18

VISION	RETIREE MONTHLY VISION RATES
EMPL ONLY	$ 4.96
EMPL & SPOUSE	$ 9.49
EMPL & CHILD	$ 10.05
EMPL & CHILDREN	$ 10.05
FAMILY	$ 15.56

ADULT CHILD (26 - 30 Yrs Old)	BIWEEKLY MEDICAL RATES		
	CIGNA HMO 1	CIGNA HMO 2	CIGNA CONSUMER DRIVEN
ADULT CHILD	$ 100.40	$ 96.26	$ 91.08
	RETIREE		
	$ 98.26	$ 94.21	$ 71.54
	COBRA MONTHLY MEDICAL RATES		
	$ 100.23	$ 96.09	$ 90.93

	MONTHLY
	NO DENTAL

ALLSTATE VOLUNTARY GAP

	GAP BIWEEKLY RATES				
Coverages	EMPL ONLY	EMPL & SPOUSE	EMPL & CHILD	EMPL & CHILDREN	FAMILY
HMO < 40 YEARS	$ 12.24	$ 22.04	$ 27.08	$ 27.08	$ 36.86
40 to 49 YEARS	$ 16.63	$ 29.95	$ 30.65	$ 30.65	$ 43.95
50 PLUS YEARS	$ 27.76	$ 49.95	$ 44.99	$ 44.99	$ 67.17
CDHP < 40 YEARS	$ 16.83	$ 30.31	$ 37.33	$ 37.33	$ 50.80
40 to 49 YEARS	$ 23.04	$ 41.48	$ 42.52	$ 42.52	$ 60.93
50 PLUS YEARS	$ 37.67	$ 67.79	$ 61.14	$ 61.14	$ 91.24

GAP MONTHLY RATES				
EMPL ONLY	EMPL & SPOUSE	EMPL & CHILD	EMPL & CHILDREN	FAMILY
$ 26.52	$ 47.75	$ 58.67	$ 58.67	$ 79.86
$ 36.03	$ 64.89	$ 66.41	$ 66.41	$ 95.23
$ 60.15	$ 108.23	$ 97.48	$ 97.48	$ 145.54
$ 36.47	$ 65.67	$ 80.88	$ 80.88	$ 110.07
$ 49.92	$ 89.87	$ 92.13	$ 92.13	$ 132.02
$ 81.62	$ 146.88	$ 132.47	$ 132.47	$ 197.69

Scenario 2

2016 Monthly Rates with 6% on HMO1 and 4% on HMO2 and CDHP Increase Adjusted for Additional City Contribution ($15 Teamster / $66 Firefighters PEPM)

	2015 Plan Enrollment			2015 Employee Rates			2016 City Contribution	2016 Employee Rates			% Change from 2015			% Plan Tier Rates		
Management	HMO1	HMO2	CDHP	HMO1	HMO2	CDHP	PEPM	HMO1	HMO2	CDHP	HMO1	HMO2	CDHP	HMO1	HMO2	CDHP
Employee	98	11	65	$194.02	$150.14	$80.84	$702.00	$205.66	$156.14	$84.08	6%	4%	4%	245%	186%	100%
Employee & Spouse	35	7	19	$397.28	$304.89	$166.30	$702.00	$421.12	$317.09	$172.96	6%	4%	4%	205%	203%	206%
Employee & Child	20	2	14	$263.31	$200.95	$110.87	$702.00	$279.11	$208.99	$115.30	6%	4%	4%	136%	134%	137%
Employee & Children	15	4	10	$358.02	$274.86	$150.14	$702.00	$379.50	$285.86	$156.14	6%	4%	4%	185%	183%	186%
Family	57	8	70	$552.04	$422.69	$230.98	$702.00	$585.16	$439.60	$240.22	6%	4%	4%	285%	282%	286%
Total = 435	**225**	**32**	**178**													

	2015 Plan Enrollment			2015 Employee Rates			2016 City Contribution	2016 Employee Rates			% Change from 2015			% Plan Tier Rates		
Teamsters	HMO1	HMO2	CDHP	HMO1	HMO2	CDHP	PEPM	HMO1	HMO2	CDHP	HMO1	HMO2	CDHP	HMO1	HMO2	CDHP
Employee	147	39	144	$216.74	$170.54	$101.25	$675.00	$214.74	$162.36	$90.30	-1%	-5%	-11%	238%	180%	100%
Employee & Spouse	58	21	36	$445.41	$355.32	$212.12	$675.00	$457.13	$354.53	$205.60	3%	0%	-3%	213%	218%	228%
Employee & Child	51	7	25	$292.96	$232.91	$138.21	$675.00	$295.54	$227.23	$128.74	1%	-2%	-7%	138%	140%	143%
Employee & Children	22	8	35	$401.52	$318.37	$191.22	$675.00	$410.61	$316.10	$183.87	2%	-1%	-4%	191%	195%	204%
Family	63	22	86	$620.95	$496.22	$290.65	$675.00	$643.21	$501.07	$287.28	4%	1%	-1%	300%	309%	318%
Total = 764	**341**	**97**	**326**													

	2015 Plan Enrollment			2015 Employee Rates			2016 City Contribution	2016 Employee Rates			% Change from 2015			% Plan Tier Rates		
Firefighters	HMO1	HMO2	CDHP	HMO1	HMO2	CDHP	PEPM	HMO1	HMO2	CDHP	HMO1	HMO2	CDHP	HMO1	HMO2	CDHP
Employee	22	2	70	$272.55	$226.36	$157.06	$629.00	$222.90	$169.41	$97.34	-18%	-25%	-38%	229%	174%	100%
Employee & Spouse	5	1	15	$556.66	$464.26	$321.06	$629.00	$524.06	$416.83	$267.90	-6%	-10%	-17%	235%	246%	275%
Employee & Child	15	0	6	$367.25	$307.20	$210.19	$629.00	$323.29	$253.49	$152.60	-12%	-17%	-27%	145%	150%	157%
Employee & Children	12	2	17	$501.22	$418.07	$288.72	$629.00	$465.29	$368.79	$234.27	-7%	-12%	-19%	209%	218%	241%
Family	25	4	78	$773.77	$644.43	$445.79	$629.00	$754.20	$604.21	$397.62	-3%	-6%	-11%	338%	357%	408%
Total = 274	**79**	**9**	**186**													

2015 City Contribution	
Management	$702.00
Teamsters	$660.00
Firefighters	$563.00

Projected Expenses 2015	$17,588,921
Projected Expenses 2016	$18,774,369
Projected Expenses Increase	**$1,185,449**
	6.74%

Projected Expenses 2016 Total	**$18,774,369**
Projected Contributions 2016 Total	**$18,145,546**
Projected City Contributions 2016	$11,920,992
Projected Employee Contributions 2016	$4,933,687
Proj. Retiree/COBRA/Other Contributions 2016	$1,290,867
PROJECTED IMPACT TO SURPLUS	**($628,823)**

2016 Equivalent Rates			
	HMO1	HMO2	CDHP
Employee	$1,099.88	$824.91	$421.62
Employee & Spouse	$1,814.80	$1,361.10	$695.67
Employee & Child	$1,264.86	$948.64	$484.86
Employee & Children	$1,539.83	$1,154.87	$590.27
Family	$1,814.80	$1,361.10	$695.67

2016 Average Monthly COLA Increase for Bottom 33.3% of Employee Salary		Monthly Difference Between 2015 and 2016 Employee Rates - Family Plan					
		HMO1	HMO2	CDHP	HMO1	HMO2	CDHP
Management	$82.00	$33.12	$16.91	$9.24	40%	21%	11%
Teamsters	$53.00	$22.26	$4.85	-$3.37	42%	9%	-6%
Firefighters	$91.00	-$19.57	-$40.22	-$48.17	-22%	-44%	-53%

Approved
BF
10/12/15

PEPM = Per Employee Per Month

City of Fort Lauderdale, Florida "Venice of America"

Attachment 1 b)

HEALTH REVENUES vs EXPENSES - FY 2015

REVENUES	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	YEAR
CONTRIBUTIONS/PREMIUMS													
G113: City Health Contributions	$937,560.92	$935,454.00	$939,760.92	$930,404.07	$949,299.57	$1,027,802.13	$1,029,980.00	$1,026,464.23	$1,018,813.28	$1,012,141.58	$1,014,451.94	$1,009,371.90	$11,831,504.54
G114: Employee Health Premiums	$306,990.25	$373,904.44	$375,974.08	$383,495.92	$380,540.60	$583,018.55	$348,678.61	$772,314.33	$354,275.61	$502,587.83	$363,250.99	$425,051.23	$5,170,082.44
G115: Retiree Health Premiums	$103,337.60	$102,660.60	$100,162.35	$99,691.48	$98,579.13	$172,731.71	$108,218.41	$100,852.18	$105,670.38	$290,616.37	($86,128.61)	$99,900.14	$1,296,291.74
G116: COBRA Health Premiums	$10,020.13	$0.00	$10,020.13	$0.00	$24,495.32	$5,943.79	$5,911.84	$4,323.28	$4,323.28	$4,275.53	$0.00	$5,364.50	$74,677.80
G118: City Life Insurance Contributions (Fed/Mgmt)	$0.00	$0.00	$0.00	$0.00	$0.00	$4,717.04	$715.11	$716.51	$720.71	$733.31	$2,035.51	$891.71	$10,529.90
N103: Investment Interest Earnings	$0.00	$0.00	$0.00	$0.00	$0.00	$4,917.94	$0.00	$7,383.81	$0.00	$0.00	$0.00	$7,837.02	$20,138.77
Total Revenue	**$1,357,908.90**	**$1,412,019.04**	**$1,425,917.48**	**$1,413,591.47**	**$1,452,914.62**	**$1,799,131.16**	**$1,493,503.97**	**$1,912,054.34**	**$1,483,803.26**	**$1,810,354.62**	**$1,293,609.83**	**$1,548,416.50**	**$18,403,225.19**

CLAIMS EXPENDITURES	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	YEAR
MEDICAL/PHARMACY CLAIMS													
5131: Medical/Pharmacy Claims	$0.00	$1,501,325.17	$1,191,848.34	$1,187,321.34	$1,530,397.95	$1,317,343.33	$1,176,044.78	$1,247,208.45	$1,131,107.61	$1,463,747.45	$1,189,482.86	$2,445,296.84	$15,381,124.12
N938: Pharmacy Rebates	$0.00	$0.00	($56,429.62)	$0.00	($422.58)	($56,417.88)	$0.00	$0.00	($47,102.11)	$0.00	$0.00	($86,723.46)	($247,095.65)
Total ClaimS Expenditures	**$0.00**	**$1,501,325.17**	**$1,135,418.72**	**$1,187,321.34**	**$1,529,975.37**	**$1,260,925.45**	**$1,176,044.78**	**$1,247,208.45**	**$1,084,005.50**	**$1,463,747.45**	**$1,189,482.86**	**$2,358,573.38**	**$15,134,028.47**

OPERATING EXPENDITURES	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	YEAR
LIFE INSURANCE EXPENDITURES													
5135: UNUM - Life Insurance Product (Employer Paid)	$0.00	$0.00	$737.80	$2,269.40	$0.00	$1,468.60	$0.00	$1,492.40	$0.00	$750.40	$1,528.80	$1,610.00	$9,857.40
Net Life Insurance Expenditures	**$0.00**	**$0.00**	**$737.80**	**$2,269.40**	**$0.00**	**$1,468.60**	**$0.00**	**$1,492.40**	**$0.00**	**$750.40**	**$1,528.80**	**$1,610.00**	**$9,857.40**
DENTAL INSURANCE EXPENDITURES													
5140: Dental Carrier Premiums (Humana)	$0.00	$103,321.76	$203,059.75	$100,620.94	$107,092.89	$106,911.52	$208,535.54	$0.00	$103,217.37	$0.00	$215,622.50	$102,504.39	$1,250,886.66
G121: City Dental Insurance Contributions (Fire)	$0.00	$0.00	$0.00	$0.00	$0.00	($103,046.16)	($7,186.89)	($8,031.86)	($6,410.26)	($6,410.26)	($6,447.55)	($6,383.16)	($143,916.14)
Net Dental Insurance Expenditures	**$0.00**	**$103,321.76**	**$203,059.75**	**$100,620.94**	**$107,092.89**	**$3,865.36**	**$201,348.65**	**($8,031.86)**	**$96,807.11**	**($6,410.26)**	**$209,174.95**	**$96,121.23**	**$1,106,970.52**
HEALTH AND WELLNESS CENTER EXPENDITURES													
5199: Other Self Ins Claims (Marathon Service Agrmt)	$0.00	$0.00	$215,664.00	$71,888.00	$71,888.00	$71,888.00	$0.00	$0.00	$215,664.00	$71,888.00	$71,888.00	$71,888.00	$862,656.00
5131: Marathon (Operating Exp Meds)	$0.00	$24,985.11	$4,335.37	$4,507.44	$2,955.85	$13,987.64	($2,471.90)	$0.00	$15,115.85	$4,205.31	$3,516.23	$10,586.94	$81,723.84
3222: Custodial Services (Sunshine Cleaning)	$0.00	$0.00	$4,600.00	$0.00	$0.00	$1,725.00	$575.00	$575.00	$575.00	$575.00	$575.00	$575.00	$9,775.00
3249: Security Services (Burglar Alarm Services)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$119.85	$0.00	$0.00	$119.85	$0.00	$0.00	$239.70
3299: Other Services (Exterminator, Misc.)	$0.00	$218.10	$337.28	$0.00	$0.00	$0.00	$72.64	$36.32	$0.00	$0.00	$0.00	$0.00	$664.34
3319: Office Space Rent (Vernon Pierce)	$7,894.96	$0.00	$7,894.96	$3,947.48	$3,947.48	$3,947.48	$3,947.48	$3,947.48	$0.00	$4,065.90	$4,365.90	$0.00	$43,959.12
3425: Building Repair Materials	$0.00	$0.00	$0.00	$0.00	$96.00	$132.32	$0.00	$36.32	$0.00	$72.64	$96.00	$132.32	$565.60
3428: Building Repair and Maintenance	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$200.00	$0.00	$0.00	$0.00	$0.00	$0.00	$200.00
3601: Electricity (FPL)	$0.00	$0.00	$424.83	$194.71	$199.54	$190.21	$228.69	$234.34	$285.31	$237.04	$1,072.01	$486.56	$3,553.24
3616: Postage	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$13.44	$13.44
3628: Telephone/Cable TV (Comcast 9043 - Business)	$0.00	$0.00	$1,238.54	$0.00	$0.00	$1,359.57	$538.51	$401.68	$0.00	$595.98	$0.00	$812.10	$4,946.38
3634: Water/Sewer/Storm (Fort Lauderdale Water)	$285.18	$0.00	$274.11	$558.99	$0.00	$198.68	$343.49	$0.00	$375.81	$198.68	$209.46	$198.68	$2,643.08
Total Health and Wellness Center Expenditures	**$8,180.14**	**$25,203.21**	**$234,769.09**	**$81,096.62**	**$79,086.87**	**$93,428.90**	**$3,553.76**	**$5,231.14**	**$232,015.97**	**$81,958.40**	**$81,722.60**	**$84,693.04**	**$1,010,939.74**
OTHER OPERATING EXPENDITURES													
5130: Health Ins Adm FF (Cigna Stop Loss)	$0.00	$0.00	$202,001.16	$67,234.44	$0.00	$68,089.84	$135,751.98	$68,618.13	$65,651.95	$68,432.00	$0.00	$134,994.31	$810,773.81
5130: Health Ins Adm FF (Cigna ASO)	$0.00	$0.00	$208,903.44	$70,114.58	$0.00	$71,044.18	$142,148.80	$71,630.31	$68,993.80	$71,399.88	$0.00	$140,936.71	$845,171.70

3199: Other Professional Services (Rhodes Insurance)	$0.00	$0.00	$2,934.38	$4,179.38	$0.00	$4,514.38	$2,158.75	$4,223.75	$0.00	$0.00	$2,951.25	$14,011.88	$34,973.77
3199: Other Professional Services (Wakely Consulting)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$7,612.50	$7,612.50
3928: Office Supplies	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$18.84	$568.76	$200.00	$36.32	$0.00	$823.92
3999: Other Supplies	$17.40	$0.00	$0.00	$0.00	$0.00	$300.00	$20.00	$0.00	($320.00)	($23.76)	$11,820.33	($11,884.29)	($70.32)
5132: Section 125 Benefits - FSA Admin Fees	$0.00	$0.00	$0.00	$3,546.00	$756.00	$1,521.00	$753.00	$0.00	$750.00	$0.00	$1,488.00	$741.00	$9,555.00
5132: Section 125 Benefits - COBRA Admin Fees	$0.00	$618.00	$0.00	$1,858.00	$630.00	$629.60	$630.80	$629.60	$627.20	$623.20	$625.60	$1,252.00	$8,124.00
5130: PPORI ACA Tax	$0.00	$0.00	$0.00	$226,064.79	$0.00	$0.00	$0.00	$0.00	$0.00	$7,436.00	$0.00	$0.00	$233,500.79
Total Other Operating Expenditures	**$17.40**	**$618.00**	**$413,838.98**	**$372,997.19**	**$1,386.00**	**$146,099.00**	**$281,463.33**	**$145,120.63**	**$136,271.71**	**$148,067.32**	**$16,921.50**	**$287,664.11**	**$1,950,465.17**
Total Operating Expenditures	**$8,197.54**	**$129,142.97**	**$852,405.62**	**$556,984.15**	**$187,565.76**	**$244,861.86**	**$486,365.74**	**$143,812.31**	**$465,094.79**	**$224,365.86**	**$309,347.85**	**$470,088.38**	**$4,078,232.83**

TOTAL REVENUES	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	YEAR
TOTAL	$1,357,908.90	$1,412,019.04	$1,425,917.48	$1,413,591.47	$1,452,914.62	$1,799,131.16	$1,493,503.97	$1,912,054.34	$1,483,803.26	$1,810,354.62	$1,293,609.83	$1,548,416.50	$18,403,225.19

TOTAL EXPENDITURES	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	YEAR
TOTAL	$8,197.54	$1,630,468.14	$1,987,824.34	$1,744,305.49	$1,717,541.13	$1,505,787.31	$1,662,410.52	$1,391,020.76	$1,549,100.29	$1,688,113.31	$1,498,830.71	$2,828,661.76	$19,212,261.30

REVENUE LESS EXPENDITURES	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	YEAR
TOTAL	$1,349,711.36	($218,449.10)	($561,906.86)	($330,714.02)	($264,626.51)	$293,343.85	($168,906.55)	$521,033.58	($65,297.03)	$122,241.31	($205,220.88)	($1,280,245.26)	($809,036.11)

City of Fort Lauderdale, Florida "Venice of America"

Attachment 1 c)

HEALTH REVENUES vs EXPENSES - FY 2016

REVENUES	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	YEAR
CONTRIBUTIONS/PREMIUMS													
G113: City Health Contributions	$1,027,870.86	$1,025,563.08	$1,026,782.42	$1,117,121.37									$4,197,337.73
G114: Employee Health Premiums	$856,030.74	$193,666.59	$419,397.92	$423,814.03									$1,892,909.28
G115: Retiree Health Premiums	$291,079.69	($82,928.01)	$105,304.60										$313,456.28
G116: COBRA Health Premiums	$2,873.41	$1,294.77	$3,510.98										$7,679.16
G118: City Life Insurance Contributions (Fed/Mgmt)	$886.11	$885.62	$1,772.64										$3,544.37
N103: Investment Interest Earnings	$0.00	$0.00	$0.00										$0.00
Total Revenue	**$2,178,740.81**	**$1,138,482.05**	**$1,556,768.56**	**$1,540,935.40**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$6,414,926.82**

CLAIMS EXPENDITURES	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	YEAR
MEDICAL/PHARMACY CLAIMS													
5131: Medical/Pharmacy Claims	$0.00	$1,563,607.63	$1,165,703.07										$2,729,310.70
N938: Pharmacy Rebates	$0.00	$0.00	($126,099.31)										($126,099.31)
Total ClaimS Expenditures	**$0.00**	**$1,563,607.63**	**$1,039,603.76**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$2,603,211.39**

OPERATING EXPENDITURES	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	YEAR
LIFE INSURANCE EXPENDITURES													
5135: UNUM - Life Insurance Product (Employer Paid)	$0.00	$0.00	$1,626.80										$1,626.80
Net Life Insurance Expenditures	**$0.00**	**$0.00**	**$1,626.80**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$1,626.80**
DENTAL INSURANCE EXPENDITURES													
5140: Dental Carrier Premiums (Humana)	$0.00	$0.00	$313,798.26										$313,798.26
G121: City Dental Insurance Contributions (Fire)	($8,658.98)	($7,114.86)	($6,399.54)										($22,173.38)
Net Dental Insurance Expenditures	**($8,658.98)**	**($7,114.86)**	**$307,398.72**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$291,624.88**
HEALTH AND WELLNESS CENTER EXPENDITURES													
5199: Other Self Ins Claims (Marathon Service Agrmt)	$0.00	$0.00	$220,839.00										$220,839.00
5131: Marathon (Operating Exp Meds)	$0.00	$0.00	$8,873.99										$8,873.99
3222: Custodial Services (Sunshine Cleaning)	$575.00	$575.00	$575.00										$1,725.00
3249: Security Services (Burglar Alarm Services)	$0.00	$119.85	$0.00										$119.85
3299: Other Services (Exterminator, Misc.)	$0.00	$0.00	$0.00										$0.00
3319: Office Space Rent (Vernon Pierce)	$8,731.80	$4,365.90	$4,365.90										$17,463.60
3425: Building Repair Materials	$0.00	$368.64	$0.00										$368.64
3428: Building Repair and Maintenance	$0.00	$0.00	$0.00										$0.00
3601: Electricity (FPL)	$241.01	$265.46	$201.51										$707.98
3616: Postage	$0.00	$0.00	$0.00										$0.00
3628: Telephone/Cable TV (Comcast 9043 - Business)	$0.00	$811.92	$0.00										$811.92
3634: Water/Sewer/Storm (Fort Lauderdale Water)	$0.00	$457.51	$235.57										$693.08
Total Health and Wellness Center Expenditures	**$9,547.81**	**$6,964.28**	**$235,090.97**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$251,603.06**
OTHER OPERATING EXPENDITURES													
5130: Health Ins Adm FF (Cigna Stop Loss)	$0.00	$0.00	$209,658.54										$209,658.54
5130: Health Ins Adm FF (Cigna ASO)	$0.00	$0.00	$218,913.86										$218,913.86

3199: Other Professional Services (Rhodes Insurance)	$5,020.63	$0.00	$0.00										$5,020.63
3199: Other Professional Services (Wakely Consulting)	$0.00	$0.00	$0.00										$0.00
3928: Office Supplies	$6.14	$0.00	$0.00										$6.14
3999: Other Supplies	$639.56	$291.99	($843.44)										$88.11
5132: Section 125 Benefits - FSA Admin Fees	$0.00	$0.00	$1,479.00										$1,479.00
5132: Section 125 Benefits - COBRA Admin Fees	$0.00	$0.00	$1,250.40										$1,250.40
5130: PPORI ACA Tax	$0.00	$0.00	$0.00										$0.00
Total Other Operating Expenditures	**$5,666.33**	**$291.99**	**$430,458.36**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$436,416.68**
Total Operating Expenditures	**$6,555.16**	**$141.41**	**$974,574.85**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$981,271.42**

TOTAL REVENUES	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	YEAR
TOTAL	$2,178,740.81	$1,138,482.05	$1,556,768.56	$1,540,935.40	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6,414,926.82

TOTAL EXPENDITURES	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	YEAR
TOTAL	$6,555.16	$1,563,749.04	$2,014,178.61	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3,584,482.81

REVENUE LESS EXPENDITURES	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	YEAR
TOTAL	$2,172,185.65	($425,266.99)	($457,410.05)	$1,540,935.40	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2,830,444.01

City of Fort Lauderdale

OPEN ACCESS PLUS MEDICAL BENEFITS

Health Reimbursement Arrangement

EFFECTIVE DATE: January 1, 2016

ASO9

3335139

This document printed in February, 2016 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Important Information 5
Special Plan Provisions 7
Important Notices 8
How To File Your Claim 9
Eligibility - Effective Date 10
Employee Insurance 10
Waiting Period 10
Dependent Insurance 10
Important Information About Your Medical Plan 11
Open Access Plus Medical Benefits 12
The Schedule 12
Certification Requirements - Out-of-Network 24
Prior Authorization/Pre-Authorized 24
Covered Expenses 25
Prescription Drug Benefits 34
The Schedule 34
Covered Expenses 36
Limitations 36
Your Payments 36
Exclusions 37
Reimbursement/Filing a Claim 37
Exclusions, Expenses Not Covered and General Limitations 38
Coordination of Benefits 40
Expenses For Which A Third Party May Be Responsible 43
Payment of Benefits 44
Termination of Insurance 45
Employees 45
Dependents 45
Rescissions 45
Medical Benefits Extension Upon Policy Cancellation 45
Federal Requirements 46
Notice of Provider Directory/Networks 46
Qualified Medical Child Support Order (QMCSO) 46
Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA) 46
Effect of Section 125 Tax Regulations on This Plan 48
Eligibility for Coverage for Adopted Children 48

Coverage for Maternity Hospital Stay 49
Women's Health and Cancer Rights Act (WHCRA) 49
Group Plan Coverage Instead of Medicaid 49
Requirements of Medical Leave Act of 1993 (as amended) (FMLA) 49
Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA) 50
Claim Determination Procedures 50
Medical - When You Have a Complaint or an Appeal 52
COBRA Continuation Rights Under Federal Law 53

Definitions 56

What You Should Know About Cigna Choice Fund® – Health Reimbursement Account 66

Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY CITY OF FORT LAUDERDALE WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

HC-NOT1

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Special Plan Provisions

When you select a Participating Provider, this Plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction With Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card.

HC-SPP1 04-10
V1

Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, your dependent or an attending Physician can request Case Management services by calling the **toll-free number** shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate).
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

HC-SPP2 04-10
V1

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well being of our members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

HC-SPP3 04-10
V1

Care Management and Care Coordination Services

Your plan may enter into specific collaborative arrangements with health care professionals committed to improving quality care, patient satisfaction and affordability. Through these collaborative arrangements, health care professionals commit to proactively providing participants with certain care management and care coordination services to facilitate achievement of these goals. Reimbursement is provided at 100% for these services when rendered by designated health care professionals in these collaborative arrangements.

HC-SPP27 06-15
V1

Important Notices

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Selection of a Primary Care Provider

This plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

HC-NOT5 01-11

Important Information

Mental Health Parity and Addiction Equity Act

The Certificate is amended as stated below:

In the event of a conflict between the provisions of your plan documents and the provisions of this notice, the provisions that provide the better benefit shall apply.

The Schedule and Mental Health and Substance Abuse Covered Expenses:

Partial Hospitalization charges for Mental Health and Substance Abuse will be paid at the Outpatient level. Covered Expenses are changed as follows:

Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the

appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services are Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, or for Partial Hospitalization sessions, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Inpatient Substance Abuse Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Residential Treatment services.

Substance Abuse Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

Substance Abuse Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Abuse Intensive Outpatient Therapy Program and for Partial Hospitalization sessions.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Mental Health and Substance Abuse Exclusions:

The following exclusion is hereby deleted and no longer applies:

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.

Terms within the agreement:

The term “mental retardation” within your Certificate is hereby changed to “intellectual disabilities”.

Visit Limits:

Any health care service billed with a Mental Health or Substance Abuse diagnosis, will not incur a visit limit, including but not limited to genetic counseling and nutritional evaluation/counseling.

HC-NOT69 12-14

How To File Your Claim

There’s no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out-of-Network claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the

provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by using the toll-free number on your identification card.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 180 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 days for Out-of-Network benefits, the claim will not be considered valid and will be denied.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

HC-CLM25 01-11
V11

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee who normally works at least 30 hours a week; or
- you are an eligible, variable hour Employee who normally works an average of 30 hours per week during the City's Measurement period as required by the Affordable Care Act; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

The first day of the month following date of hire.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as

defined will be included. A newborn child will be covered for the first 31 days of life even if you fail to enroll the child. If you enroll the child after the first 31 days and by the 60th day after his birth, coverage will be offered at an additional premium. Coverage for an adopted child will become effective from the date of placement in your home or from birth for the first 31 days even if you fail to enroll the child. However, if you enroll the adopted child between the 31st and 60th days after his birth or placement in your home, coverage will be offered at an additional premium.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

HC-ELG1 04-10
V6 M

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

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Open Access Plus Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible or Coinsurance.

When you receive services from an In-Network Provider, remind your provider to utilize In-Network Providers for x-rays, lab tests and other services to ensure the cost may be considered at the In-Network level.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

Deductibles

Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

Out-of-Pocket Expenses - For In-Network Charges Only

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in the Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

Out-of-Pocket Expenses - For Out-of-Network Charges Only

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%:

- Coinsurance.
- Plan Deductible.

The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:

- Non-compliance penalties.
- Any benefit deductibles.
- Provider charges in excess of the Maximum Reimbursable Charge.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums will accumulate in one direction (that is, Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.

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Open Access Plus Medical Benefits

The Schedule

Note:
For information about your health fund benefit and how it can help you pay for expenses that may not be covered under this plan, refer to "What You Should Know about Cigna Choice Fund".

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
The Percentage of Covered Expenses the Plan Pays **Note:** "No charge" means an insured person is not required to pay Coinsurance.	90%	70% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maximum Reimbursable Charge Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or A percentage of a schedule that we have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider's normal charge for a similar service or supply; or • the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Insurance Company. **Note:** The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles and coinsurance. **Note:** Some providers forgive or waive the cost share obligation (e.g. your deductible and/or coinsurance) that this plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this plan. For more details, see the Exclusions Section.	Not Applicable	110% of Medicare allowable

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
Employee	$2,000 per employee	$2,000 per employee
Employee Plus One	$3,000 per employee plus one	$3,000 per employee plus one
Employee Two or More	$4,000 per employee two or more	$4,000 per employee two or more
Family Maximum Calculation **Collective Deductible:** All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.		
Combined Medical/Pharmacy Calendar Year Deductible		
Combined Medical/Pharmacy Deductible: includes retail and home delivery prescription drugs	Yes	In-Network coverage only
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Deductible	Yes	In-Network coverage only
Combined Out-of-Pocket Maximum for Medical and Pharmacy expenses		
Employee	$5,000	$5,000
Employee – within a family	$5,000	$5,000
Employee Plus One	$7,000	$7,000
Employee Two or More	$10,000	$10,000
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Combined Medical/Pharmacy Out-of-Pocket Maximum		
Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery prescription drugs	Yes	In-Network coverage only
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	Yes	In-Network coverage only
Physician's Services		
Primary Care Physician's Office Visit	90% after plan deductible	70% after plan deductible
Specialty Care Physician's Office Visits	90% after plan deductible	70% after plan deductible
Consultant and Referral Physician's Services		
Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.		
Surgery Performed in the Physician's Office	90% after plan deductible	70% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	90% after plan deductible	70% after plan deductible
Allergy Treatment/Injections	90% after plan deductible	70% after plan deductible
Allergy Serum (dispensed by the Physician in the office)	90% after plan deductible	70% after plan deductible
Preventive Care		
Note: Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.		
Routine Preventive Care (for children to age16 yrs)	No charge	70%
Immunizations (for children to age16 yrs)	No charge	70%
Routine Preventive Care (for ages 16 years and over)	No charge	70% after plan deductible
Immunizations (for ages 16 years and over)	No charge	70% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mammograms, PSA, PAP Smear, Early Cancer Detection Colon/Rectal		
Preventive Care Related Services (i.e. "routine" services)	No charge	70% after plan deductible
Diagnostic Related Services (i.e. "non-routine" services)	No charge	70% after plan deductible
Note: Colonoscopies and all associated charges covered at 100% preventive/diagnostic		
Inpatient Hospital - Facility Services	90% after plan deductible	70% after plan deductible
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	90% after plan deductible	70% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	90% after plan deductible	70% after plan deductible
Inpatient Hospital Professional Services Surgeon, Radiologist, Pathologist, Anesthesiologist	90% after plan deductible	70% after plan deductible
Outpatient Professional Services Surgeon, Radiologist, Pathologist, Anesthesiologist	90% after plan deductible	70% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency and Urgent Care Services		
Physician's Office Visit	90% after plan deductible	90% after plan deductible
Hospital Emergency Room	90% after plan deductible	90% after plan deductible
Outpatient Professional Services (radiology, pathology and ER Physician)	90% after plan deductible	90% after plan deductible
Urgent Care Facility or Outpatient Facility	90% after plan deductible	90% after plan deductible
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	90% after plan deductible	90% after plan deductible
Independent x-ray and/or Lab Facility in conjunction with an ER visit	90% after plan deductible	90% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	90% after plan deductible	90% after plan deductible
Ambulance	90% after plan deductible	90% after plan deductible
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 90 days combined	90% after plan deductible	70% after plan deductible
Laboratory and Radiology Services (includes pre-admission testing)		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Outpatient Hospital Facility	90% after plan deductible	70% after plan deductible
Independent X-ray and/or Lab Facility	90% after plan deductible	70% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: 60 days for each therapy Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab **Note:** The Short-Term Rehabilitative Therapy maximum does not apply to the treatment of autism. Cognitive therapy can be related to any therapy and will be combined with the respective therapy.	90% after plan deductible	70% after plan deductible
Outpatient Cardiac Rehabilitation Calendar Year Maximum: 18 days	90% after plan deductible	70% after plan deductible
Chiropractic Care Calendar Year Maximum: 20 days Physician's Office Visit	90% after plan deductible	70% after plan deductible
Home Health Care Calendar Year Maximum: 60 days (includes outpatient private nursing when approved as Medically Necessary)	90% after plan deductible	70% after plan deductible
Hospice Inpatient Services Outpatient Services (same coinsurance level as Home Health Care)	90% after plan deductible 90% after plan deductible	70% after plan deductible 70% after plan deductible
Bereavement Counseling Services provided as part of Hospice Care Inpatient Outpatient Services provided by Mental Health Professional	90% after plan deductible 90% after plan deductible Covered under Mental Health Benefit	70% after plan deductible 70% after plan deductible Covered under Mental Health Benefit

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services		
Initial Visit to Confirm Pregnancy	90% after plan deductible	70% after plan deductible
Note: OB/GYN providers will be considered either as a PCP or Specialist depending on how the provider contracts with the Insurance Company.		
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	90% after plan deductible	70% after plan deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	90% after plan deductible	70% after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	90% after plan deductible	70% after plan deductible
Abortion		
Includes elective and non-elective procedures		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after plan deductible	70% after plan deductible
Women's Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling	No charge	70% after plan deductible
Note: Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.		
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)		
Physician's Office Visit	No charge	70% after plan deductible
Inpatient Facility	No charge	70% after plan deductible
Outpatient Facility	No charge	70% after plan deductible
Physician's Services	No charge	70% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Men's Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling	90% after plan deductible	70% after plan deductible
Surgical Sterilization Procedures for Vasectomy (excludes reversals)		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after plan deductible	70% after plan deductible
Infertility Treatment		
Services Not Covered include: • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc). **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Not Covered	Not Covered
Organ Transplants		
Includes all medically appropriate, non-experimental transplants		
Physician's Office Visit	90% after plan deductible	In-Network coverage only
Inpatient Facility	100% at Lifesource center after plan deductible, otherwise 90% after plan deductible	In-Network coverage only
Physician's Services	100% at Lifesource center after plan deductible, otherwise 90% after plan deductible	In-Network coverage only
Lifetime Travel Maximum: $10,000 per transplant	No charge (only available when using Lifesource facility)	In-Network coverage only
Durable Medical Equipment	90% after plan deductible	70% after plan deductible
Calendar Year Maximum: Unlimited		

Cigna

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Breast Feeding Equipment and Supplies **Note:** Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	No charge	70% after plan deductible
External Prosthetic Appliances Calendar Year Maximum: Unlimited	90% after plan deductible	70% after plan deductible
Diabetic Equipment Calendar Year Maximum: Unlimited	90% after plan deductible	70% after plan deductible
Penile Pump Note: For use as a result of Prostate Cancer treatment based on Cigna's coverage position.	90% after plan deductible	70% after plan deductible
Nutritional Evaluation Calendar Year Maximum: 3 visits per person		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after plan deductible	70% after plan deductible
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after plan deductible	70% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Bariatric Surgery **Note:** Subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate.		
Physician's Office Visit	90% after plan deductible	In-Network coverage only
Inpatient Facility	90% after plan deductible	In-Network coverage only
Outpatient Facility	90% after plan deductible	In-Network coverage only
Physician's Services	90% after plan deductible	In-Network coverage only
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		
Mental Health		
Inpatient	90% after plan deductible	70% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Substance Abuse		
Inpatient	90% after plan deductible	70% after plan deductible
Outpatient (Includes Individual and Intensive Outpatient)		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible

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Open Access Plus Medical Benefits

Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- as a registered bed patient, except for 48/96 hour maternity stays;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
- for Mental Health or Substance Abuse Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 72 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will be reduced by 50% for Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, within 72 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Outpatient Certification Requirements – Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-standing Surgical Facility, Other Health Care Facility or a Physician's office. You or your Dependent should call the toll-free number on the back of your I.D. card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient Certification should only be requested for nonemergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses incurred will be reduced by 50% for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Hysterectomy.

HC-PAC1 11-14
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Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- outpatient facility services;
- intensive outpatient programs;
- advanced radiological imaging;
- non-emergency ambulance; or
- transplant services.

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- charges made for the following preventive care services (detailed information is available at www.healthcare.gov.):
  (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
  (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
  (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
  (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- charges made for diagnosis and Medically Necessary surgical procedures to treat dysfunction of the temporomandibular joint
- charges made for acupuncture.
- coverage for diagnosis and treatment of autism spectrum disorder to include autistic disorder, Asperger's Syndrome

and pervasive developmental disorder not otherwise specified, when prescribed by a treating Physician in accordance with a treatment plan for individuals diagnosed at age 8 or younger. Coverage is provided for Dependents to age 18, or older if attending High School. Treatment includes well-baby and well-child screening for diagnosis and treatment through speech therapy, occupational therapy, physical therapy and applied behavior analysis. Day or visit maximums applied to such treatment for other causes will not apply to treatment of autism spectrum disorder.

- charges made by a Physician, certified diabetes educator or licensed dietitian for a program which provides instruction on an outpatient basis for a person who has been diagnosed as having diabetes, for the purpose of instructing such person about the condition and its control.
- charges for general anesthesia and hospitalization services for dental procedures for an individual who is under age 8 and for whom it is determined by a licensed Dentist and the child's Physician that treatment in a Hospital or ambulatory surgical center is necessary due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proven to be ineffective; or has one or more medical conditions that would create significant or undue medical risk if the procedure were not rendered in a Hospital or ambulatory surgical center.
- charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of whether or not such services are received in a home birth setting.
- charges for the treatment of cleft lip and cleft palate including medical, dental, speech therapy, audiology and nutrition services, when prescribed by a Physician.
- charges for newborn and infant hearing screening and Medically Necessary follow-up evaluations. When ordered by the treating Physician, a newborn’s hearing screening must include auditory brainstem responses or evoked otacoustic emissions or other appropriate technology approved by the FDA. All screenings shall be conducted by a licensed audiologist, Physician, or supervised individual who has training specific to newborn hearing screening. Newborn means an age range from birth through 29 days. Infant means an age range from 30 days through 12 months.
- charges for or in connection with Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals. This includes, but is not limited to individuals who: have vertebral abnormalities; are receiving long-term glucocorticoid (steroid) therapy; have primary hyperparathyroidism; have a family history of osteoporosis; and/or are estrogen-deficient individuals who are at clinical risk for osteoporosis.
- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but not limited to: a baseline mammogram for women ages 35 through 39; a mammogram for women ages 40 through 49, every two years or more frequently based on the attending Physician's recommendations; a mammogram every year for women age 50 and over; and one or more mammograms upon the recommendation of a Physician for any woman who is at risk for breast cancer due to her family history; has biopsy proven benign breast disease; or has not given birth before age 30. A mammogram will be covered with or without a Physician’s recommendation, provided the mammogram is performed at an approved facility for breast cancer screening.
- charges for an inpatient Hospital stay following a mastectomy will be covered for a period determined to be Medically Necessary by the Physician and in consultation with the patient. Postsurgical follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.

In addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below, for a Dependent child who is age 15 or less, for charges made for Child Preventive Care Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

● a history;

● physical examination;

● development assessment;

● anticipatory guidance; and

● appropriate immunizations and laboratory tests; excluding any charges for:

● more than one visit to one provider for Child Preventive Care Services at each of the Approximate Age Intervals, up to a total of 18 visits for each Dependent child;

● services for which benefits are otherwise provided under this Covered Expenses section;

● services for which benefits are not payable, according to the Expenses Not Covered section.

It is provided that any Deductible that would otherwise apply will be waived for those Covered Expenses incurred for Child Preventive Care Services. Approximate Age Intervals are: Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years and 15 years.

Clinical Trials

This benefit plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

(a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

(b) either

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
- the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements:

The study or investigation must:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

- services required solely for the provision of the investigational drug, item, device or service;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:

- the investigational drug, item, device, or service, itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

If your plan includes In-Network providers, Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

- there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual's state of residence.

Genetic Testing

Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- a person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and post-genetic testing.

Nutritional Evaluation

Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Internal Prosthetic/Medical Appliances

Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Orthognathic Surgery

- orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not correct, provided:
  - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
  - the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

HC-COV3 04-10
V1

Cardiac Rehabilitation

- Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

  Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

HC-COV4 04-10
V1

Home Health Services

- charges made for Home Health Services when you: require skilled care; are unable to obtain the required care as an ambulatory outpatient; and do not require confinement in a Hospital or Other Health Care Facility.

  Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

  Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

HC-COV5 04-10
V1

Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;

- part-time or intermittent services of an Other Health Care Professional;
- physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living.

HC-COV6 04-10
V1

Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Inpatient Substance Abuse Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions and Residential Treatment services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Substance Abuse Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

Substance Abuse Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Abuse Services:

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

HC-COV7 04-10
V4

Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric

chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.

- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

HC-COV8 04-10
V2

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

Orthoses and Orthotic Devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses;
  - semirigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - no more than once every 24 months for persons 19 years of age and older;
  - no more than once every 12 months for persons 18 years of age and under; and
  - replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.

HC-COV9 04-10
V2

Short-Term Rehabilitative Therapy

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to Short-term Rehabilitative Therapy:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

- sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.

Multiple outpatient services provided on the same day constitute one day.

Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

Chiropractic Care Services

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

The following limitation applies to Chiropractic Care Services:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- vitamin therapy.

HC-COV13 04-10
V2

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance;

postoperative breast prostheses; and mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

HC-COV14 04-10
V1

Transplant Services

- charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

All Transplant services, other than cornea, are covered at 100% when received at Cigna LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than Cigna LIFESOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are not covered.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for reasonable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, your domestic partner, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses: travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.

HC-COV15 04-10
V2 M

Cigna

Prescription Drug Benefits

The Schedule

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion includes any applicable Copayment, Deductible and/or Coinsurance.

Coinsurance

The term Coinsurance means the percentage of Charges for covered Prescription Drugs and Related Supplies that you or your Dependent are required to pay under this plan.

Charges

The term Charges means the amount charged by the Insurance Company to the plan when the Pharmacy is a Participating Pharmacy.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Lifetime Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Calendar Year Deductible		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Out-of-Pocket Maximum		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Preventive Medications Generic prescription medications used to prevent any of the following medical conditions are not subject to the Deductible: • hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency		
Retail Prescription Drugs **	**The amount you pay for each 30-day supply**	**The amount you pay for each 30-day supply**
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no copayment or deductible.		
Tier 1		
Generic* Preventive drugs on the Prescription Drug List	No charge	In-network coverage only

Cigna

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Generic* Non-Preventive drugs on the Prescription Drug List	30% after plan deductible	In-network coverage only
Tier 2 Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	40% after plan deductible	In-network coverage only
Tier 3 Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	60% after plan deductible	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		
** You pay 100% of Cigna's discounted cost after the first fill of Specialty Medication.		
Home Delivery Prescription Drugs	**The amount you pay for each 90-day supply**	**The amount you pay for each 90-day supply**
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no copayment or deductible.		
Tier 1		
Generic* Preventive drugs on the Prescription Drug List	No charge	In-network coverage only
Generic* Non-Preventive drugs on the Prescription Drug List	30% after plan deductible	In-network coverage only
Tier 2 Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	40% after plan deductible	In-network coverage only
Tier 3 Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	60% after plan deductible	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		

Cigna

Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in The Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, excluding Specialty Medications, at a retail Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
- up to a consecutive 90-day supply at a home delivery Participating Pharmacy, unless limited by the drug manufacturer’s packaging; or
- to one fill of Specialty Medication at a retail Participating Pharmacy. If you exceed the one fill allowed at a retail Participating Pharmacy, you will be required to pay 100% of Cigna's discounted cost; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

HC-PHR1 08-15
V7

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to Cigna to request a prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P&T Committee clinically evaluates the Prescription Drug for a different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

HC-PHR2 04-10
V6

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance shown in the Schedule, after you have satisfied your Prescription Drug Deductible, if applicable. Please refer

to the Schedule for any required Copayments, Coinsurance, Deductibles or Maximums if applicable.

In no event will the Copayment or Coinsurance for the Prescription Drug or Related Supply exceed the amount paid by the plan to the Pharmacy, or the Pharmacy's Usual and Customary (U&C) charge. Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers regardless of the customer's payment source.

HC-PHR3 04-10
V4

Exclusions

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law unless state or federal law requires coverage of such drugs;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in the standard reference compendia (AHFS or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in peer-reviewed English-language bio-medical journals;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;
- any fertility drug;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue;
- any drugs that are experimental or investigational as described under the Medical "Exclusions" section of your certificate.

Other limitations are shown in the Medical "Exclusions" section of your certificate.

HC-PHR4 05-12
V24

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, you pay any applicable Copayment, Coinsurance or Deductible shown in the Schedule at the time of purchase. You do not need to file a claim form unless you are unable to purchase Prescription Drugs at a Participating Pharmacy for Emergency Services.

To purchase Prescription Drugs or Related Supplies from a home delivery Participating Pharmacy, see your home delivery drug introductory kit for details, or contact member services for assistance.

See your Employer's Benefit Plan Administrator to obtain the appropriate claim form.

HC-PHR5 04-10
V2

Cigna

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung, and Blood Institute (NHLBI) guideline is covered only at

approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded:
  - medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and
  - weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male or female voluntary sterilization procedures.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, or mental retardation.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.

- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- all nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your or your Dependent's family.
- expenses incurred outside the United States other than expenses for medically necessary urgent or emergent care while temporarily traveling abroad.

HC-EXC56 10-14
V6 M

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide services and supplies under this policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligibles

Cigna will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

(a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;

(e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

Cigna will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.

- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

Domestic Partners

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan when Medicare coverage is due to age. Therefore, when Medicare coverage is due to age, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and Cigna is the Secondary Plan. However, when Medicare coverage is due to disability, the Medicare Secondary Payer rules explained above will apply.

HC-COB1 04-10
V5

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan’s subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan’s right to recover shall apply to decedents’, minors’, and incompetent or disabled persons’ settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan’s right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called “Made-Whole Doctrine”, “Rimes Doctrine”, or any other such doctrine purporting to defeat the plan’s recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan’s rights hereunder, specifically; no court costs, attorneys' fees or other

representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".

- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

HC-SUB1 04-10
V9

Payment of Benefits

To Whom Payable

Medical Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependents, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. In addition, your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable line by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

Calculation of Covered Expenses

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology,
- the methodologies as reported by generally recognized professionals or publications.

HC-POB1 09-13
V7

Cigna

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff

If your Active Service ends due to temporary layoff, your insurance will be continued until the date your Employer cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Temporary Leave of Absence

If your Active Service ends due to temporary leave of absence, your insurance will be continued until the date your Employer cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends. The City continues health coverage and contributions during approved FMLA absences. Employees who are on approved personal leave pay full premium.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Employer cancels your insurance.

Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

HC-TRM1 04-10

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Rescissions

Your coverage may not be rescinded (retroactively terminated) by Cigna or the plan sponsor unless the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

HC-TRM80 01-11

Medical Benefits Extension Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date due to an Injury, Sickness or pregnancy, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury, Sickness or pregnancy. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date a succeeding carrier agrees to provide coverage without limitation for the disabling condition;
- the date you are no longer Totally Disabled;
- 12 months from the date the policy is canceled; or
- for pregnancy, until delivery.

Totally Disabled

You will be considered Totally Disabled if, because of an Injury or a Sickness:

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or

- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

HC-BEX42 04-11

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

HC-FED1 10-10

Notice of Provider Directory/Networks

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

If your Plan utilizes a network of Providers, a separate listing of Participating Providers who participate in the network is available to you without charge by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider/Pharmacy networks consist of a group of local medical practitioners, and Hospitals, of varied specialties as well as general practice or a group of local Pharmacies who are employed by or contracted with Cigna HealthCare.

HC-FED2 10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

HC-FED4 10-10

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible

Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
- **Eligibility for Premium Assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

HC-FED71 12-14

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

- the date you meet the Special Enrollment criteria described above; or
- the date you meet the criteria shown in the following Sections B through H.

B. Change of Status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court Order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid Eligibility/Entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

G. Reduction in work hours

If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. Enrollment in Qualified Health Plan (QHP)

The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace's annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

HC-FED70 12-14

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED67 09-14

Coverage for Maternity Hospital Stay

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (*e.g.,* your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

HC-FED10 10-10

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

HC-FED12 10-10

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

HC-FED13 10-10

Requirements of Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

HC-FED17 10-10

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

HC-FED18 10-10

Claim Determination Procedures

The following complies with federal law. Provisions of the laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice Medical Necessity determination." The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents, and in the determination notices.

Preservice Medical Necessity Determinations

When you or your representative request a required Medical Necessity determination prior to care, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination

period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's Physician will defer to the determination of the treating Physician, regarding whether an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow Cigna's procedures for requesting a required preservice Medical Necessity determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Medical Necessity Determinations

When you or your representative requests a Medical Necessity determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Postservice Claim Determinations

When you or your representative requests payment for services which have been rendered, Cigna will notify you of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

Medical - When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you" or "your" also refers to a representative or provider designated by you to act on your behalf; unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you may call the toll-free number on your ID card, explanation of benefits, or claim form and explain your concern to one of our Customer Service representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Internal Appeals Procedure

To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write us at the toll-free number on your ID card, explanation of benefits, or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

We will respond in writing with a decision within 30 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination or a postservice Medical Necessity determination. We will respond within 60 calendar days after we receive an appeal for any other postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external review at the same time, if the time to complete an expedited review would be detrimental to your medical condition.

When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

External Review Procedure

If you are not fully satisfied with the decision of Cigna's internal appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by Cigna, or any of its affiliates. A decision to request an external review to an IRO will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate an external review. Cigna and your benefit plan will abide by the decision of the IRO.

To request a review, you must notify the Appeals Coordinator within 4 months of your receipt of Cigna's appeal review denial. Cigna will then forward the file to a randomly selected IRO. The IRO will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna's Physician Reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the external review shall be completed within 72 hours.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant

Information as defined below; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a), if applicable; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record or other information which: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the appeal processes. However, no action will be brought at all unless brought within three years after proof of claim is required under the Plan. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services or within three years after proof of claim is required under the Plan for Out-of-Network services.

HC-FED60 03-14

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled

"Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Employer's Service Area or Elimination of a Service Area

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Employer's service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer's Notification Requirements

Your Employer or contracted COBRA third party administrator is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must

be provided within the time frame required for the COBRA continuation coverage election notice as explained below.

- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator

within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer’s Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

HC-FED66 07-14

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1 04-10
V1

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

HC-DFS2 04-10
V2

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with Cigna for a different amount.

HC-DFS3 04-10
V1

Chiropractic Care

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

HC-DFS55 04-10
V1

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

HC-DFS4 04-10
V1

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is:
  - less than 26 years old.
  - from the end of the calendar year in which the child reaches age 26 or until the end of the calendar year in which the child reaches the age of 30, provided the child is unmarried and does not have a dependent of their own, is a Florida state resident or a full-time or part-time student, and is not covered under a plan of their own or entitled to benefits under Title XVIII of the Social Security Act. CIGNA may require such proof at least once each year until the end of the calendar year in which he attains age 30;
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

    Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of an Injury or a Sickness existing prior to the date of placement or adoption. A child also includes a foster child or a child placed in your custody by a court order from the date of placement in the home. Coverage is not required if the adopted or foster child is ultimately not placed in your home. It also includes:

• a stepchild or a child for whom you are the legal guardian;

• a child born to an insured Dependent child of yours until such child is 18 months old;

If your Domestic Partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child or student will continue until the last day of the calendar year in which the limiting age is reached.

Anyone who is eligible as an Employee can be included as a dependent of another employee.

No one may be considered as a Dependent of more than one Employee.

HC-DFS673 07-14
V1 M

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two

of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;

- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents on a pre-tax basis.

HC-DFS47 04-10
V1 M

Emergency Medical Condition

Emergency medical condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

HC-DFS394 11-10

Emergency Services

Emergency services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

HC-DFS393 11-10

Employee

The term Employee means a full-time or variable hour employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

HC-DFS7 04-10
V3 M

Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf Cigna is providing claim administration services.

HC-DFS8 04-10
V1

Essential Health Benefits

Essential health benefits means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

HC-DFS411 01-11

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

HC-DFS10 04-10
V1

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

HC-DFS11 04-10
V1

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

HC-DFS51 04-10
V1

Hospice Care Services

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

HC-DFS52 04-10
V1

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

HC-DFS53 04-10
V1

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of Mental Health and Substance Abuse or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

HC-DFS48 04-10
V1

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

HC-DFS49 04-10
V1

Injury

The term Injury means an accidental bodily injury.

HC-DFS12 04-10
V1

Maintenance Treatment

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.

HC-DFS56 04-10
V1

Maximum Reimbursable Charge - Medical

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider’s normal charge for a similar service or supply; or
- a policyholder-selected percentage of a schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

The percentage used to determine the Maximum Reimbursable Charge is listed in The Schedule.

In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider’s normal charge for a similar service or supply; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

HC-DFS13 04-10
V8

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

HC-DFS16 04-10
V1

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

HC-DFS19 04-10
V1

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

HC-DFS17 04-10
V1

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement, any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

HC-DFS21 04-10
V1

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

HC-DFS22 04-10
V1

Other Health Care Facility/Other Health Professional

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities. The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

HC-DFS23 04-10
V1

Participating Pharmacy

The term Participating Pharmacy means a retail Pharmacy with which Cigna has contracted to provide prescription services to insureds, or a designated home delivery Pharmacy with which Cigna has contracted to provide home delivery prescription services to insureds. A home delivery Pharmacy is a Pharmacy that provides Prescription Drugs through mail order.

HC-DFS60 04-10
V1

Participating Provider

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

HC-DFS45 04-10
V1

Patient Protection and Affordable Care Act of 2010 ("PPACA")

Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

HC-DFS412 01-11

Pharmacy

The term Pharmacy means a retail Pharmacy, or a home delivery Pharmacy.

HC-DFS61 04-10
V1

Pharmacy & Therapeutics (P & T) Committee

A committee of Cigna Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

HC-DFS62 04-10
V1

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

HC-DFS25 04-10
V1

Prescription Drug

Prescription Drug means; a drug which has been approved by the Food and Drug Administration for safety and efficacy; certain drugs approved under the Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

HC-DFS63 04-10
V1

Prescription Drug List

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

HC-DFS64 04-10
V1

Prescription Order

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

HC-DFS65 04-10
V1

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

HC-DFS57 04-10
V1

Primary Care Physician

The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and who has been selected by you, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents.

HC-DFS40 04-10
V1

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

HC-DFS26 04-10
V1

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes

for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

HC-DFS68 04-10
V1

Review Organization

The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

HC-DFS30 04-10
V1

Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred by the mother as a result of Sickness.

HC-DFS50 04-10
V1 M

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

HC-DFS31 04-10
V1

Specialist

The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

HC-DFS33 04-10
V1

Specialty Medication

The term Specialty Medication means high cost medications which are used to treat rare and chronic conditions which include, but are not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis.

HC-DFS69 04-10
V6

Stabilize

Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

HC-DFS413 01-11

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

HC-DFS54 04-10
V1

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation

that the insured should not travel due to any medical condition.

HC-DFS34 04-10
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The following pages describe the features of your Cigna Choice Fund - Health Reimbursement Account.
Please read them carefully.

Cigna®

What You Should Know About Cigna Choice Fund® – Health Reimbursement Account

Cigna Choice Fund is designed to give you:

Control

More control over how your health care dollars are spent. The health services you get and where you get them are up to you.

Choice

You have the freedom to choose any licensed doctor. However, your costs will be lower for services from Cigna contracted health care professionals because they have agreed to accept discounted payments to help you make the most of your health care dollars.

Flexibility

Flexibility to help you proactively manage your health and maximize your plan coverage. By using our cost and quality tools to find a higher quality and more cost effective doctor, lab or facility, you can reduce the costs that are paid out of your HRA. And if you don't use all of the money in your health reimbursement account, some or all of the unused money may be added to your account for the following year, as long as you stay in the plan. Ask your employer, call Cigna, or log into www.myCigna.com to find out if your HRA limits the amount that can roll over to the next year.

Your plan covers medical care when you're sick, but also includes coverage for preventive care services to help keep you well. Your preventive care is covered at 100% in-network; therefore no HRA funds will need to be used for these services. Preventive health coverage is one of the most important benefits of your health plan. Getting the right preventive services at the right time can help you stay healthy by preventing diseases or by detecting a health problem at a stage that may be easier to treat. Make sure you take advantage of your fully covered in-network preventive care coverage. Log in to www.myCigna.com and read the Preventive Care Quick Reference Guide under the Review My Medical Coverage section.

Health Information and Education

Is it late at night, and you're not sure if you should go to the Emergency Room for an injury or just wait until your doctor is available the next day? Just call the toll-free number on your ID card to reach Cigna's 24-Hour Health Information Line. You'll have access to trained nurses who can help! You also have access to an audio library of health topics 24 hours a day. In addition, the Cigna Healthy Pregnancies, Healthy Babies® program provides prenatal education and support for mothers-to-be.

Tools & Support

We help you keep track with online benefits information, transactions, and account activity; medical and drug cost comparisons; monthly statements; and more. You also have toll-free access to dedicated Customer Service teams, specially trained to answer your questions and address your needs. Customer Service is available 24 hours a day, 7 days a week, every day of the year!

Savings on Health and Wellness Products and Services

Through Cigna Healthy Rewards®, you can save money on a variety of health-related products and services. Offerings include laser vision correction, acupuncture, chiropractic care, weight loss programs, fitness club and equipment discounts and more.

Opportunity to earn funds for future use

If your employer offers the Cigna Healthy Future Account®, you can earn funds to cover qualified expenses for future use, such as retirement. All or a portion of unused HRA funds at the end of each plan year will transfer to this account until you meet the eligibility requirements (such as retirement, reaching age 65, or accumulating a certain number of years of service with your employer). Once you reach your qualifying event, you may then use the Healthy Future Account to pay yourself back for certain expenses defined by your employer. See your benefits administrator for more details.

The Basics

How does it work?

The Cigna Choice Fund Health Reimbursement Account combines medical coverage with a reimbursement account that includes contributions from your employer.

1. **Employer contribution:** Your employer deposits a specific amount of money in a health account to help you pay for some of the costs of covered medical expenses. The health services you receive and where you get them are up to you. The health care costs paid from your HRA typically count toward your deductible (an annual amount you'll pay before the health plan begins to pay for covered health care costs), reducing your share.
2. **Your share:** Once you've used the money in your health account, you pay your expenses up to the deductible.
3. **Your health plan:** After your deductible is met, you pay pre-determined coinsurance or copayments for eligible expenses and the plan pays the rest. When you meet your out-of-pocket maximum (the most you can pay in a plan year), your plan pays eligible expenses at 100%.

If you leave the plan or your employer, the account stays behind.

Which services are covered by my Health Reimbursement Account?

According to federal law, HRA funds can be used to cover only qualified medical expenses for you and your dependents. However, your employer may choose not to allow coverage for certain qualified expenses. Please refer to www.myCigna.com for information on the services for which your HRA funds may be used.

Which services are covered by my medical plan, and which will I have to pay out of my own pocket?

Covered services vary depending on your plan, so visit www.myCigna.com or check your plan materials in this booklet for specific information. In addition to your premiums deducted from your paycheck, you'll be responsible for paying:

- Costs for any services needed after you've spent your health fund, if you haven't met your deductible.
- Your coinsurance or copayments after you meet the deductible and your medical plan coverage begins.

If all of your medical expenses are covered services and the total cost doesn't exceed the amount in your HRA, you may not have additional out-of-pocket costs. Unused money may be available to you if you enroll in the plan again the following year. Check with your employer, call Cigna, or log into www.myCigna.com to see if this option is available to you.

Are services covered if I use out-of-network doctors?

You can visit any licensed doctor or facility. However, if you choose a doctor who participates with Cigna, your costs will be lower.

Tools and Resources at Your Fingertips

Cigna Healthy Awards Account

If your employer offers a Healthy Awards Account, take advantage of certain Cigna incentive award programs, and earn extra award dollars toward your health care expenses, all for taking charge of your health.

To encourage healthy lifestyles and wellness, your employer will deposit the incentive rewards into your health account upon completion of each activity. Your employer may limit how often you can earn awards. For details on these programs you can log into www.myCigna.com, or call Cigna 24/7/365. Always consult with your doctor before beginning or changing your treatment plan or exercise routines.

www.myCigna.com

www.myCigna.com provides fast, reliable and personalized information and services, including:

- Online access to your current account balance, past transactions and claim status, as well as your Explanation of Benefits and health statements.
- Medical cost and drug cost information, including cost estimates specific to you and your plan.
- Frequently asked questions about health care in general and Cigna Choice Fund specifically.
- A number of convenient, helpful tools that let you:

Compare costs

Use tools to compare costs and help you decide where to get care. You can compare out-of pocket estimates, specific to your coverage plan, for actual treatment, procedures and costs.

Find out more about your local hospitals

Learn how hospitals rank by number of procedures performed, patients' average length of stay, and cost. Go to our online healthcare professional directory for average costs for certain procedures, including total charges and your out-of-pocket expense, based on your Cigna plan. You can also find hospitals that earn the Centers of Excellence designation based on effectiveness in treating selected procedures/conditions and cost.

Get the facts about your medication, cost, treatment options and side effects

Use the pharmacy tools to: check your prescription drug costs, listed by specific pharmacy and location (including Cigna Home Delivery Pharmacy); and review your claims history for the past 16 months. Look at condition-specific drug treatments and compare characteristics of more than 200 common medications. Evaluate up to 10 medications at once to better understand side effects, drug interactions and alternatives.

Take control of your health

Take the health risk assessment, an online questionnaire that can help you identify and monitor your health status. You can learn about preventive care and check your progress toward healthy goals. And if your results show that you may benefit from other services, you can learn about related Cigna programs on the same site.

Explore topics on medicine, health and wellness

Get information on more than 5,000 health conditions, health and wellness, first aid and medical exams through **Healthwise**® Medical Encyclopedia, an interactive library.

Keep track of your personal health information

Health Record is your central, secure location for your medical conditions, medications, allergies, surgeries, immunizations, and emergency contacts. You can add your health risk assessment results to **Health Record**, so you can easily print and share the information with your doctor. Your lab results from certain facilities can be automatically entered into your Personal Health Record.

Chart progress of important health indicators

Input key data such as blood pressure, blood sugar, cholesterol (Total/LDL/HDL), height and weight, and exercise regimen. **Health Tracker** makes it easy to chart the results and share them with your doctor.

Getting the Most from Your HRA

You make decisions every day, from buying the family car to choosing the breakfast cereal. Make yourself a more educated health care consumer and you'll find that you, too, can make a difference in the health care services you receive and what you ultimately pay.

Fast Facts

If you choose to see a Cigna participating health care professional, the cost is based on discounted rates, so your costs will be lower. If you visit a health care professional or facility not in the network, you may still use your HRA to pay for the cost of those services, but you will pay a higher rate, and you may have to file claims.

If you need hospital care, there are several tools to help you make informed decisions about quality and cost.

- With the Hospital Comparison tool on www.myCigna.com, you can learn how hospitals rank by number of procedures performed, patients' average length of stay, and cost.
- Visit our healthcare professional directory for Cigna Centers of Excellence, providing hospital scores for specific procedures/conditions, such as cardiac care, hip and knee replacement, and bariatric surgery. Scores are based on cost and effectiveness in treating the procedure/condition, based on publicly available data.
- www.myCigna.com also includes a Healthcare Professional Excellence Recognition Directory. This directory includes information on:
  - Participating physicians who have achieved recognition from the National Committee for Quality Assurance (NCQA) for diabetes and/or heart and stroke care.
  - Hospitals that fully meet The Leapfrog Group patient safety standards.

If you're not sure where to begin, you have access to health advocates.

You now have access to health specialists, including individuals trained as nurses, coaches, nutritionists and clinicians, who will listen, understand your needs and help you find solutions, even when you're not sure where to begin. Partner with a health coach and get help to maintain good eating and exercise habits; support and encouragement to set and reach health improvement goals; and guidance to better manage conditions, including coronary artery disease, low back pain, osteoarthritis, high blood pressure, high cholesterol and more. From quick answers to health questions to assistance with managing more serious health needs, call the toll-free number on your Cigna ID card or visit www.myCigna.com. See your benefits administrator for more details about all of the services you have access to through your plan.

Wherever you go in the U.S., you take the Cigna 24-Hour Health Information Line[SM] with you.

Whether it's late at night, and your child has a fever, or you're traveling and you're not sure where to get care, or you don't feel well and you're unsure about the symptoms, you can call the Cigna 24-Hour Health Information Line whenever you have a question. Call the toll-free number on your Cigna ID card and you will speak to a nurse who will help direct you to the appropriate care.

A little knowledge goes a long way.

Getting the facts about your care, such as treatment options and health risks is important to your health and well-being, and your pocketbook. For instance:

- Getting appropriate preventive care is key to staying healthy. Visit www.myCigna.com to learn more about proper preventive care and what's covered under your plan.
- When it comes to medications, talk to your doctor about whether generic drugs are right for you. The brand name drugs you are prescribed may have generic alternatives that could lower your costs. If a generic version of your brand name drug is not available, other generic drugs with the same treatment effect may meet your needs.
- Tools on www.myCigna.com can help you take control of your health and health care spending. You can learn about medical topics and wellness, and keep track of your personal health information. You can also print personalized reports to discuss with your doctor.

NOT154 V6

City of Fort Lauderdale

OPEN ACCESS PLUS IN-NETWORK
MEDICAL BENEFITS
Plan 1

EFFECTIVE DATE: January 1, 2016

ASO10
3335139

This document printed in February, 2016 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Important Information 5
Special Plan Provisions 7
Important Notices 8
How To File Your Claim 9
Eligibility - Effective Date 10
Employee Insurance 10
Waiting Period 10
Dependent Insurance 10
Important Information About Your Medical Plan 11
Open Access Plus In-Network Medical Benefits 12
The Schedule 12
Prior Authorization/Pre-Authorized 21
Covered Expenses 21
Prescription Drug Benefits 31
The Schedule 31
Covered Expenses 33
Limitations 33
Your Payments 33
Exclusions 34
Reimbursement/Filing a Claim 34
Exclusions, Expenses Not Covered and General Limitations 35
Coordination of Benefits 37
Expenses For Which A Third Party May Be Responsible 40
Payment of Benefits 41
Termination of Insurance 42
Employees 42
Dependents 42
Rescissions 42
Medical Benefits Extension Upon Policy Cancellation 42
Federal Requirements 43
Notice of Provider Directory/Networks 43
Qualified Medical Child Support Order (QMCSO) 43
Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA) 43
Effect of Section 125 Tax Regulations on This Plan 45
Eligibility for Coverage for Adopted Children 45
Coverage for Maternity Hospital Stay 46
Women's Health and Cancer Rights Act (WHCRA) 46
Group Plan Coverage Instead of Medicaid 46

Requirements of Medical Leave Act of 1993 (as amended) (FMLA) 46
Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA) 47
Claim Determination Procedures 47
Medical - When You Have a Complaint or an Appeal 49
COBRA Continuation Rights Under Federal Law 50
Definitions 53

Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY CITY OF FORT LAUDERDALE WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

HC-NOT1

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Special Plan Provisions

Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction With Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card.

HC-SPP1 04-10
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Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, your dependent or an attending Physician can request Case Management services by calling the **toll-free number** shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate).
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

HC-SPP2 04-10
V1

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well being of our members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

HC-SPP3 04-10
V1

Care Management and Care Coordination Services

Your plan may enter into specific collaborative arrangements with health care professionals committed to improving quality care, patient satisfaction and affordability. Through these collaborative arrangements, health care professionals commit to proactively providing participants with certain care management and care coordination services to facilitate achievement of these goals. Reimbursement is provided at 100% for these services when rendered by designated health care professionals in these collaborative arrangements.

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V1

Important Notices

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Selection of a Primary Care Provider

This plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

HC-NOT5 01-11

Important Information

Mental Health Parity and Addiction Equity Act

The Certificate is amended as stated below:

In the event of a conflict between the provisions of your plan documents and the provisions of this notice, the provisions that provide the better benefit shall apply.

The Schedule and Mental Health and Substance Abuse Covered Expenses:

Partial Hospitalization charges for Mental Health and Substance Abuse will be paid at the Outpatient level. Covered Expenses are changed as follows:

Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the

appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services are Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, or for Partial Hospitalization sessions, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Inpatient Substance Abuse Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Residential Treatment services.

Substance Abuse Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

Substance Abuse Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Abuse Intensive Outpatient Therapy Program and for Partial Hospitalization sessions.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Mental Health and Substance Abuse Exclusions:

The following exclusion is hereby deleted and no longer applies:

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.

Terms within the agreement:

The term “mental retardation” within your Certificate is hereby changed to “intellectual disabilities”.

Visit Limits:

Any health care service billed with a Mental Health or Substance Abuse diagnosis, will not incur a visit limit, including but not limited to genetic counseling and nutritional evaluation/counseling.

HC-NOT69 12-14

How To File Your Claim

If your plan provides coverage when care is received only from In-Network providers, you may still have Out-of-Network claims (for example, when Emergency Services are received from an Out-of-Network provider) and should follow the claim submission instructions for those claims. Claims can

be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by using the toll-free number on your identification card.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 180 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 days for Out-of-Network benefits, the claim will not be considered valid and will be denied.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

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V11

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee who normally work at least 30 hours a week; or
- you are an eligible, variable hour Employee who work an average of 30 hours per week during the City's Measurement period as required by the Affordable Care Act; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

The first day of the month following date of hire.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction

form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included. A newborn child will be covered for the first 31 days of life even if you fail to enroll the child. If you enroll the child after the first 31 days and by the 60th day after his birth, coverage will be offered at an additional premium. Coverage for an adopted child will become effective from the date of placement in your home or from birth for the first 31 days even if you fail to enroll the child. However, if you enroll the adopted child between the 31st and 60th days after his birth or placement in your home, coverage will be offered at an additional premium.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

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Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

HC-IMP1 04-10
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Open Access Plus In-Network Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus In-Network Medical Benefits provide coverage for care In-Network. To receive Open Access Plus In-Network Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

When you receive services from an In-Network Provider, remind your provider to utilize In-Network Providers for x-rays, lab tests and other services to ensure the cost may be considered at the In-Network level.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

Copayments

Copayments are expenses to be paid by you or your Dependent for covered services. Copayments are in addition to any Coinsurance.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in the Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

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BENEFIT HIGHLIGHTS	IN-NETWORK
Lifetime Maximum	Unlimited
The Percentage of Covered Expenses the Plan Pays **Note:** "No charge" means an insured person is not required to pay Coinsurance.	100%
Combined Out-of-Pocket Maximum for Medical and Pharmacy expenses	
Individual	$5,000 per employee
Employee Plus 1	$7,000 per employee plus one
Family Maximum	$10,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.	
Combined Medical/Pharmacy Out-of-Pocket Maximum	
Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery prescription drugs	Yes
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	Yes
Physician's Services	
Primary Care Physician's Office Visit	No charge after $40 per office visit copay
Specialty Care Physician's Office Visits	No charge after $60 per office visit copay
Consultant and Referral Physician's Services **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.	
Surgery Performed in the Physician's Office	No charge after the $40 PCP or $60 Specialist per office visit copay
Second Opinion Consultations (provided on a voluntary basis)	No charge after the $40 PCP or $60 Specialist per office visit copay
Allergy Treatment/Injections (includes Allergy Skin Testing)	No charge after $10 per office visit copay
Allergy Serum (dispensed by the Physician in the office)	No charge

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BENEFIT HIGHLIGHTS	IN-NETWORK
Preventive Care **Note:** Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.	
Routine Preventive Care - all ages	No charge
Immunizations - all ages	No charge
Acupuncture Calendar maximum: Unlimited	No charge after $60 per visit copay
Mammograms, PSA, PAP Smear/ Early Cancer Detection Colon/Rectal	
Preventive Care Related Services (i.e. "routine" services)	No charge
Diagnostic Related Services (i.e. "non-routine" services) **Note:** Colonoscopies and all associated charges covered at 100% preventive/diagnostic	No charge
Inpatient Hospital - Facility Services	$500 per day copay, then 100% (Copays will not exceed $2,500 per Calendar Year)
Semi-Private Room and Board	Limited to the semi-private negotiated rate
Private Room	Limited to the semi-private negotiated rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room **Note:** Non-surgical treatment procedures are not subject to the facility copay/deductible.	$500 per visit copay, then 100% Upper GI: $200 per visit copay, then 100%
Inpatient Hospital Physician's Visits/Consultations	100%
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	100%

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BENEFIT HIGHLIGHTS	IN-NETWORK
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	100%
Emergency and Urgent Care Services	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Hospital Emergency Room	No charge after $200 per visit copay* *waived if admitted
Outpatient Professional services (radiology, pathology and ER Physician)	No charge
Urgent Care Facility or Outpatient Facility	No charge after $60 per visit copay* *waived if admitted
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	No charge
Independent x-ray and/or Lab Facility in conjunction with an ER visit	No charge
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	No charge
Ambulance	100%
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 90 days combined	90%
Laboratory and Radiology Services (includes pre-admission testing)	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Outpatient Hospital Facility	90%
Independent X-ray and/or Lab Facility	90%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans) The scan copay applies per type of scan per day	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Inpatient Facility	100%
Outpatient Facility	$200 scan copay, then 100%

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BENEFIT HIGHLIGHTS	IN-NETWORK
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: 60 days for each therapy Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab **Note:** The Short-Term Rehabilitative Therapy maximum does not apply to the treatment of autism. Cognitive Therapy can be related to any therapy and will be combined with the respective therapy.	No charge after $20 per office visit copay **Note:** Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.
Outpatient Cardiac Rehabilitation Calendar Year Maximum: 18 days	No charge after the $20 per office visit copay
Chiropractic Care Calendar Year Maximum: 20 days Physician's Office Visit	 No charge after $60 per office visit copay
Home Health Care Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as Medically Necessary)	90%
Hospice Inpatient Services Outpatient Services (same coinsurance level as Home Health Care)	 90% 90%
Bereavement Counseling Services Provided as part of Hospice Care Inpatient Outpatient Services Provided by Mental Health Professional	 90% 90% Covered under Mental Health benefit

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BENEFIT HIGHLIGHTS	IN-NETWORK
Maternity Care Services	
Initial Visit to Confirm Pregnancy	No charge after the $40 PCP or $60 Specialist per office visit copay
Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.	
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	100%
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	No charge after the $40 PCP or $60 Specialist per office visit copay
Delivery - Facility (Inpatient Hospital, Birthing Center)	$500 per day copay, then 100% (Copays will not exceed $2,500 per Calendar Year)
Abortion	
Includes elective and non-elective procedures	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Inpatient Facility	$500 per day copay, then 100% (Copays will not exceed $2,500 per Calendar Year)
Outpatient Facility	$500 per visit copay, then 100%
Physician's Services	100%
Women's Family Planning Services	
Office Visits, Lab and Radiology Tests and Counseling	No charge
Note: Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.	
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)	
Physician's Office Visit	No charge
Inpatient Facility	No charge
Outpatient Facility	No charge
Physician's Services	No charge

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BENEFIT HIGHLIGHTS	IN-NETWORK
Men's Family Planning Services	
Office Visits, Lab and Radiology Tests and Counseling	No charge after the $40 PCP or $60 Specialist per office visit copay
Surgical Sterilization Procedures for Vasectomy (excludes reversals)	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Inpatient Facility	$500 per day copay, then 100% (Copays will not exceed $2,500 per Calendar Year)
Outpatient Facility	$500 per visit copay, then 100%
Physician's Services	100%
Infertility Treatment Services Not Covered include: • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc). **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Not Covered
Organ Transplants Includes all medically appropriate, non-experimental transplants	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Inpatient Facility	100% at Lifesource center after $500 per admission copay, otherwise 100% after $500 per day copay, then 100% (Copays will not exceed $2,500 per Calendar Year)
Physician's Services	100% at Lifesource center, otherwise 100%
Lifetime Travel Maximum: $10,000 per transplant	No charge (only available when using Lifesource facility)
Durable Medical Equipment Calendar Year Maximum: Unlimited	90%

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BENEFIT HIGHLIGHTS	IN-NETWORK
Breast Feeding Equipment and Supplies **Note:** Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	No charge
External Prosthetic Appliances Calendar Year Maximum: Unlimited	90%
Penile Pump **Note:** For use as a result of Prostate Cancer treatment based on Cigna's coverage position.	100%
Diabetic Equipment Calendar Year Maximum: Unlimited	100%
Nutritional Evaluation Calendar Year Maximum: 3 visits per person	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Inpatient Facility	$500 per day copay, then 100% (Copays will not exceed $2,500 per Calendar Year)
Outpatient Facility	$500 per visit copay, then 100%
Physician's Services	100%
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Inpatient Facility	$500 per day copay, then 100% (Copays will not exceed $2,500 per Calendar Year)
Outpatient Facility	$500 per visit copay, then 100%
Physician's Services	100%

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BENEFIT HIGHLIGHTS	IN-NETWORK
Bariatric Surgery **Note:** Subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate.	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Inpatient Facility	$500 per day copay, then 100% (Copays will not exceed $2,500 per Calendar Year)
Outpatient Facility	$500 per visit copay, then 100%
Physician's Services	100%
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.	
Mental Health	
Inpatient	$500 per day copay, then 100% (Copays will not exceed $2,500 per Calendar Year)
Outpatient (Includes Individual, Group and Intensive Outpatient)	
Physician's Office Visit	$40 per visit copay
Outpatient Facility	100%
Substance Abuse	
Inpatient	$500 per day copay, then 100% (Copays will not exceed $2,500 per Calendar Year)
Outpatient (Includes Individual and Intensive Outpatient)	
Physician's Office Visit	$40 per visit copay
Outpatient Facility	100%

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Open Access Plus In-Network Medical Benefits

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- outpatient facility services;
- intensive outpatient programs;
- advanced radiological imaging;
- non-emergency ambulance; or
- transplant services.

HC-PRA1 11-14
V5

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- charges made for the following preventive care services (detailed information is available at www.healthcare.gov.):
  (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
  (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
  (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in

the comprehensive guidelines supported by the Health Resources and Services Administration;

(4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

- charges made for diagnosis and Medically Necessary surgical procedures to treat dysfunction of the temporomandibular joint.
- charges made for acupuncture.
- coverage for diagnosis and treatment of autism spectrum disorder to include autistic disorder, Asperger's Syndrome and pervasive developmental disorder not otherwise specified, when prescribed by a treating Physician in accordance with a treatment plan for individuals diagnosed at age 8 or younger. Coverage is provided for Dependents to age 18, or older if attending High School. Treatment includes well-baby and well-child screening for diagnosis and treatment through speech therapy, occupational therapy, physical therapy and applied behavior analysis. Day or visit maximums applied to such treatment for other causes will not apply to treatment of autism spectrum disorder.
- charges made by a Physician, certified diabetes educator or licensed dietitian for a program which provides instruction on an outpatient basis for a person who has been diagnosed as having diabetes, for the purpose of instructing such person about the condition and its control.
- charges for general anesthesia and hospitalization services for dental procedures for an individual who is under age 8 and for whom it is determined by a licensed Dentist and the child's Physician that treatment in a Hospital or ambulatory surgical center is necessary due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proven to be ineffective; or has one or more medical conditions that would create significant or undue medical risk if the procedure were not rendered in a Hospital or ambulatory surgical center.
- charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of whether or not such services are received in a home birth setting.
- charges for the treatment of cleft lip and cleft palate including medical, dental, speech therapy, audiology and nutrition services, when prescribed by a Physician.
- charges for newborn and infant hearing screening and Medically Necessary follow-up evaluations. When ordered by the treating Physician, a newborn’s hearing screening must include auditory brainstem responses or evoked otacoustic emissions or other appropriate technology approved by the FDA. All screenings shall be conducted by a licensed audiologist, Physician, or supervised individual who has training specific to newborn hearing screening. Newborn means an age range from birth through 29 days. Infant means an age range from 30 days through 12 months.
- charges for or in connection with Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals. This includes, but is not limited to individuals who: have vertebral abnormalities; are receiving long-term glucocorticoid (steroid) therapy; have primary hyperparathyroidism; have a family history of osteoporosis; and/or are estrogen-deficient individuals who are at clinical risk for osteoporosis.
- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but not limited to: a baseline mammogram for women ages 35 through 39; a mammogram for women ages 40 through 49, every two years or more frequently based on the attending Physician's recommendations; a mammogram every year for women age 50 and over; and one or more mammograms upon the recommendation of a Physician for any woman who is at risk for breast cancer due to her family history; has biopsy proven benign breast disease; or has not given birth before age 30. A mammogram will be covered with or without a Physician’s recommendation, provided the mammogram is performed at an approved facility for breast cancer screening.
- charges for an inpatient Hospital stay following a mastectomy will be covered for a period determined to be Medically Necessary by the Physician and in consultation with the patient. Postsurgical follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.

In addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below, for a Dependent child who is age 15 or less, for charges made for Child Preventive Care Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

- a history;
- physical examination;
- development assessment;
- anticipatory guidance; and
- appropriate immunizations and laboratory tests;
- excluding any charges for:
- more than one visit to one provider for Child Preventive Care Services at each of the Approximate Age Intervals, up to a total of 18 visits for each Dependent child;
- services for which benefits are otherwise provided under this Covered Expenses section;

- services for which benefits are not payable, according to the Expenses Not Covered section.

It is provided that any Deductible that would otherwise apply will be waived for those Covered Expenses incurred for Child Preventive Care Services. Approximate Age Intervals are: Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years and 15 years.

Clinical Trials

This benefit plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

(a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

(b) either

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
- the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements:

The study or investigation must:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

- services required solely for the provision of the investigational drug, item, device or service;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:

- the investigational drug, item, device, or service, itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

If your plan includes In-Network providers, Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

- there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual's state of residence.

Genetic Testing

Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- a person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and post-genetic testing.

Nutritional Evaluation

Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

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Internal Prosthetic/Medical Appliances

Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

HC-COV1 06-14
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Orthognathic Surgery

- orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not correct, provided:
  - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
  - the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

HC-COV3 04-10
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Cardiac Rehabilitation

- Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

  Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

HC-COV4 04-10
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Home Health Services

- charges made for Home Health Services when you: require skilled care; are unable to obtain the required care as an ambulatory outpatient; and do not require confinement in a Hospital or Other Health Care Facility.

  Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

  Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

HC-COV5 04-10
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Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies;
  - by a Hospice Facility for services provided on an outpatient basis;

- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies;
- by an Other Health Care Facility for:
  - part-time or intermittent nursing care by or under the supervision of a Nurse;
  - part-time or intermittent services of an Other Health Care Professional;
- physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living.

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Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Inpatient Substance Abuse Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions and Residential Treatment services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Substance Abuse Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

Substance Abuse Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Abuse Services:

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

HC-COV7 04-10
V4

Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

Cigna

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

HC-COV8 04-10
V2

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts.

Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

Orthoses and Orthotic Devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses;
  - semirigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - no more than once every 24 months for persons 19 years of age and older;
  - no more than once every 12 months for persons 18 years of age and under; and
  - replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.

HC-COV9 04-10
V2

Short-Term Rehabilitative Therapy

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to Short-term Rehabilitative Therapy:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

- sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.

Multiple outpatient services provided on the same day constitute one day.

A separate Copayment will apply to the services provided by each provider.

Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

Chiropractic Care Services

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

The following limitation applies to Chiropractic Care Services:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;

- vitamin therapy.

HC-COV13 04-10
V2

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

HC-COV14 04-10
V1

Transplant Services

- charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

All Transplant services, other than cornea, are covered at 100% when received at Cigna LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than Cigna LIFESOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are not covered.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for reasonable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, your domestic partner, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses: travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.

HC-COV15 04-10
V2

Cigna

Prescription Drug Benefits

The Schedule

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion includes any applicable Copayment, Deductible and/or Coinsurance.

Copayments

Copayments are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Lifetime Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Out-of-Pocket Maximum		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Retail Prescription Drugs **	**The amount you pay for each 30-day supply**	**The amount you pay for each 30-day supply**
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no copayment or deductible.		
Tier 1		
Generic* Preventive drugs on the Prescription Drug List	No charge	In-network coverage only
Generic* Non-Preventive drugs on the Prescription Drug List	No charge after $20 copay	In-network coverage only
Tier 2		
Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after $40 copay	In-network coverage only
Tier 3		
Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after $60 copay	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		

Cigna

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
** You pay 100% of Cigna's discounted cost after the first fill of Specialty Medication.		
Home Delivery Prescription Drugs	**The amount you pay for each 90-day supply**	**The amount you pay for each 90-day supply**
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no copayment or deductible.		
Tier 1		
Generic* Preventive drugs on the Prescription Drug List	No charge	In-network coverage only
Generic* Non-Preventive drugs on the Prescription Drug List	No charge after $40 copay	In-network coverage only
Tier 2		
Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after $80 copay	In-network coverage only
Tier 3		
Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after $120 copay	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		

Cigna

Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in The Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, excluding Specialty Medications, at a retail Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
- up to a consecutive 90-day supply at a home delivery Participating Pharmacy, unless limited by the drug manufacturer’s packaging; or
- to one fill of Specialty Medication at a retail Participating Pharmacy. If you exceed the one fill allowed at a retail Participating Pharmacy, you will be required to pay 100% of Cigna's discounted cost; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

HC-PHR1 08-15
V7

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to Cigna to request a prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P&T Committee clinically evaluates the Prescription Drug for a different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

HC-PHR2 04-10
V6

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance shown in the Schedule, after you have satisfied your Prescription Drug Deductible, if applicable. Please refer

to the Schedule for any required Copayments, Coinsurance, Deductibles or Maximums if applicable.

When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for your, or your Dependent's convenience, a Copayment will apply to each Prescription Drug.

In no event will the Copayment or Coinsurance for the Prescription Drug or Related Supply exceed the amount paid by the plan to the Pharmacy, or the Pharmacy's Usual and Customary (U&C) charge. Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers regardless of the customer's payment source.

HC-PHR3 04-10
V4

Exclusions

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law unless state or federal law requires coverage of such drugs;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in the standard reference compendia (AHFS or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in peer-reviewed English-language bio-medical journals;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;
- any fertility drug;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue;
- any drugs that are experimental or investigational as described under the Medical "Exclusions" section of your certificate.

Other limitations are shown in the Medical "Exclusions" section of your certificate.

HC-PHR4 05-12
V24

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, you pay any applicable Copayment, Coinsurance or Deductible shown in the Schedule at the time of purchase. You do not need to file a claim form unless you are unable to purchase Prescription Drugs at a Participating Pharmacy for Emergency Services.

To purchase Prescription Drugs or Related Supplies from a home delivery Participating Pharmacy, see your home delivery drug introductory kit for details, or contact member services for assistance.

See your Employer's Benefit Plan Administrator to obtain the appropriate claim form.

HC-PHR5 04-10
V2

Cigna

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung, and Blood Institute (NHLBI) guideline is covered only at

approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded:
  - medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and
  - weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male or female voluntary sterilization procedures.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, or mental retardation.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.

- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- all nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your or your Dependent's family.
- expenses incurred outside the United States other than expenses for medically necessary urgent or emergent care while temporarily traveling abroad.

HC-EXC56 10-14

V6 M

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide services and supplies under this policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligibles

Cigna will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

(a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;

(e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

Cigna will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.

- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

Domestic Partners

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan when Medicare coverage is due to age. Therefore, when Medicare coverage is due to age, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and Cigna is the Secondary Plan. However, when Medicare coverage is due to disability, the Medicare Secondary Payer rules explained above will apply.

HC-COB1 04-10
V5

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan’s subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan’s right to recover shall apply to decedents’, minors’, and incompetent or disabled persons’ settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan’s right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called “Made-Whole Doctrine”, “Rimes Doctrine”, or any other such doctrine purporting to defeat the plan’s recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan’s rights hereunder, specifically; no court costs, attorneys' fees or other

representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".

- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

HC-SUB1 04-10
V9

Payment of Benefits

To Whom Payable

Medical Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependents, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. In addition, your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable line by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

Calculation of Covered Expenses

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology,
- the methodologies as reported by generally recognized professionals or publications.

HC-POB1 09-13
V7

Cigna

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff

If your Active Service ends due to temporary, your insurance will be continued until the date your Employer cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Temporary Leave of Absence

If your Active Service ends due to temporary leave of absence, your insurance will be continued until the date your Employer cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends. The City continues health coverage and contributions during approved FMLA absences. Employees who are on approved personal leave pay the full premium.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Employer cancels your insurance.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer cancels the insurance.

Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

HC-TRM1 04-10

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Rescissions

Your coverage may not be rescinded (retroactively terminated) by Cigna or the plan sponsor unless the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

HC-TRM80 01-11

Medical Benefits Extension Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date due to an Injury, Sickness or pregnancy, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury, Sickness or pregnancy. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date a succeeding carrier agrees to provide coverage without limitation for the disabling condition;
- the date you are no longer Totally Disabled;
- 12 months from the date the policy is canceled; or
- for pregnancy, until delivery.

Totally Disabled

You will be considered Totally Disabled if, because of an Injury or a Sickness:

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or

- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

HC-BEX42 04-11

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

HC-FED1 10-10

Notice of Provider Directory/Networks

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

If your Plan utilizes a network of Providers, a separate listing of Participating Providers who participate in the network is available to you without charge by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider/Pharmacy networks consist of a group of local medical practitioners, and Hospitals, of varied specialties as well as general practice or a group of local Pharmacies who are employed by or contracted with Cigna HealthCare.

HC-FED2 10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

HC-FED4 10-10

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special

enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
- **Eligibility for Premium Assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

HC-FED71 12-14

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

- the date you meet the Special Enrollment criteria described above; or
- the date you meet the criteria shown in the following Sections B through H.

B. Change of Status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court Order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid Eligibility/Entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

G. Reduction in work hours

If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. Enrollment in Qualified Health Plan (QHP)

The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace's annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

HC-FED70 12-14

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED67 09-14

Coverage for Maternity Hospital Stay

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (*e.g.,* your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

HC-FED10 10-10

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

HC-FED12 10-10

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

HC-FED13 10-10

Requirements of Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

HC-FED17 10-10

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

HC-FED18 10-10

Claim Determination Procedures

The following complies with federal law. Provisions of the laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice Medical Necessity determination." The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents, and in the determination notices.

Preservice Medical Necessity Determinations

When you or your representative request a required Medical Necessity determination prior to care, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination

period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's Physician will defer to the determination of the treating Physician, regarding whether an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow Cigna's procedures for requesting a required preservice Medical Necessity determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Medical Necessity Determinations

When you or your representative requests a Medical Necessity determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Postservice Claim Determinations

When you or your representative requests payment for services which have been rendered, Cigna will notify you of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

Medical - When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you" or "your" also refers to a representative or provider designated by you to act on your behalf; unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you may call the toll-free number on your ID card, explanation of benefits, or claim form and explain your concern to one of our Customer Service representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Internal Appeals Procedure

To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write us at the toll-free number on your ID card, explanation of benefits, or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

We will respond in writing with a decision within 30 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination or a postservice Medical Necessity determination. We will respond within 60 calendar days after we receive an appeal for any other postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external review at the same time, if the time to complete an expedited review would be detrimental to your medical condition.

When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

External Review Procedure

If you are not fully satisfied with the decision of Cigna's internal appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by Cigna, or any of its affiliates. A decision to request an external review to an IRO will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate an external review. Cigna and your benefit plan will abide by the decision of the IRO.

To request a review, you must notify the Appeals Coordinator within 4 months of your receipt of Cigna's appeal review denial. Cigna will then forward the file to a randomly selected IRO. The IRO will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna's Physician Reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the external review shall be completed within 72 hours.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant

Information as defined below; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a), if applicable; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record or other information which: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the appeal processes. However, no action will be brought at all unless brought within three years after proof of claim is required under the Plan. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services.

HC-FED60 03-14

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled

"Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Employer's Service Area or Elimination of a Service Area

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to emergency services only. Because the Plan does not provide out-of-network coverage, nonemergency services will not be covered under the plan outside of the Employer's service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer's Notification Requirements

Your Employer or contracted COBRA third party administrator is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must

be provided within the time frame required for the COBRA continuation coverage election notice as explained below.

- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator

within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer’s Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

HC-FED66 07-14

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1 04-10
V1

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

HC-DFS2 04-10
V2

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with Cigna for a different amount.

HC-DFS3 04-10
V1

Chiropractic Care

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

HC-DFS55 04-10
V1

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

HC-DFS4 04-10
V1

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is:
  - less than 26 years old.
  - from the end of the calendar year in which the child reaches age 26 or until the end of the calendar year in which the child reaches the age of 30, provided the child is unmarried and does not have a dependent of their own, is a Florida state resident or a full-time or part-time student, and is not covered under a plan of their own or entitled to benefits under Title XVIII of the Social Security Act. CIGNA may require such proof at least once each year until the end of the calendar year in which he attains age 30;
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

    Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of an Injury or a Sickness existing prior to the date of placement or adoption. A child also includes a foster child or a child placed in your custody by a court order from the date of placement in the home. Coverage is not required if the adopted or foster child is ultimately not placed in your home. It also includes:

• a stepchild or a child for whom you are the legal guardian;

• a child born to an insured Dependent child of yours until such child is 18 months old.

If your Domestic Partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child or student will continue until the last day of the calendar year in which the limiting age is reached.

Anyone who is eligible as an Employee can be included as a dependent of another employee.

No one may be considered as a Dependent of more than one Employee.

HC-DFS673 07-14
V1 M

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two

of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;

- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents on a pre-tax basis.

HC-DFS47 04-10
V1 M

Emergency Medical Condition

Emergency medical condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

HC-DFS394 11-10

Emergency Services

Emergency services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

HC-DFS393 11-10

Employee

The term Employee means a full-time or variable hour employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

HC-DFS7 04-10
V3 M

Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf Cigna is providing claim administration services.

HC-DFS8 04-10
V1

Essential Health Benefits

Essential health benefits means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

HC-DFS411 01-11

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

HC-DFS10 04-10
V1

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

HC-DFS11 04-10
V1

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

HC-DFS51 04-10
V1

Hospice Care Services

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

HC-DFS52 04-10
V1

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

HC-DFS53 04-10
V1

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of Mental Health and Substance Abuse or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

HC-DFS48 04-10
V1

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

HC-DFS49 04-10
V1

Injury

The term Injury means an accidental bodily injury.

HC-DFS12 04-10
V1

Maintenance Treatment

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.

HC-DFS56 04-10
V1

Maximum Reimbursable Charge - Medical

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider’s normal charge for a similar service or supply; or
- a policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

The percentile used to determine the Maximum Reimbursable Charge can be obtained by contacting Member Services/Customer Service.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

HC-DFS13 04-10
V8

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

HC-DFS16 04-10
V1

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

HC-DFS19 04-10
V1

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

HC-DFS17 04-10
V1

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement, any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

HC-DFS21 04-10
V1

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

HC-DFS22 04-10
V1

Other Health Care Facility/Other Health Professional

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities. The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

HC-DFS23 04-10
V1

Participating Pharmacy

The term Participating Pharmacy means a retail Pharmacy with which Cigna has contracted to provide prescription services to insureds, or a designated home delivery Pharmacy with which Cigna has contracted to provide home delivery prescription services to insureds. A home delivery Pharmacy is a Pharmacy that provides Prescription Drugs through mail order.

HC-DFS60 04-10
V1

Participating Provider

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

HC-DFS45 04-10
V1

Patient Protection and Affordable Care Act of 2010 ("PPACA")

Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

HC-DFS412 01-11

Pharmacy

The term Pharmacy means a retail Pharmacy, or a home delivery Pharmacy.

HC-DFS61 04-10
V1

Pharmacy & Therapeutics (P & T) Committee

A committee of Cigna Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

HC-DFS62 04-10
V1

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

HC-DFS25 04-10
V1

Prescription Drug

Prescription Drug means; a drug which has been approved by the Food and Drug Administration for safety and efficacy; certain drugs approved under the Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

HC-DFS63 04-10
V1

Prescription Drug List

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

HC-DFS64 04-10
V1

Prescription Order

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

HC-DFS65 04-10
V1

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

HC-DFS57 04-10
V1

Primary Care Physician

The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and who has been selected by you, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents.

HC-DFS40 04-10
V1

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

HC-DFS26 04-10
V1

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes

for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

HC-DFS68 04-10
V1

Review Organization

The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

HC-DFS30 04-10
V1

Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

HC-DFS50 04-10
V1

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

HC-DFS31 04-10
V1

Specialist

The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

HC-DFS33 04-10
V1

Specialty Medication

The term Specialty Medication means high cost medications which are used to treat rare and chronic conditions which include, but are not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis.

HC-DFS69 04-10
V6

Stabilize

Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

HC-DFS413 01-11

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

HC-DFS54 04-10
V1

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation

that the insured should not travel due to any medical condition.

HC-DFS34 04-10
V1

City of Fort Lauderdale

OPEN ACCESS PLUS IN-NETWORK
MEDICAL BENEFITS
Plan 2

EFFECTIVE DATE: January 1, 2016

ASO11
3335139

This document printed in February, 2016 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Important Information 5
Special Plan Provisions 7
Important Notices 8
How To File Your Claim 9
Eligibility - Effective Date 10
Employee Insurance 10
Waiting Period 10
Dependent Insurance 10
Important Information About Your Medical Plan 11
Open Access Plus In-Network Medical Benefits 12
The Schedule 12
Prior Authorization/Pre-Authorized 22
Covered Expenses 22
Prescription Drug Benefits 32
The Schedule 32
Covered Expenses 34
Limitations 34
Your Payments 34
Exclusions 35
Reimbursement/Filing a Claim 35
Exclusions, Expenses Not Covered and General Limitations 36
Coordination of Benefits 38
Expenses For Which A Third Party May Be Responsible 41
Payment of Benefits 42
Termination of Insurance 43
Employees 43
Dependents 43
Rescissions 43
Medical Benefits Extension Upon Policy Cancellation 43
Federal Requirements 44
Notice of Provider Directory/Networks 44
Qualified Medical Child Support Order (QMCSO) 44
Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA) 44
Effect of Section 125 Tax Regulations on This Plan 46
Eligibility for Coverage for Adopted Children 46
Coverage for Maternity Hospital Stay 47
Women's Health and Cancer Rights Act (WHCRA) 47
Group Plan Coverage Instead of Medicaid 47

Requirements of Medical Leave Act of 1993 (as amended) (FMLA) 47
Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA) 48
Claim Determination Procedures 48
Medical - When You Have a Complaint or an Appeal 50
COBRA Continuation Rights Under Federal Law 51
Definitions 54

Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY CITY OF FORT LAUDERDALE WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

HC-NOT1

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Special Plan Provisions

Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction With Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card.

HC-SPP1 04-10
V1

Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, your dependent or an attending Physician can request Case Management services by calling the **toll-free number** shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate).
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

HC-SPP2 04-10
V1

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well being of our members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

HC-SPP3 04-10
V1

Care Management and Care Coordination Services

Your plan may enter into specific collaborative arrangements with health care professionals committed to improving quality care, patient satisfaction and affordability. Through these collaborative arrangements, health care professionals commit to proactively providing participants with certain care management and care coordination services to facilitate achievement of these goals. Reimbursement is provided at 100% for these services when rendered by designated health care professionals in these collaborative arrangements.

HC-SPP27 06-15
V1

Important Notices

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Selection of a Primary Care Provider

This plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

HC-NOT5 01-11

Important Information

Mental Health Parity and Addiction Equity Act

The Certificate is amended as stated below:

In the event of a conflict between the provisions of your plan documents and the provisions of this notice, the provisions that provide the better benefit shall apply.

The Schedule and Mental Health and Substance Abuse Covered Expenses:

Partial Hospitalization charges for Mental Health and Substance Abuse will be paid at the Outpatient level. Covered Expenses are changed as follows:

Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the

appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services are Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, or for Partial Hospitalization sessions, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Inpatient Substance Abuse Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Residential Treatment services.

Substance Abuse Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

Substance Abuse Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Abuse Intensive Outpatient Therapy Program and for Partial Hospitalization sessions.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Mental Health and Substance Abuse Exclusions:

The following exclusion is hereby deleted and no longer applies:

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.

Terms within the agreement:

The term “mental retardation” within your Certificate is hereby changed to “intellectual disabilities”.

Visit Limits:

Any health care service billed with a Mental Health or Substance Abuse diagnosis, will not incur a visit limit, including but not limited to genetic counseling and nutritional evaluation/counseling.

HC-NOT69 12-14

How To File Your Claim

If your plan provides coverage when care is received only from In-Network providers, you may still have Out-of-Network claims (for example, when Emergency Services are received from an Out-of-Network provider) and should follow the claim submission instructions for those claims. Claims can

be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by using the toll-free number on your identification card.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 180 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 days for Out-of-Network benefits, the claim will not be considered valid and will be denied.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

HC-CLM25 01-11

V11

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee who normally work at least 30 hours a week; or
- you are an eligible, variable hour Employee who work an average of 30 hours per week during the City's Measurement period as required by the Affordable Care Act; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

The first day of the month following date of hire.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction

form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included. A newborn child will be covered for the first 31 days of life even if you fail to enroll the child. If you enroll the child after the first 31 days and by the 60th day after his birth, coverage will be offered at an additional premium. Coverage for an adopted child will become effective from the date of placement in your home or from birth for the first 31 days even if you fail to enroll the child. However, if you enroll the adopted child between the 31st and 60th days after his birth or placement in your home, coverage will be offered at an additional premium.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

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Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

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Open Access Plus In-Network Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus In-Network Medical Benefits provide coverage for care In-Network. To receive Open Access Plus In-Network Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

When you receive services from an In-Network Provider, remind your provider to utilize In-Network Providers for x-rays, lab tests and other services to ensure the cost may be considered at the In-Network level.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for covered services. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in the Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

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BENEFIT HIGHLIGHTS	IN-NETWORK
Lifetime Maximum	Unlimited
The Percentage of Covered Expenses the Plan Pays **Note:** "No charge" means an insured person is not required to pay Coinsurance.	80%
Calendar Year Deductible	
Employee	$1,000 per employee
Employee Plus One	$2,000 per employee plus one
Family Maximum	$3,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.	
Combined Out-of-Pocket Maximum for Medical and Pharmacy expenses	
Employee	$6,350 per employee
Employee Plus One	$10,000 per employee plus one
Family Maximum	$12,700 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.	

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BENEFIT HIGHLIGHTS	IN-NETWORK
Combined Medical/Pharmacy Out-of-Pocket Maximum	
Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery prescription drugs	Yes
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	Yes
Physician's Services	
Primary Care Physician's Office Visit	No charge after $40 per office visit copay
Specialty Care Physician's Office Visits	No charge after $60 per office visit copay
Consultant and Referral Physician's Services **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.	
Surgery Performed in the Physician's Office	No charge after the $40 PCP or $60 Specialist per office visit copay
Second Opinion Consultations (provided on a voluntary basis)	No charge after the $40 PCP or $60 Specialist per office visit copay
Allergy Treatment/Injections (includes Allergy Skin Testing)	No charge after $10 per office visit copay
Allergy Serum (dispensed by the Physician in the office)	No charge
Preventive Care **Note:** Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.	
Routine Preventive Care - all ages	No charge
Immunizations - all ages	No charge
Mammograms, PSA, PAP Smear, Early Cancer Detection Colon/Rectal	
Preventive Care Related Services (i.e. "routine" services)	No charge
Diagnostic Related Services (i.e. "non-routine" services) **Note**: Including Colonoscopies and all associated charges covered at 100% preventive/diagnostic	No charge

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BENEFIT HIGHLIGHTS	IN-NETWORK
Inpatient Hospital - Facility Services	80% after plan deductible
Semi-Private Room and Board	Limited to the semi-private negotiated rate
Private Room	Limited to the semi-private negotiated rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	80% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	80% after plan deductible
Outpatient Hospital Physician's Visits/Consultations	100% after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	100%
Emergency and Urgent Care Services	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Hospital Emergency Room	No charge after $200 per visit copay* *waived if admitted
Outpatient Professional services (radiology, pathology and ER Physician)	No charge
Urgent Care Facility or Outpatient Facility	No charge after $60 per visit copay* *waived if admitted
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	No charge
Independent x-ray and/or Lab Facility in conjunction with an ER visit	No charge
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	No charge
Ambulance	No charge after $100 per trip copay

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BENEFIT HIGHLIGHTS	IN-NETWORK
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 90 days combined	80% after plan deductible
Laboratory and Radiology Services (includes pre-admission testing)	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Outpatient Hospital Facility	90%
Independent X-ray and/or Lab Facility	90%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans) The scan copay applies per type of scan per day	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Inpatient Facility	80% after plan deductible
Outpatient Facility	$200 scan copay, then 100%
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: 60 days for each therapy Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab **Note:** The Short-Term Rehabilitative Therapy maximum does not apply to the treatment of autism. Cognitive therapy can be related to any therapy and will be combined with the respective therapy.	No charge after $20 per office visit copay **Note:** Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.
Outpatient Cardiac Rehabilitation Calendar Year Maximum: 18 days	No charge after the $20 per office visit copay
Chiropractic Care Calendar Year Maximum: 20 days	
Physician's Office Visit	No charge after $60 per office visit copay

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BENEFIT HIGHLIGHTS	IN-NETWORK
Home Health Care	
Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as Medically Necessary)	80% after plan deductible
Hospice	
Inpatient Services	80% after plan deductible
Outpatient Services (same coinsurance level as Home Health Care)	80% after plan deductible
Bereavement Counseling	
Services Provided as part of Hospice Care	
Inpatient	80% after plan deductible
Outpatient	80% after plan deductible
Services Provided by Mental Health Professional	Covered under Mental Health benefit
Maternity Care Services	
Initial Visit to Confirm Pregnancy **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.	No charge after the $40 PCP or $60 Specialist per office visit copay
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	80% after plan deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	No charge after the $40 PCP or $60 Specialist per office visit copay
Delivery - Facility (Inpatient Hospital, Birthing Center)	80% after plan deductible
Abortion	
Includes elective and non-elective procedures	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Inpatient Facility	80% after plan deductible
Outpatient Facility	80% after plan deductible
Inpatient Professional Services	80% after plan deductible
Outpatient Professional Services	100%

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BENEFIT HIGHLIGHTS	IN-NETWORK
Women's Family Planning Services	
Office Visits, Lab and Radiology Tests and Counseling	No charge
Note: Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.	
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)	
Physician's Office Visit	No charge
Inpatient Facility	No charge
Outpatient Facility	No charge
Physician's Services	No charge
Men's Family Planning Services	
Office Visits, Lab and Radiology Tests and Counseling	No charge after the $40 PCP or $60 Specialist per office visit copay
Surgical Sterilization Procedures for Vasectomy (excludes reversals)	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Inpatient Facility	80% after plan deductible
Outpatient Facility	80% after plan deductible
Inpatient Professional Services	80% after plan deductible
Outpatient Professional Services	100%
Infertility Treatment	
Services Not Covered include: • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).	Not Covered
Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	

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BENEFIT HIGHLIGHTS	IN-NETWORK
Organ Transplants Includes all medically appropriate, non-experimental transplants	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Inpatient Facility	100% at Lifesource center after plan deductible , otherwise 80% after plan deductible
Physician's Services	100% at Lifesource center after plan deductible , otherwise 80% after plan deductible
Lifetime Travel Maximum: $10,000 per transplant	No charge (only available when using Lifesource facility)
Durable Medical Equipment Calendar Year Maximum: Unlimited	80%
Breast Feeding Equipment and Supplies **Note:** Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	No charge
External Prosthetic Appliances Calendar Year Maximum: Unlimited	80%
Acupuncture Calendar Year Maximum: Unlimited	No charge after $60 per office visit copay
Penile Pump **Note:** For use as a result of Prostate Cancer treatment based on Cigna's coverage position.	80% after plan deductible
Diabetic Equipment Calendar Year Maximum: Unlimited	80% after plan deductible
Nutritional Evaluation Calendar Year Maximum: 3 visits per person	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Inpatient Facility	80% after plan deductible
Outpatient Facility	80% after plan deductible
Inpatient Professional Services	80% after plan deductible
Outpatient Professional Services	100%

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BENEFIT HIGHLIGHTS	IN-NETWORK
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Inpatient Facility	80% after plan deductible
Outpatient Facility	80% after plan deductible
Inpatient Professional Services	80% after plan deductible
Outpatient Professional Services	100%
Bariatric Surgery **Note:** Subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate.	
Physician's Office Visit	No charge after the $40 PCP or $60 Specialist per office visit copay
Inpatient Facility	80% after plan deductible
Outpatient Facility	80% after plan deductible
Inpatient Professional Services	80% after plan deductible
Outpatient Professional Services	100%
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.	
Mental Health	
Inpatient	80% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)	
Physician's Office Visit	$40 per visit copay
Outpatient Facility	80% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK
Substance Abuse	
Inpatient	80% after plan deductible
Outpatient (Includes Individual and Intensive Outpatient)	
Physician's Office Visit	$40 per visit copay
Outpatient Facility	80% after plan deductible

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Open Access Plus In-Network Medical Benefits

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- outpatient facility services;
- intensive outpatient programs;
- advanced radiological imaging;
- non-emergency ambulance; or
- transplant services.

HC-PRA1 11-14
V5

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- charges made for the following preventive care services (detailed information is available at www.healthcare.gov.):
  (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
  (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
  (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in

the comprehensive guidelines supported by the Health Resources and Services Administration;

(4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

- charges made for diagnosis and Medically Necessary surgical procedures to treat dysfunction of the temporomandibular joint.
- charges made for acupuncture.
- coverage for diagnosis and treatment of autism spectrum disorder to include autistic disorder, Asperger's Syndrome and pervasive developmental disorder not otherwise specified, when prescribed by a treating Physician in accordance with a treatment plan for individuals diagnosed at age 8 or younger. Coverage is provided for Dependents to age 18, or older if attending High School. Treatment includes well-baby and well-child screening for diagnosis and treatment through speech therapy, occupational therapy, physical therapy and applied behavior analysis. Day or visit maximums applied to such treatment for other causes will not apply to treatment of autism spectrum disorder.
- charges made by a Physician, certified diabetes educator or licensed dietitian for a program which provides instruction on an outpatient basis for a person who has been diagnosed as having diabetes, for the purpose of instructing such person about the condition and its control.
- charges for general anesthesia and hospitalization services for dental procedures for an individual who is under age 8 and for whom it is determined by a licensed Dentist and the child's Physician that treatment in a Hospital or ambulatory surgical center is necessary due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proven to be ineffective; or has one or more medical conditions that would create significant or undue medical risk if the procedure were not rendered in a Hospital or ambulatory surgical center.
- charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of whether or not such services are received in a home birth setting.
- charges for the treatment of cleft lip and cleft palate including medical, dental, speech therapy, audiology and nutrition services, when prescribed by a Physician.
- charges for newborn and infant hearing screening and Medically Necessary follow-up evaluations. When ordered by the treating Physician, a newborn’s hearing screening must include auditory brainstem responses or evoked otacoustic emissions or other appropriate technology approved by the FDA. All screenings shall be conducted by a licensed audiologist, Physician, or supervised individual who has training specific to newborn hearing screening. Newborn means an age range from birth through 29 days. Infant means an age range from 30 days through 12 months.
- charges for or in connection with Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals. This includes, but is not limited to individuals who: have vertebral abnormalities; are receiving long-term glucocorticoid (steroid) therapy; have primary hyperparathyroidism; have a family history of osteoporosis; and/or are estrogen-deficient individuals who are at clinical risk for osteoporosis.
- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but not limited to: a baseline mammogram for women ages 35 through 39; a mammogram for women ages 40 through 49, every two years or more frequently based on the attending Physician's recommendations; a mammogram every year for women age 50 and over; and one or more mammograms upon the recommendation of a Physician for any woman who is at risk for breast cancer due to her family history; has biopsy proven benign breast disease; or has not given birth before age 30. A mammogram will be covered with or without a Physician’s recommendation, provided the mammogram is performed at an approved facility for breast cancer screening.
- charges for an inpatient Hospital stay following a mastectomy will be covered for a period determined to be Medically Necessary by the Physician and in consultation with the patient. Postsurgical follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.

In addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below, for a Dependent child who is age 15 or less, for charges made for Child Preventive Care Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

- a history;
- physical examination;
- development assessment;
- anticipatory guidance; and
- appropriate immunizations and laboratory tests;
- excluding any charges for:
- more than one visit to one provider for Child Preventive Care Services at each of the Approximate Age Intervals, up to a total of 18 visits for each Dependent child;
- services for which benefits are otherwise provided under this Covered Expenses section;

- services for which benefits are not payable, according to the Expenses Not Covered section.

It is provided that any Deductible that would otherwise apply will be waived for those Covered Expenses incurred for Child Preventive Care Services. Approximate Age Intervals are: Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years and 15 years.

Clinical Trials

This benefit plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

(a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

(b) either

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
- the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements:

The study or investigation must:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

- services required solely for the provision of the investigational drug, item, device or service;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:

- the investigational drug, item, device, or service, itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

If your plan includes In-Network providers, Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

- there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual's state of residence.

Genetic Testing

Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- a person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and post-genetic testing.

Nutritional Evaluation

Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Internal Prosthetic/Medical Appliances

Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

HC-COV1 06-14
V12

Orthognathic Surgery

- orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not correct, provided:
  - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
  - the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

HC-COV3 04-10
V1

Cardiac Rehabilitation

- Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

  Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

HC-COV4 04-10
V1

Home Health Services

- charges made for Home Health Services when you: require skilled care; are unable to obtain the required care as an ambulatory outpatient; and do not require confinement in a Hospital or Other Health Care Facility.

  Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

  Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

HC-COV5 04-10
V1

Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies;
  - by a Hospice Facility for services provided on an outpatient basis;

- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies;
- by an Other Health Care Facility for:
  - part-time or intermittent nursing care by or under the supervision of a Nurse;
  - part-time or intermittent services of an Other Health Care Professional;
- physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living.

HC-COV6 04-10
V1

Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Inpatient Substance Abuse Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions and Residential Treatment services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Substance Abuse Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

Substance Abuse Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Abuse Services:

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

HC-COV7 04-10
V4

Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

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Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

HC-COV8 04-10
V2

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts.

Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

Orthoses and Orthotic Devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses;
  - semirigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - no more than once every 24 months for persons 19 years of age and older;
  - no more than once every 12 months for persons 18 years of age and under; and
  - replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.

HC-COV9 04-10
V2

Short-Term Rehabilitative Therapy

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to Short-term Rehabilitative Therapy:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

- sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.

Multiple outpatient services provided on the same day constitute one day.

A separate Copayment will apply to the services provided by each provider.

Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

Chiropractic Care Services

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

The following limitation applies to Chiropractic Care Services:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;

- vitamin therapy.

HC-COV13 04-10
V2

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

HC-COV14 04-10
V1

Transplant Services

- charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

All Transplant services, other than cornea, are covered at 100% when received at Cigna LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than Cigna LIFESOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are not covered.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for reasonable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, your domestic partner, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses: travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.

HC-COV15 04-10
V2

Cigna

Prescription Drug Benefits

The Schedule

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion includes any applicable Copayment, Deductible and/or Coinsurance.

Copayments

Copayments are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Lifetime Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Out-of-Pocket Maximum		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Retail Prescription Drugs **	**The amount you pay for each 30-day supply**	**The amount you pay for each 30-day supply**
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no copayment or deductible.		
Tier 1		
Generic* Preventive drugs on the Prescription Drug List	No charge	In-network coverage only
Generic* Non-Preventive drugs on the Prescription Drug List	No charge after $20 copay	In-network coverage only
Tier 2		
Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after $40 copay	In-network coverage only
Tier 3		
Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after $60 copay	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		

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BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
** You pay 100% of Cigna's discounted cost after the first fill of Specialty Medication.		
Home Delivery Prescription Drugs	**The amount you pay for each 90-day supply**	**The amount you pay for each 90-day supply**
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no copayment or deductible.		
Tier 1		
Generic* Preventive drugs on the Prescription Drug List	No charge	In-network coverage only
Generic* Non-Preventive drugs on the Prescription Drug List	No charge after $40 copay	In-network coverage only
Tier 2		
Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after $80 copay	In-network coverage only
Tier 3		
Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after $120 copay	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		

Cigna

Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in The Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, excluding Specialty Medications, at a retail Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
- up to a consecutive 90-day supply at a home delivery Participating Pharmacy, unless limited by the drug manufacturer’s packaging; or
- to one fill of Specialty Medication at a retail Participating Pharmacy. If you exceed the one fill allowed at a retail Participating Pharmacy, you will be required to pay 100% of Cigna's discounted cost; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

HC-PHR1 08-15
V7

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to Cigna to request a prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P&T Committee clinically evaluates the Prescription Drug for a different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

HC-PHR2 04-10
V6

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance shown in the Schedule, after you have satisfied your Prescription Drug Deductible, if applicable. Please refer

to the Schedule for any required Copayments, Coinsurance, Deductibles or Maximums if applicable.

When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for your, or your Dependent's convenience, a Copayment will apply to each Prescription Drug.

In no event will the Copayment or Coinsurance for the Prescription Drug or Related Supply exceed the amount paid by the plan to the Pharmacy, or the Pharmacy's Usual and Customary (U&C) charge. Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers regardless of the customer's payment source.

HC-PHR3 04-10
V4

Exclusions

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law unless state or federal law requires coverage of such drugs;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in the standard reference compendia (AHFS or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in peer-reviewed English-language bio-medical journals;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;
- any fertility drug;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue;
- any drugs that are experimental or investigational as described under the Medical "Exclusions" section of your certificate.

Other limitations are shown in the Medical "Exclusions" section of your certificate.

HC-PHR4 05-12
V24

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, you pay any applicable Copayment, Coinsurance or Deductible shown in the Schedule at the time of purchase. You do not need to file a claim form unless you are unable to purchase Prescription Drugs at a Participating Pharmacy for Emergency Services.

To purchase Prescription Drugs or Related Supplies from a home delivery Participating Pharmacy, see your home delivery drug introductory kit for details, or contact member services for assistance.

See your Employer's Benefit Plan Administrator to obtain the appropriate claim form.

HC-PHR5 04-10
V2

Cigna

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung, and Blood Institute (NHLBI) guideline is covered only at

approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded:
  - medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and
  - weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male or female voluntary sterilization procedures.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, or mental retardation.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.

- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- all nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents:

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your or your Dependent's family.
- expenses incurred outside the United States other than expenses for medically necessary urgent or emergent care while temporarily traveling abroad.

HC-EXC56 10-14

V6 M

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide services and supplies under this policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligibles

Cigna will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

(a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;

(e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

Cigna will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.

- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

Domestic Partners

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan when Medicare coverage is due to age. Therefore, when Medicare coverage is due to age, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and Cigna is the Secondary Plan. However, when Medicare coverage is due to disability, the Medicare Secondary Payer rules explained above will apply.

HC-COB1 04-10
V5

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other

representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".

- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

HC-SUB1 04-10
V9

Payment of Benefits

To Whom Payable

Medical Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependents, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. In addition, your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable line by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

Calculation of Covered Expenses

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology,
- the methodologies as reported by generally recognized professionals or publications.

HC-POB1 09-13
V7

Cigna

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends. The City continues health coverage and contributions during approved FMLA absences. Employees who are on approved personal leave pay the full premium.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Employer cancels your insurance.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer cancels the insurance.

Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

HC-TRM1 04-10

V1 M

Rescissions

Your coverage may not be rescinded (retroactively terminated) by Cigna or the plan sponsor unless the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

HC-TRM80 01-11

Medical Benefits Extension Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date due to an Injury, Sickness or pregnancy, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury, Sickness or pregnancy. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date a succeeding carrier agrees to provide coverage without limitation for the disabling condition;
- the date you are no longer Totally Disabled;
- 12 months from the date the policy is canceled; or
- for pregnancy, until delivery.

Totally Disabled

You will be considered Totally Disabled if, because of an Injury or a Sickness:

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

HC-BEX42 04-11

Cigna

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

HC-FED1 10-10

Notice of Provider Directory/Networks

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

If your Plan utilizes a network of Providers, a separate listing of Participating Providers who participate in the network is available to you without charge by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider/Pharmacy networks consist of a group of local medical practitioners, and Hospitals, of varied specialties as well as general practice or a group of local Pharmacies who are employed by or contracted with Cigna HealthCare.

HC-FED2 10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

HC-FED4 10-10

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already

enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
- **Eligibility for Premium Assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

Cigna

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

- the date you meet the Special Enrollment criteria described above; or
- the date you meet the criteria shown in the following Sections B through H.

B. Change of Status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court Order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid Eligibility/Entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

G. Reduction in work hours

If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. Enrollment in Qualified Health Plan (QHP)

The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace's annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

HC-FED70 12-14

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED67 09-14

Coverage for Maternity Hospital Stay

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (*e.g.,* your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

HC-FED10 10-10

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

HC-FED12 10-10

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

HC-FED13 10-10

Requirements of Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

HC-FED17 10-10

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

HC-FED18 10-10

Claim Determination Procedures

The following complies with federal law. Provisions of the laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice Medical Necessity determination." The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents, and in the determination notices.

Preservice Medical Necessity Determinations

When you or your representative request a required Medical Necessity determination prior to care, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination

period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's Physician will defer to the determination of the treating Physician, regarding whether an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow Cigna's procedures for requesting a required preservice Medical Necessity determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Medical Necessity Determinations

When you or your representative requests a Medical Necessity determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Postservice Claim Determinations

When you or your representative requests payment for services which have been rendered, Cigna will notify you of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

Medical - When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you" or "your" also refers to a representative or provider designated by you to act on your behalf; unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you may call the toll-free number on your ID card, explanation of benefits, or claim form and explain your concern to one of our Customer Service representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Internal Appeals Procedure

To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write us at the toll-free number on your ID card, explanation of benefits, or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

We will respond in writing with a decision within 30 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination or a postservice Medical Necessity determination. We will respond within 60 calendar days after we receive an appeal for any other postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external review at the same time, if the time to complete an expedited review would be detrimental to your medical condition.

When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

External Review Procedure

If you are not fully satisfied with the decision of Cigna's internal appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by Cigna, or any of its affiliates. A decision to request an external review to an IRO will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate an external review. Cigna and your benefit plan will abide by the decision of the IRO.

To request a review, you must notify the Appeals Coordinator within 4 months of your receipt of Cigna's appeal review denial. Cigna will then forward the file to a randomly selected IRO. The IRO will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna's Physician Reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the external review shall be completed within 72 hours.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant

Information as defined below; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a), if applicable; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record or other information which: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the appeal processes. However, no action will be brought at all unless brought within three years after proof of claim is required under the Plan. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services.

HC-FED60 03-14

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled

"Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Employer's Service Area or Elimination of a Service Area

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to emergency services only. Because the Plan does not provide out-of-network coverage, nonemergency services will not be covered under the plan outside of the Employer's service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer's Notification Requirements

Your Employer or contracted COBRA third party administrator is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must

be provided within the time frame required for the COBRA continuation coverage election notice as explained below.

- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator

within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer’s Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

HC-FED66 07-14

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1 04-10
V1

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

HC-DFS2 04-10
V2

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with Cigna for a different amount.

HC-DFS3 04-10
V1

Chiropractic Care

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

HC-DFS55 04-10
V1

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

HC-DFS4 04-10
V1

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is:
  - less than 26 years old.
  - from the end of the calendar year in which the child reaches age 26 or until the end of the calendar year in which the child reaches the age of 30, provided the child is unmarried and does not have a dependent of their own, is a Florida state resident or a full-time or part-time student, and is not covered under a plan of their own or entitled to benefits under Title XVIII of the Social Security Act. CIGNA may require such proof at least once each year until the end of the calendar year in which he attains age 30;
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

    Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of an Injury or a Sickness existing prior to the date of placement or adoption. A child also includes a foster child or a child placed in your custody by a court order from the date of placement in the home. Coverage is not required if the adopted or foster child is ultimately not placed in your home. It also includes:

• a stepchild or a child for whom you are the legal guardian;

• a child born to an insured Dependent child of yours until such child is 18 months old.

If your Domestic Partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child or student will continue until the last day of the calendar year in which the limiting age is reached.

Anyone who is eligible as an Employee can be included as a dependent of another employee.

No one may be considered as a Dependent of more than one Employee.

HC-DFS673 07-14
V1 M

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two

of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;

- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents on a pre-tax basis.

HC-DFS47 04-10
V1 M

Emergency Medical Condition

Emergency medical condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

HC-DFS394 11-10

Emergency Services

Emergency services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

HC-DFS393 11-10

Employee

The term Employee means a full-time or variable hour employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

HC-DFS7 04-10
V3 M

Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf Cigna is providing claim administration services.

HC-DFS8 04-10
V1

Essential Health Benefits

Essential health benefits means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

HC-DFS411 01-11

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

HC-DFS10 04-10
V1

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

HC-DFS11 04-10
V1

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

HC-DFS51 04-10
V1

Hospice Care Services

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

HC-DFS52 04-10
V1

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

HC-DFS53 04-10
V1

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of Mental Health and Substance Abuse or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

HC-DFS48 04-10
V1

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

HC-DFS49 04-10
V1

Injury

The term Injury means an accidental bodily injury.

HC-DFS12 04-10
V1

Maintenance Treatment

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.

HC-DFS56 04-10
V1

Maximum Reimbursable Charge - Medical

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider’s normal charge for a similar service or supply; or
- a policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

The percentile used to determine the Maximum Reimbursable Charge can be obtained by contacting Member Services/Customer Service.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

HC-DFS13 04-10
V8

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

HC-DFS16 04-10
V1

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

HC-DFS19 04-10
V1

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

HC-DFS17 04-10
V1

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement, any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

HC-DFS21 04-10
V1

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

HC-DFS22 04-10
V1

Other Health Care Facility/Other Health Professional

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities. The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

HC-DFS23 04-10
V1

Participating Pharmacy

The term Participating Pharmacy means a retail Pharmacy with which Cigna has contracted to provide prescription services to insureds, or a designated home delivery Pharmacy with which Cigna has contracted to provide home delivery prescription services to insureds. A home delivery Pharmacy is a Pharmacy that provides Prescription Drugs through mail order.

HC-DFS60 04-10
V1

Participating Provider

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

HC-DFS45 04-10
V1

Patient Protection and Affordable Care Act of 2010 ("PPACA")

Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

HC-DFS412 01-11

Pharmacy

The term Pharmacy means a retail Pharmacy, or a home delivery Pharmacy.

HC-DFS61 04-10
V1

Pharmacy & Therapeutics (P & T) Committee

A committee of Cigna Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

HC-DFS62 04-10
V1

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

HC-DFS25 04-10
V1

Prescription Drug

Prescription Drug means; a drug which has been approved by the Food and Drug Administration for safety and efficacy; certain drugs approved under the Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

HC-DFS63 04-10
V1

Prescription Drug List

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

HC-DFS64 04-10
V1

Prescription Order

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

HC-DFS65 04-10
V1

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

HC-DFS57 04-10
V1

Primary Care Physician

The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and who has been selected by you, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents.

HC-DFS40 04-10
V1

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

HC-DFS26 04-10
V1

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes

for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

HC-DFS68 04-10
V1

Review Organization

The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

HC-DFS30 04-10
V1

Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

HC-DFS50 04-10
V1

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

HC-DFS31 04-10
V1

Specialist

The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

HC-DFS33 04-10
V1

Specialty Medication

The term Specialty Medication means high cost medications which are used to treat rare and chronic conditions which include, but are not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis.

HC-DFS69 04-10
V6

Stabilize

Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

HC-DFS413 01-11

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

HC-DFS54 04-10
V1

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation

that the insured should not travel due to any medical condition.

HC-DFS34 04-10
V1

Attachment 3

BUSINESS ASSOCIATE AGREEMENT

This Agreement is made and entered into this _____ day of _____, 2015, by and between the City of Fort Lauderdale, a Florida municipality (hereinafter referred to as the "Covered Entity" or “City”) and _____, Inc., a _____ corporation (hereinafter referred to as “Business Associate”).

WHEREAS, the Covered Entity and the Business Associate have established a business relationship in which Business Associate, acting for or on behalf of Covered Entity, receives Protected Health Information as defined by the Health Insurance Portability and Accountability Act of 1996 (“Act”); and

WHEREAS, the Covered Entity and the Business Associate desire to comply with the requirements of the Act’s Privacy Rule as further set out below.

NOW, THEREFORE, in consideration of the mutual covenants, promises and agreements set forth herein, the Covered Entity and the Business Associate agree as follows:

1. Definitions

a. Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy and Security Rules (“Privacy Rule”), as codified in 45 Code of Federal Regulations Parts 160 through 164, as may be amended.

2. Obligations and Activities of Business Associate

a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required by Law.

b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.

Attachment 3

e. Business Associate agrees to ensure that any agent or subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

f. Business Associate agrees to provide access, at the request of Covered Entity, and in a reasonable time and manner, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524, if the Business Associate has Protected Health Information in a Designated Record Set.

g. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526 at the request of Covered Entity or an Individual, in a reasonable time and manner, if Business Associate has Protected Health Information in a Designated Record Set.

h. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or to the Secretary, in a reasonable time and manner or as designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

i. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

j. Business Associate agrees to provide to Covered Entity or an Individual, within thirty (30) days of receipt of a written request from the Covered Entity or an Individual, information collected in accordance with Section 2.i of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

Attachment 3

k. Sections 164.308, 164.310, 164.312, and 164.316 of Title 45, Code of Federal Regulations, shall apply to Business Associate in the same manner that such sections apply to Covered Entity.

l. Business Associate shall comply with the privacy, security, and security breach notification provisions applicable to a business associate pursuant to Subtitle D of the Health Information Technology for Economic and Clinical Health Act which is Title XIII of Division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), 42 U.S.C.A. §13400 *et seq.* (2010), as may be amended or revised, ("HITECH"), any regulations promulgated thereunder, and any amendments to the Privacy Rule, all of which are hereby incorporated herein by reference.

3. Permitted Uses and Disclosures by Business Associate

a. Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Pharmacy Benefit Management Agreement, No. 195-10309, between the City of Fort Lauderdale and the Business Associate ("Original Contract"), provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

4. Specific Use and Disclosure Provisions

a. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

b. Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

c. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

d. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(1).

Attachment 3

5. Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

6. Permissible Requests by Covered Entity

a. Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, except that Business Associate may use or disclose Protected Health Information for data aggregation or management and administrative activities of Business Associate if required by the terms of the Original Contract.

7. Term and Termination

a. The Term of this Agreement shall be effective as of the effective date of the Original Contract, and shall terminate when the Original Contract terminates. Upon termination, all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, shall be destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, or if it is illegal to destroy Protected Health Information, the protections are extended to such information, in accordance with the termination provisions in this Section.

b. Upon either party's knowledge of a material breach by the other party, the nonbreaching party shall either:

1. Provide an opportunity of at least thirty (30) days for the breaching party to cure the breach or end the violation and terminate this Agreement and the Original Contract if the breaching party does not cure the breach or end the violation within the time specified by the nonbreaching party;

Attachment 3

2. Immediately terminate this Agreement and the Original Contract if the breaching party has breached a material term of this Agreement and cure is not possible; or

3. If neither termination nor cure is feasible, the nonbreaching party shall report the violation to the Secretary.

c. Effect of Termination

1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return, or destroy, except as prohibited by the Florida public records law, all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

2. In the event that Business Associate's return or destruction of the Protected Health Information would be infeasible or illegal, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible or illegal, for so long as Business Associate maintains such Protected Health Information. Upon written request from the Covered Entity, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible or illegal. At all times Business Associate shall comply with the Florida public records law and exemptions therefrom, and applicable Florida records retention requirements.

8. Miscellaneous

a. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended or revised.

b. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191. If the parties are unable to reach agreement regarding an amendment to this Agreement, either Business Associate or Covered Entity may terminate this Agreement upon ninety (90) days written notice to the other party.

c. The respective rights and obligations of Business Associate under Sections 7(c)(1) and 7(c)(2) of this Agreement shall survive the termination of this Agreement.

Attachment 3

d. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

e. Business Associate shall indemnify, hold harmless, and defend at Business Associate's expense, counsel being subject to Covered Entity's approval, the Covered Entity, and the Covered Entity's officers and employees (collectively "indemnitees"), against any and all claims, actions, lawsuits, damages, losses, liabilities, judgments, fines, penalties, costs, and expenses incurred by any of the indemnitees arising out of or in connection with Business Associate's or any of Business Associate's officers', employees', agents', or subcontractors' breach of this Agreement or any act or omission by Business Associate or by any of Business Associate's officers, employees, agents, or subcontractors, including Business Associate's failure to perform any of its obligations under the Privacy Rule. Business Associate shall pay any and all expenses, fines, judgments, and penalties, including court costs and attorney fees, which may be imposed upon any of the indemnitees resulting from or arising out of Business Associate's or any of Business Associate's officers', employees', agents', or subcontractors' breach of this Agreement or other act or omission.

f. Venue for any lawsuit or any other legal proceedings brought by either party against the other party or otherwise arising out of this Agreement, shall be in Broward County, Florida, or, in the event of federal jurisdiction, in the United States District Court for the Southern District of Florida, with appellate jurisdiction in the respective corresponding appellate tribunals.

IN WITNESS WHEREOF, the City of Fort Lauderdale and P & A Administrative Services, Inc., execute this Business Associate Agreement as follows:

CITY OF FORT LAUDERDALE

By:_____
Director of Finance

WITNESSES:

_____
(Signature)
Print Name:
_____

(company name)

By_____
Chairman

Attachment 3

(Signature)
Print Name:

ATTEST:

_____
Secretary

(CORPORATE SEAL)

STATE OF _____:
COUNTY OF _____:

The foregoing Business Associate Agreement was acknowledged before me this _____day of _____, 2015, by _____ as (title) _____for (name of company) _____.

(SEAL)

_____
Notary Public, State of _____
(Signature of Notary Public - State of _____)

_____
(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known _____ OR Produced Identification

Type of Identification Produced _____

RFP #745-11427
ATTACHMENT 4

Questionnaire - Actuarial RFP

1. State the number of years Contractor's firm has been in existence, the number of years Contractor has provided the Scope of Services requested, the current number of actuaries in the organization, total number of employees, location of the office to service the City and the primary markets served.

2. Describe the firm, including the size and range of services performed. Particular emphasis should be given as to how the firm-wide experience and expertise in the areas addressed by the RFP Scope of Services will be brought to bear on the proposed work.

3. Describe and include documentation of any relevant licenses and/or certifications held by the Contractor or actuary to be assigned to the City's projects.

4. Describe key personnel assigned to the City's projects, specifically experience in providing self-funded health and pharmacy related services including setting employee/employer contributions, contribution strategies, recommending plan design alternatives, and analyzing provider network discounts.

5. List the name of the principal actuary who will provide ongoing actuarial services to the County under this contract. For this individual provide the following: resume, description of actuarial experience, education, length of employment at your firm or length of contract to provide services to your firm, (**if sub-contracted please note this here and also complete Section: Sub-Contractors),** length of employment as an actuary, professional credentials and affiliations.

6. Describe experience providing services requested including annual certification, rates renewal process for self-funded health/pharmacy plans, development of rate equivalents, rate projections, CDHP/HRA analysis, Return on Investment (ROI) for employer health and centers and the analysis of provider network discounts.

7. Provide narratives of specific projects you have completed regarding the services requested including recommendations that have been accepted by your clients. Place emphasis on annual rate renewals, modeling contribution strategy and plan design changes.

8. State the location of the office from which the actuary's work will be performed.

9. Describe any experience working with employer health and wellness centers and analyzing ROI.
10. Describe experience in modeling plan designs and cost impact at onsite meetings.

11. Has your firm performed an actuarial attestation of a self-insured pharmacy plan for Medicare D subsidies? Describe your firm's experience with preparing attestation for Medicare D employer credit.
12. Describe your firm’s experience with annual (Florida Office of Insurance Regulations (FLOIR) filing for self-insured plans.

13. Does your firm have experience working with third party claims or a data analysis vendor? If yes, in what capacity?

14. To perform actuarial services on a self-insured plan, describe your methodology for projecting reserve levels.

15. Describe your approach and methodology for the evaluation of historical trend factors and development of trend assumptions for future claims projections.

16. Describe your firm's expertise in monitoring, evaluating, and determining ROI for wellness and disease management programs.

17. Is your firm using any sub-contractors?

18. If so, please list the name of any subcontractor to be used to provide services to the County and detail their experience and credentials. List why you have selected this sub-contractor.

19. What are the scopes of services the sub-contractors will perform? How do you monitor quality and correctness?

CITY OF FORT LAUDERDALE
GENERAL CONDITIONS

These instructions are standard for all contracts for commodities or services issued through the City of Fort Lauderdale Procurement Services Division. The City may delete, supersede, or modify any of these standard instructions for a particular contract by indicating such change in the Invitation to Bid (ITB) Special Conditions, Technical Specifications, Instructions, Proposal Pages, Addenda, and Legal Advertisement. In this general conditions document, Invitation to Bid (ITB) and Request for Proposal (RFP) are interchangeable.

PART I BIDDER PROPOSAL PAGE(S) CONDITIONS:

1.01 **BIDDER ADDRESS**: The City maintains automated vendor address lists that have been generated for each specific Commodity Class item through our bid issuing service, BidSync. Notices of Invitations to Bid (ITB'S) are sent by e-mail to the selection of bidders who have fully registered with BidSync or faxed (if applicable) to every vendor on those lists, who may then view the bid documents online. Bidders who have been informed of a bid's availability in any other manner are responsible for registering with BidSync in order to view the bid documents. There is no fee for doing so. If you wish bid notifications be provided to another e-mail address or fax, please contact BidSync. If you wish purchase orders sent to a different address, please so indicate in your bid response. If you wish payments sent to a different address, please so indicate on your invoice.

1.02 **DELIVERY:** Time will be of the essence for any orders placed as a result of this ITB. The City reserves the right to cancel any orders, or part thereof, without obligation if delivery is not made in accordance with the schedule specified by the Bidder and accepted by the City.

1.03 **PACKING SLIPS:** It will be the responsibility **of** the awarded Contractor, to attach all packing slips to the OUTSIDE of each shipment. Packing slips must provide a detailed description of what is to be received and reference the City of Fort Lauderdale purchase order number that is associated with the shipment. Failure to provide a detailed packing slip attached to the outside of shipment may result in refusal of shipment at Contractor's expense.

1.04 **PAYMENT TERMS AND CASH DISCOUNTS:** Payment terms, unless otherwise stated in this ITB, will be considered to be net 45 days after the date of satisfactory delivery at the place of acceptance and receipt of correct invoice at the office specified, whichever occurs last. Bidder may offer cash discounts for prompt payment but they will not be considered in determination of award. If a Bidder offers a discount, it is understood that the discount time will be computed from the date of satisfactory delivery, at the place of acceptance, and receipt of correct invoice, at the office specified, whichever occurs last**.**

1.05 **TOTAL BID DISCOUNT:** If Bidder offers a discount for award of all items listed in the bid, such discount shall be deducted from the total of the firm net unit prices bid and shall be considered in tabulation and award of bid**.**

1.06 **BIDS FIRM FOR ACCEPTANCE:** Bidder warrants, by virtue of bidding, that the bid and the prices quoted in the bid will be firm for acceptance by the City for a period of one hundred twenty (120) days from the date of bid opening unless otherwise stated in the ITB**.**

1.07 **VARIANCES:** For purposes of bid evaluation, Bidder's must indicate any variances, no matter how slight, from ITB General Conditions, Special Conditions, Specifications or Addenda in the space provided in the ITB. No variations or exceptions by a Bidder will be considered or deemed a part of the bid submitted unless such variances or exceptions are listed in the bid and referenced in the space provided on the bidder proposal pages. If variances are not stated, or referenced as required, it will be assumed that the product or service fully complies with the City's terms, conditions, and specifications**.**

By receiving a bid, City does not necessarily accept any variances contained in the bid. All variances submitted are subject to review and approval by the City. If any bid contains material variances that, in the City's sole opinion, make that bid conditional in nature, the City reserves the right to reject the bid or part of the bid that is declared, by the City as conditional.

1.08 **NO BIDS:** If you do not intend to bid please indicate the reason, such as insufficient time to respond, do not offer product or service, unable to meet specifications, schedule would not permit, or any other reason, in the space provided in this ITB. Failure to bid or return no bid comments prior to the bid due and opening date and time, indicated in this ITB, may result in your firm being deleted from our Bidder's registration list for the Commodity Class Item requested in this ITB.

1.09 **MINORITY AND WOMEN BUSINESS ENTERPRISE PARTICIPATION AND BUSINESS DEFINITIONS:** The City of Fort Lauderdale wants to increase the participation of Minority Business Enterprises (MBE), Women Business Enterprises (WBE), and Small Business Enterprises (SBE) in its procurement activities. If your firm qualifies in accordance with the below definitions please indicate in the space provided in this ITB.

Minority Business Enterprise (MBE) "A Minority Business" is a business enterprise that is owned or controlled by one or more socially or economically disadvantaged persons. Such disadvantage may arise from cultural, racial, chronic economic circumstances or background or other similar cause. Such persons include, but are not limited to: Blacks, Hispanics, Asian Americans, and Native Americans.

The term "Minority Business Enterprise" means a business at least 51 percent of which is owned by minority group members or, in the case of a publicly owned business, at least 51 percent of the stock of which is owned by minority group members. For the purpose of the preceding sentence, minority group members are citizens of the United States who include, but are not limited to: Blacks, Hispanics, Asian Americans, and Native Americans.

Women Business Enterprise (WBE) a "Women Owned or Controlled Business" is a business enterprise at least 51 percent of which is owned by females or, in the case of a publicly owned business, at least 51 percent of the stock of which is owned by females.

Small Business Enterprise (SBE) "Small Business" means a corporation, partnership, sole proprietorship, or other legal entity formed for the purpose of making a profit, which is independently owned and operated, has either fewer than 100 employees or less than $1,000,000 in annual gross receipts.

BLACK, which includes persons having origins in any of the Black racial groups of Africa.

WHITE, which includes persons whose origins are Anglo-Saxon and Europeans and persons of Indo-European decent including Pakistani and East Indian.
HISPANIC, which includes persons of Mexican, Puerto Rican, Cuban, Central and South American, or other Spanish culture or origin, regardless of race.
NATIVE AMERICAN, which includes persons whose origins are American Indians, Eskimos, Aleuts, or Native Hawaiians.
ASIAN AMERICAN, which includes persons having origin in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands.

1.10 MINORITY-WOMEN BUSINESS ENTERPRISE PARTICIPATION
It is the desire of the City of Fort Lauderdale to increase the participation of minority (MBE) and women-owned (WBE) businesses in its contracting and procurement programs. While the City does not have any preference or set aside programs in place, it is committed to a policy of equitable participation for these firms. Proposers are requested to include in their proposals a narrative describing their past accomplishments and intended actions in this area. If proposers are considering minority or women owned enterprise participation in their proposal, those firms, and their specific duties have to be identified in the proposal. If a proposer is considered for award, he or she will be asked to meet with City staff so that the intended MBE/WBE participation can be formalized and included in the subsequent contract.

1.11 SCRUTINIZED COMPANIES
This Section applies to any contract for goods or services of $1 million or more:
The Contractor certifies that it is not on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List and that it does not have business operations in Cuba or Syria as provided in section 287.135, Florida Statutes (2011), as may be amended or revised. The City may terminate this Contract at the City's option if the Contractor is found to have submitted a false certification as provided under subsection (5) of section 287.135, Florida Statutes (2011), as may be amended or revised, or been placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List or has engaged in business operations in Cuba or Syria, as defined in Section 287.135, Florida Statutes (2011), as may be amended or revised.

1.12 DEBARRED OR SUSPENDED BIDDERS OR PROPOSERS
The bidder or proposer certifies, by submission of a response to this solicitation, that neither it nor its principals and subcontractors are presently debarred or suspended by any Federal department or agency.

Part II DEFINITIONS/ORDER OF PRECEDENCE:

2.01 BIDDING DEFINITIONS The City will use the following definitions in its general conditions, special conditions, technical specifications, instructions to bidders, addenda and any other document used in the bidding process:
INVITATION TO BID (ITB) when the City is requesting bids from qualified Bidders.
REQUEST FOR PROPOSALS (RFP) when the City is requesting proposals from qualified Proposers.
BID – a price and terms quote received in response to an ITB.
PROPOSAL – a proposal received in response to an RFP.
BIDDER – Person or firm submitting a Bid.
PROPOSER – Person or firm submitting a Proposal.
RESPONSIVE BIDDER – A person whose bid conforms in all material respects to the terms and conditions included in the ITB.
RESPONSIBLE BIDDER – A person who has the capability in all respects to perform in full the contract requirements, as stated in the ITB, and the integrity and reliability that will assure good faith performance.
FIRST RANKED PROPOSER – That Proposer, responding to a City RFP, whose Proposal is deemed by the City, the most advantageous to the City after applying the evaluation criteria contained in the RFP.
SELLER – Successful Bidder or Proposer who is awarded a Purchase Order or Contract to provide goods or services to the City.
CONTRACTOR – Successful Bidder or Proposer who is awarded a Purchase Order, award Contract, Blanket Purchase Order agreement, or Term Contract to provide goods or services to the City.
CONTRACT – A deliberate verbal or written agreement between two or more competent parties to perform or not to perform a certain act or acts, including all types of agreements, regardless of what they may be called, for the procurement or disposal of equipment, materials, supplies, services or construction.
CONSULTANT – Successful Bidder or Proposer who is awarded a contract to provide professional services to the City.
The following terms may be used interchangeably by the City: ITB and/or RFP; Bid or Proposal; Bidder, Proposer, or Seller; Contractor or Consultant; Contract, Award, Agreement or Purchase Order**.**

2.02 SPECIAL CONDITIONS: Any and all Special Conditions contained in this ITB that may be in variance or conflict with these General Conditions shall have precedence over these General Conditions. If no changes or deletions to General Conditions are made in the Special Conditions, then the General Conditions shall prevail in their entirety,

PART III BIDDING AND AWARD PROCEDURES:

3.01 SUBMISSION AND RECEIPT OF BIDS: To receive consideration, bids must be received prior to the bid opening date and time. Unless otherwise specified, Bidders should use the proposal forms provided by the City. These forms may be duplicated, but failure to use the forms may cause the bid to be rejected. Any erasures or corrections on the bid must be made in ink and initialed by Bidder in ink. All information submitted by the Bidder shall be printed, typewritten or filled in with pen and ink. Bids shall be signed in ink. Separate bids must be submitted for each ITB issued by the City in separate sealed envelopes properly marked. When a particular ITB or RFP requires multiple copies of bids or proposals they may be included in a single envelope or package properly sealed and identified. Only send bids via facsimile transmission (FAX) if the ITB specifically states that bids sent via FAX will be considered. If such a statement is not included in the ITB, bids sent via FAX will be rejected. Bids will be publicly opened in the Procurement Office, or other designated area, in the presence of Bidders, the public, and City staff. Bidders and the public are invited and encouraged to attend bid openings. Bids will be tabulated and made available for review by Bidder's and the public in accordance with applicable regulations.

3.02 MODEL NUMBER CORRECTIONS: If the model number for the make specified in this ITB is incorrect, or no longer available and replaced with an updated model with new specifications, the Bidder shall enter the correct model number on the bidder proposal page. In the case of an updated model with new specifications, Bidder shall provide adequate information to allow the City to determine if the model bid meets the City's requirements.
Form G-107 Rev. 02/15

3.03 **PRICES QUOTED:** Deduct trade discounts, and quote firm net prices. Give both unit price and extended total. In the case of a discrepancy in computing the amount of the bid, the unit price quoted will govern. All prices quoted shall be F.O.B. destination, freight prepaid (Bidder pays and bears freight charges, Bidder owns goods in transit and files any claims), unless otherwise stated in Special Conditions. Each item must be bid separately. No attempt shall be made to tie any item or items contained in the ITB with any other business with the City.

3.04 **TAXES:** The City of Fort Lauderdale is exempt from Federal Excise and Florida Sales taxes on direct purchase of tangible property. Exemption **number for EIN is 59-6000319, and State Sales tax exemption number is 85-8013875578C-1.**

3.05 **WARRANTIES OF USAGE:** Any quantities listed in this ITB as estimated or projected are provided for tabulation and information purposes only. No warranty or guarantee of quantities is given or implied. It is understood that the Contractor will furnish the City's needs as they arise.

3.06 **APPROVED EQUAL:** When the technical specifications call for a brand name, manufacturer, make, model, or vendor catalog number with acceptance of APPROVED EQUAL, it shall be for the purpose of establishing a level of quality and features desired and acceptable to the City. In such cases, the City will be receptive to any unit that would be considered by qualified City personnel as an approved equal. In that the specified make and model represent a level of quality and features desired by the City, the Bidder must state clearly in the bid any variance from those specifications. It is the Bidder's responsibility to provide adequate information, in the bid, to enable the City to ensure that the bid meets the required criteria. If adequate information is not submitted with the bid, it may be rejected. The City will be the sole judge in determining if the item bid qualifies as an approved equal.

3.07 **MINIMUM AND MANDATORY TECHNICAL SPECIFICATIONS:** The technical specifications may include items that are considered minimum, mandatory, or required. If any Bidder is unable to meet or exceed these items, and feels that the technical specifications are overly restrictive, the bidder must notify the Procurement Services Division immediately. Such notification must be received by the Procurement Services Division prior to the deadline contained in the ITB, for questions of a material nature, or prior to five (5) days before bid due and open date, whichever occurs first. If no such notification is received prior to that deadline, the City will consider the technical specifications to be acceptable to all bidders.

3.08 **MISTAKES:** Bidders are cautioned to examine all terms, conditions, specifications, drawings, exhibits, addenda, delivery instructions and special conditions pertaining to the ITB. Failure of the Bidder to examine all pertinent documents shall not entitle the bidder to any relief from the conditions imposed in the contract.

3.09 **SAMPLES AND DEMONSTRATIONS:** Samples or inspection of product may be requested to determine suitability. Unless otherwise specified in Special Conditions, samples shall be requested after the date of bid opening, and if requested should be received by the City within seven (7) working days of request. Samples, when requested, must be furnished free of expense to the City and if not used in testing or destroyed, will upon request of the Bidder, be returned within thirty (30) days of bid award at Bidder's expense. When required, the City may request full demonstrations of units prior to award. When such demonstrations are requested, the Bidder shall respond promptly and arrange a demonstration at a convenient location. Failure to provide samples or demonstrations as specified by the City may result in rejection of a bid.

3.10 **LIFE CYCLE COSTING**: If so specified in the ITB, the City may elect to evaluate equipment proposed on the basis of total cost of ownership. In using Life Cycle Costing, factors such as the following may be considered: estimated useful life, maintenance costs, cost of supplies, labor intensity, energy usage, environmental impact, and residual value. The City reserves the right to use those or other applicable criteria, in its sole opinion that will most accurately estimate total cost of use and ownership.

3.11 **BIDDING ITEMS WITH RECYCLED CONTENT:** In addressing environmental concerns, the City of Fort Lauderdale encourages Bidders to submit bids or alternate bids containing items with recycled content. When submitting bids containing items with recycled content, Bidder shall provide documentation adequate for the City to verify the recycled content. The City prefers packaging consisting of materials that are degradable or able to be recycled. When specifically stated in the ITB, the City may give preference to bids containing items manufactured with recycled material or packaging that is able to be recycled.

3.12 **USE OF OTHER GOVERNMENTAL CONTRACTS:** The City reserves the right to reject any part or all of any bids received and utilize other available governmental contracts, if such action is in its best interest**.**

3.13 **QUALIFICATIONS/INSPECTION:** Bids will only be considered from firms normally engaged in providing the types of commodities/services specified herein. The City reserves the right to inspect the Bidder's facilities, equipment, personnel, and organization at any time, or to take any other action necessary to determine Bidder's ability to perform. The Procurement Director reserves the right to reject bids where evidence or evaluation is determined to indicate inability to perform**.**

3.14 **BID SURETY:** If Special Conditions require a bid security, it shall be submitted in the amount stated. A bid security can be in the form of a bid bond or cashier's check. Bid security will be returned to the unsuccessful bidders as soon as practicable after opening of bids. Bid security will be returned to the successful bidder after acceptance of the performance bond, if required; acceptance of insurance coverage, if required; and full execution of contract documents, if required; or conditions as stated in Special Conditions**.**

3.15 **PUBLIC RECORDS/TRADE SECRETS/COPYRIGHT:** The Proposer's response to the RFP is a public record pursuant to Florida law, which is subject to disclosure by the City under the State of Florida Public Records Law, Florida Statutes Chapter 119.07 ("Public Records Law"). The City shall permit public access to all documents, papers, letters or other material submitted in connection with this RFP and the Contract to be executed for this RFP, subject to the provisions of Chapter 119.07 of the Florida Statutes.

Any language contained in the Proposer's response to the RFP purporting to require confidentiality of any portion of the Proposer's response to the RFP, except to the extent that certain information is in the City's opinion a Trade Secret pursuant to Florida law, shall be void. If a Proposer submits any documents or other information to the City which the Proposer claims is Trade Secret information and exempt from Florida Statutes Chapter 119.07 ("Public Records Laws"), the Proposer shall clearly designate that it is a Trade Secret and that it is asserting that the document or information is exempt. The Proposer must specifically identify the exemption being claimed under Florida Statutes 119.07. The City shall be the final arbiter of whether any information contained in the Proposer's response to the RFP constitutes a Trade Secret. The city's determination of whether an exemption applies shall be final, and the proposer agrees to defend, indemnify, and hold

harmless the city and the city's officers, employees, and agent, against any loss or damages incurred by any person or entity as a result of the city's treatment of records as public records. Proposals purporting to be subject to copyright protection in full or in part will be rejected.

EXCEPT FOR CLEARLY MARKED PORTIONS THAT ARE BONA FIDE TRADE SECRETS PURSUANT TO FLORIDA LAW, DO NOT MARK YOUR RESPONSE TO THE RFP AS PROPRIETARY OR CONFIDENTIAL. DO NOT MARK YOUR RESPONSE TO THE RFP OR ANY PART THEREOF AS COPYRIGHTED.

3.16 **PROHIBITION OF INTEREST:** No contract will be awarded to a bidding firm who has City elected officials, officers or employees affiliated with it, unless the bidding firm has fully complied with current Florida State Statutes and City Ordinances relating to this issue. Bidders must disclose any such affiliation. Failure to disclose any such affiliation will result in disqualification of the Bidder and removal of the Bidder from the City's bidder lists and prohibition from engaging in any business with the City**.**

3.17 **RESERVATIONS FOR AWARD AND REJECTION OF BIDS:** The City reserves the right to accept or reject any or all bids, part of bids, and to waive minor irregularities or variations to specifications contained in bids, and minor irregularities in the bidding process. The City also reserves the right to award the contract on a split order basis, lump sum basis, individual item basis, or such combination as shall best serve the interest of the City. The City reserves the right to make an award to the responsive and responsible bidder whose product or service meets the terms, conditions, and specifications of the ITB and whose bid is considered to best serve the City's interest. In determining the responsiveness of the offer and the responsibility of the Bidder, the following shall be considered when applicable: the ability, capacity and skill of the Bidder to perform as required; whether the Bidder can perform promptly, or within the time specified, without delay or interference; the character, integrity, reputation, judgment, experience and efficiency of the Bidder; the quality of past performance by the Bidder; the previous and existing compliance by the Bidder with related laws and ordinances; the sufficiency of the Bidder's financial resources; the availability, quality and adaptability of the Bidder's supplies or services to the required use; the ability of the Bidder to provide future maintenance, service or parts; the number and scope of conditions attached to the bid**.**

If the ITB provides for a contract trial period, the City reserves the right, in the event the selected bidder does not perform satisfactorily, to award a trial period to the next ranked bidder or to award a contract to the next ranked bidder, if that bidder has successfully provided services to the City in the past. This procedure to continue until a bidder is selected or the contract is re-bid, at the sole option of the City.

3.18 **LEGAL REQUIREMENTS:** Applicable provisions of all federal, state, county laws, and local ordinances, rules and regulations, shall govern development, submittal and evaluation of all bids received in response hereto and shall govern any and all claims and disputes which may arise between person(s) submitting a bid response hereto and the City by and through its officers, employees and authorized representatives, or any other person, natural or otherwise; and lack of knowledge by any bidder shall not constitute a cognizable defense against the legal effect thereof**.**

3.19 **BID PROTEST PROCEDURE: ANY PROPOSER OR BIDDER WHO IS NOT RECOMMENDED FOR AWARD OF A CONTRACT AND WHO ALLEGES A FAILURE BY THE CITY TO FOLLOW THE CITY'S PROCUREMENT ORDINANCE OR ANY APPLICABLE LAW MAY PROTEST TO THE DIRECTOR OF PROCUREMENT SERVICES DIVISION (DIRECTOR), BY DELIVERING A LETTER OF PROTEST TO THE DIRECTOR WITHIN FIVE (5) DAYS AFTER A NOTICE OF INTENT TO AWARD IS POSTED ON THE CITY'S WEB SITE AT THE FOLLOWING LINK: http://www.fortlauderdale.gov/purchasing/notices_of_intent.htm**

THE COMPLETE PROTEST ORDINANCE MAY BE FOUND ON THE CITY'S WEB SITE AT THE FOLLOWING LINK: http://www.fortlauderdale.gov/purchasing/protestordinance.pdf

PART IV BONDS AND INSURANCE

4.01 **PERFORMANCE BOND:** If a performance bond is required in Special Conditions, the Contractor shall within fifteen (15) working days after notification of award, furnish to the City a Performance Bond, payable to the City of Fort Lauderdale, Florida, in the face amount specified in Special Conditions as surety for faithful performance under the terms and conditions of the contract. If the bond is on an annual coverage basis, renewal for each succeeding year shall be submitted to the City thirty (30) days prior to the termination date of the existing Performance Bond. The Performance Bond must be executed by a surety company of recognized standing, authorized to do business in the State of Florida and having a resident agent.

Acknowledgement and agreement is given by both parties that the amount herein set for the Performance Bond is not intended to be nor shall be deemed to be in the nature of liquidated damages nor is it intended to limit the liability of the Contractor to the City in the event of a material breach of this Agreement by the Contractor**.**

4.02 **INSURANCE:** If the Contractor is required to go on to City property to perform work or services as a result of ITB award, the Contractor shall assume full responsibility and expense to obtain all necessary insurance as required by City or specified in Special Conditions**.**

The Contractor shall provide to the Procurement Services Division original certificates of coverage and receive notification of approval of those certificates by the City's Risk Manager prior to engaging in any activities under this contract. The Contractors insurance is subject to the approval of the City's Risk Manager. The certificates must list the City as an ADDITIONAL INSURED for General Liability Insurance, and shall have no less than thirty (30) days written notice of cancellation or material change. Further modification of the insurance requirements may be made at the sole discretion of the City's Risk Manager if circumstances change or adequate protection of the City is not presented. Bidder, by submitting the bid, agrees to abide by such modifications**.**

PART V PURCHASE ORDER AND CONTRACT TERMS:

5.01 **COMPLIANCE TO SPECIFICATIONS, LATE DELIVERIES/PENALTIES:** Items offered may be tested for compliance to bid specifications. Items delivered which do not conform to bid specifications may be rejected and returned at Contractor's expense. Any violation resulting in contract termination for cause or delivery of items not conforming to specifications, or late delivery may also result in:

- Bidders name being removed from the City's bidder's mailing list for a specified period and Bidder will not be recommended for any award during that period.
- All City Departments being advised to refrain from doing business with the Bidder.
- All other remedies in law or equity.

5.02 ACCEPTANCE, CONDITION, AND PACKAGING: The material delivered in response to ITB award shall remain the property of the Seller until a physical inspection is made and the material accepted to the satisfaction of the City. The material must comply fully with the terms of the ITB, be of the required quality, new, and the latest model. All containers shall be suitable for storage and shipment by common carrier, and all prices shall include standard commercial packaging. The City will not accept substitutes of any kind. Any substitutes or material not meeting specifications will be returned at the Bidder's expense. Payment will be made only after City receipt and acceptance of materials or services.

5.03 SAFETY STANDARDS: All manufactured items and fabricated assemblies shall comply with applicable requirements of the Occupation Safety and Health Act of 1970 as amended, and be in compliance with Chapter 442, Florida Statutes. Any toxic substance listed in Section 38F-41.03 of the Florida Administrative Code delivered as a result of this order must be accompanied by a completed Safety Data Sheet (SDS).

5.04 ASBESTOS STATEMENT: All material supplied must be 100% asbestos free. Bidder, by virtue of bidding, certifies that if awarded any portion of the ITB the bidder will supply only material or equipment that is 100% asbestos free.

5.05 OTHER GOVERNMENTAL ENTITIES: If the Bidder is awarded a contract as a result of this ITB, the bidder may, if the bidder has sufficient capacity or quantities available, provide to other governmental agencies, so requesting, the products or services awarded in accordance with the terms and conditions of the ITB and resulting contract. Prices shall be F.O.B. delivered to the requesting agency.

5.06 VERBAL INSTRUCTIONS PROCEDURE: No negotiations, decisions, or actions shall be initiated or executed by the Contractor as a result of any discussions with any City employee. Only those communications which are in writing from an authorized City representative may be considered. Only written communications from Contractors, which are assigned by a person designated as authorized to bind the Contractor, will be recognized by the City as duly authorized expressions on behalf of Contractors.

5.07 INDEPENDENT CONTRACTOR: The Contractor is an independent contractor under this Agreement. Personal services provided by the Proposer shall be by employees of the Contractor and subject to supervision by the Contractor, and not as officers, employees, or agents of the City. Personnel policies, tax responsibilities, social security, health insurance, employee benefits, procurement policies unless otherwise stated in this ITB, and other similar administrative procedures applicable to services rendered under this contract shall be those of the Contractor.

5.08 INDEMNITY/HOLD HARMLESS AGREEMENT: The Contractor agrees to protect, defend, indemnify, and hold harmless the City of Fort Lauderdale and its officers, employees and agents from and against any and all losses, penalties, damages, settlements, claims, costs, charges for other expenses, or liabilities of every and any kind including attorney's fees, in connection with or arising directly or indirectly out of the work agreed to or performed by Contractor under the terms of any agreement that may arise due to the bidding process. Without limiting the foregoing, any and all such claims, suits, or other actions relating to personal injury, death, damage to property, defects in materials or workmanship, actual or alleged violations of any applicable Statute, ordinance, administrative order, rule or regulation, or decree of any court shall be included in the indemnity hereunder.

5.09 TERMINATION FOR CAUSE: If, through any cause, the Contractor shall fail to fulfill in a timely and proper manner its obligations under this Agreement, or if the Contractor shall violate any of the provisions of this Agreement, the City may upon written notice to the Contractor terminate the right of the Contractor to proceed under this Agreement, or with such part or parts of the Agreement as to which there has been default, and may hold the Contractor liable for any damages caused to the City by reason of such default and termination. In the event of such termination, any completed services performed by the Contractor under this Agreement shall, at the option of the City, become the City's property and the Contractor shall be entitled to receive equitable compensation for any work completed to the satisfaction of the City. The Contractor, however, shall not be relieved of liability to the City for damages sustained by the City by reason of any breach of the Agreement by the Contractor, and the City may withhold any payments to the Contractor for the purpose of setoff until such time as the amount of damages due to the City from the Contractor can be determined.

5.10 TERMINATION FOR CONVENIENCE: The City reserves the right, in its best interest as determined by the City, to cancel contract by giving written notice to the Contractor thirty (30) days prior to the effective date of such cancellation.

5.11 CANCELLATION FOR UNAPPROPRIATED FUNDS: The obligation of the City for payment to a Contractor is limited to the availability of funds appropriated in a current fiscal period, and continuation of the contract into a subsequent fiscal period is subject to appropriation of funds, unless otherwise authorized by law.

5.12 RECORDS/AUDIT: The Contractor shall maintain during the term of the contract all books of account, reports and records in accordance with generally accepted accounting practices and standards for records directly related to this contract. The Contractor agrees to make available to the City Auditor or designee, during normal business hours and in Broward, Miami-Dade or Palm Beach Counties, all books of account, reports and records relating to this contract should be retained for the duration of the contract and for three years after the final payment under this Agreement, or until all pending audits, investigations or litigation matters relating to the contract are closed, whichever is later.

5.13 PERMITS, TAXES, LICENSES: The successful Contractor shall, at their own expense, obtain all necessary permits, pay all licenses, fees and taxes, required to comply with all local ordinances, state and federal laws, rules and regulations applicable to business to be carried out under this contract.

5.14 LAWS/ORDINANCES: The Contractor shall observe and comply with all Federal, state, local and municipal laws, ordinances rules and regulations that would apply to this contract.

5.15 NON-DISCRIMINATION: There shall be no discrimination as to race, sex, color, creed, age or national origin in the operations conducted under this contract.

5.16 UNUSUAL CIRCUMSTANCES: If during a contract term where costs to the City are to remain firm or adjustments are restricted by a percentage or CPI cap, unusual circumstances that could not have been foreseen by either party of the contract occur, and those circumstances significantly affect the Contractor's cost in providing the required prior items or services, then the Contractor may request adjustments to the costs to the City to reflect the changed circumstances. The circumstances must be beyond the control of the Contractor,

and the requested adjustments must be fully documented. The City may, after examination, refuse to accept the adjusted costs if they are not properly documented, increases are considered to be excessive, or decreases are considered to be insufficient. In the event the City does not wish to accept the adjusted costs and the matter cannot be resolved to the satisfaction of the City, the City will reserve the following options:

1. The contract can be canceled by the City upon giving thirty (30) days written notice to the Contractor with no penalty to the City or Contractor. The Contractor shall fill all City requirements submitted to the Contractor until the termination date contained in the notice.

2. The City requires the Contractor to continue to provide the items and services at the firm fixed (non-adjusted) cost until the termination of the contract term then in effect.

3. If the City, in its interest and in its sole opinion, determines that the Contractor in a capricious manner attempted to use this section of the contract to relieve them of a legitimate obligation under the contract, and no unusual circumstances had occurred, the City reserves the right to take any and all action under law or equity. Such action shall include, but not be limited to, declaring the Contractor in default and disqualifying him for receiving any business from the City for a stated period of time.

If the City does agree to adjusted costs, these adjusted costs shall not be invoiced to the City until the Contractor receives notice in writing signed by a person authorized to bind the City in such matters.

5.17 ELIGIBILITY: If applicable, the Contractor must first register with the Department of State of the State of Florida, in accordance with Florida State Statutes, prior to entering into a contract with the City.

5.18 PATENTS AND ROYALTIES: The Contractor, without exception, shall indemnify and save harmless the City and its employees from liability of any nature and kind, including cost and expenses for or on account of any copyrighted, patented or un-patented invention, process, or article manufactured or used in the performance of the contract, including its use by the City. If the Contractor uses any design, device, or materials covered by letters, patent or copyright, it is mutually agreed and understood without exception that the bid prices shall include all royalties or costs arising from the use of such design, device, or materials in any way involved in the work.

5.19 ASSIGNMENT: Contractor shall not transfer or assign the performance required by this ITB without the prior written consent of the City. Any award issued pursuant to this ITB, and the monies, which may become due hereunder, are not assignable except with the prior written approval of the City Commission or the City Manager or City Manager's designee, depending on original award approval.

5.20 LITIGATION VENUE: The parties waive the privilege of venue and agree that all litigation between them in the state courts shall take place in Broward County, Florida and that all litigation between them in the federal courts shall take place in the Southern District in and for the State of Florida.

5.21 LOCATION OF UNDERGROUND FACILITIES: If the Contractor, for the purpose of responding to this solicitation, requests the location of underground facilities through the Sunshine State One-Call of Florida, Inc. notification system or through any person or entity providing a facility locating service, and underground facilities are marked with paint, stakes or other markings within the City pursuant to such a request, then the Contractor, shall be deemed non-responsive to this solicitation in accordance with Section 2-184(5) of the City of Fort Lauderdale Code of Ordinances.

5.22 PUBLIC AGENCY CONTRACTS FOR SERVICES: if applicable, for each public agency contract for services, Contractor is required to comply with F.S. 119.0701, which includes the following:

a) Keep and maintain public records that ordinarily and necessarily would be required by the public agency in order to perform the service.
(b) Provide the public with access to public records on the same terms and conditions that the public agency would provide the records and at a cost that does not exceed the cost provided in this chapter or as otherwise provided by law.
(c) Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law.
(d) Meet all requirements for retaining public records and transfer, at no cost, to the public agency, all public records in possession of the contractor upon termination of the contract and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. All records stored electronically must be provided to the public agency in a format that is compatible with the information technology systems of the public agency.

NON-COLLUSION STATEMENT:

By signing this offer, the vendor/contractor certifies that this offer is made independently and *free* from collusion. Vendor shall disclose below any City of Fort Lauderdale, FL officer or employee, or any relative of any such officer or employee who is an officer or director of, or has a material interest in, the vendor's business, who is in a position to influence this procurement.

Any City of Fort Lauderdale, FL officer or employee who has any input into the writing of specifications or requirements, solicitation of offers, decision to award, evaluation of offers, or any other activity pertinent to this procurement is presumed, for purposes hereof, to be in a position to influence this procurement.

For purposes hereof, a person has a material interest if they directly or indirectly own more than 5 percent of the total assets or capital stock of any business entity, or if they otherwise stand to personally gain if the contract is awarded to this vendor.

In accordance with City of Fort Lauderdale, FL Policy and Standards Manual, 6.10.8.3,

3.3. City employees may not contract with the City through any corporation or business entity in which they or their immediate family members hold a controlling financial interest (e.g. ownership of five (5) percent or more).

3.4. Immediate family members (spouse, parents and children) are also prohibited from contracting with the City subject to the same general rules.

Failure of a vendor to disclose any relationship described herein shall be reason for debarment in accordance with the provisions of the City Procurement Code.

NAME	RELATIONSHIPS
_____	_____
_____	_____
	_____
	_____

In the event the vendor does not indicate any names, the City shall interpret this to mean that the vendor has indicated that no such relationships exist.

CONTRACT PAYMENT METHOD BY P-CARD

THIS FORM MUST BY SUBMITTED WITH YOUR RESPONSE

The City of Fort Lauderdale has implemented a Procurement Card (P-Card) program which changes how payments are remitted to its vendors. The City has transitioned from traditional paper checks to payment by credit card via MasterCard or Visa. This allows you as a vendor of the City of Fort Lauderdale to receive your payment fast and safely. No more waiting for checks to be printed and mailed.

Payments will be made utilizing the City's P-Card (MasterCard or Visa). Accordingly, firms must presently have the ability to accept credit card payment or take whatever steps necessary to implement acceptance of a credit card before the commencement of a contract.

Please indicate which credit card payment you prefer:

_____ Master Card

_____ Visa Card

Company Name: _____

_____ _____
Name (printed) Signature

_____ _____
Date: Title

LOCAL BUSINESS PREFERENCE CERTIFICATION STATEMENT

The Business identified below certifies that it qualifies for the local BUSINESS preference classification as indicated herein, and further certifies and agrees that it will re-affirm it's local preference classification annually no later than thirty (30) calendar days prior to the anniversary of the date of a contract awarded pursuant to this ITB. Violation of the foregoing provision may result in contract termination.

(1) _____ Business Name is a **Class A** Business as defined in City of Fort Lauderdale Ordinance No. C-12-04, Sec.2-199.2. A copy of the City of Fort Lauderdale current year Business Tax Receipt **and** a complete list of full-time employees and evidence of their addresses shall be provided within 10 calendar days of a formal request by the City.

(2) _____ Business Name is a **Class B** Business as defined in the City of Fort Lauderdale Ordinance No. C-12-04, Sec.2-199.2. A copy of the Business Tax Receipt **or** a complete list of full-time employees and evidence of their addresses shall be provided within 10 calendar days of a formal request by the City.

(3) _____ Business Name is a **Class C** Business as defined in the City of Fort Lauderdale Ordinance No. C-12-04, Sec.2-199.2. A copy of the Broward County Business Tax Receipt shall be provided within 10 calendar days of a formal request by the City.

(4) _____ Business Name requests a **Conditional Class A** classification as defined in the City of Fort Lauderdale Ordinance No. C-12-04, Sec.2-199.2. Written certification of intent shall be provided within 10 calendar days of a formal request by the City.

(5) _____ Business Name requests a **Conditional Class B** classification as defined in the City of Fort Lauderdale Ordinance No. C-12-04, Sec.2-199.2. Written certification of intent shall be provided within 10 calendar days of a formal request by the City.

(6) _____ Business Name is considered a **Class D** Business as defined in the City of Fort Lauderdale Ordinance No. C-12-04, Sec.2-199.2. and does not qualify for Local Preference consideration.

BIDDER'S COMPANY: _____

AUTHORIZED COMPANY PERSON: _____
NAME SIGNATURE DATE

BID/PROPOSAL CERTIFICATION

Please Note: All fields below must be completed. If the field does not apply to you, please note N/A in that field.

If you are a foreign corporation, you may be required to obtain a certificate of authority from the department of state, in accordance with Florida Statute §607.1501 (visit http://www.dos.state.fl.us/).

Company: (Legal Registration) _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No. _____ FAX No. _____ Email: _____

Delivery: Calendar days after receipt of Purchase Order **(section 1.02 of General Conditions)**: _____

Payment Terms **(section 1.04 of General Conditions)**: _____

Total Bid Discount **(section 1.05 of General Conditions)**: _____

Does your firm qualify for MBE or WBE status **(section 1.09 of General Conditions)**: MBE _____ WBE _____

ADDENDUM ACKNOWLEDGEMENT - Proposer acknowledges that the following addenda have been received and are included in the proposal:

Addendum No.	Date Issued	Addendum No.	Date Issued
_____	_____	_____	_____
_____	_____	_____	_____

VARIANCES: If you take exception or have variances to any term, condition, specification, scope of service, or requirement in this competitive solicitation you must specify such exception or variance in the space provided below or reference in the space provided below all variances contained on other pages within your response. Additional pages may be attached if necessary. No exceptions or variances will be deemed to be part of the response submitted unless such is listed and contained in the space provided below. The City does not, by virtue of submitting a variance, necessarily accept any variances. If no statement is contained in the below space, it is hereby implied that your response is in full compliance with this competitive solicitation. If you do not have variances, simply mark N/A. **If submitting your response electronically through BIDSYNC you must also click the "Take Exception" button.**

_____

_____

The below signatory hereby agrees to furnish the following article(s) or services at the price(s) and terms stated subject to all instructions, conditions, specifications addenda, legal advertisement, and conditions contained in the bid/proposal. I have read all attachments including the specifications and fully understand what is required. By submitting this signed proposal I will accept a contract if approved by the City and such acceptance covers all terms, conditions, and specifications of this bid/proposal. The below signatory also hereby agrees, by virtue of submitting or attempting to submit a response, that in no event shall the City's liability for respondent's direct, indirect, incidental, consequential, special or exemplary damages, expenses, or lost profits arising out of this competitive solicitation process, including but not limited to public advertisement, bid conferences, site visits, evaluations, oral presentations, or award proceedings exceed the amount of Five Hundred Dollars ($500.00). This limitation shall not apply to claims arising under any provision of indemnification or the City's protest ordinance contained in this competitive solicitation.

Submitted by:

_____ _____
Name (printed) Signature

_____ _____
Date: Title

revised 04/10/15

City of Fort Lauderdale
Employee Census - March 2016

Relation	Gender	Birth Date	Branch	Benefit	City	State	Zip
EE	M	01/13/1965	GENA	HDHP	COCONUT CREEK	FL	33073-0000
CH	M	02/28/2011	GENA	HDHP	DAVIE	FL	33324-0000
CH	M	06/30/2005	GENA	HDHP	DAVIE	FL	33324-0000
EE	M	01/06/1966	FIRA	HDHP	WEST PALM BEACH	FL	33412-0000
EE	M	12/27/1988	GENA	HDHP	POMPANO BEACH	FL	33062-0000
SP	F	08/30/1990	GENA	HDHP	POMPANO BEACH	FL	33062-0000
EE	M	03/16/1953	GENA	HDHP	TAMARAC	FL	33321-0000
EE	M	11/24/1980	FIRA	HDHP	TAMARAC	FL	33321-0000
CH	M	01/20/2007	FIRA	HDHP	TAMARAC	FL	33321-0000
CH	M	10/02/2008	FIRA	HDHP	TAMARAC	FL	33321-0000
EE	M	05/22/1992	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	11/11/1985	GENA	HMO 1	POMPANO BEACH	FL	33064-0000
EE	M	09/24/1977	PASA	HMO 1	HIALEAH	FL	33015-0000
SP	F	07/09/1970	GENA	HDHP	HIALEAH	FL	33010-0000
EE	F	02/28/1962	GENA	HMO 1	FORT LAUDERDALE	FL	33309-0000
SP	M	06/19/1970	GENA	HMO 1	FORT LAUDERDALE	FL	33309-0000
CH	F	08/11/1995	PASU65	HMO 1	CORAL SPRINGS	FL	33071-0000
EE	M	09/16/1952	MGTU65	HMO 1	CORAL SPRINGS	FL	33071-0000
EE	M	09/30/1965	MGTA	HMO 1	WEST PALM BCH	FL	33405-0000
SP	F	11/16/1971	MGTA	HMO 1	WEST PALM BCH	FL	33405-0000
CH	F	05/19/2005	MGTA	HMO 1	WEST PALM BCH	FL	33405-0000
CH	F	11/29/2001	MGTA	HMO 1	WEST PALM BCH	FL	33405-0000
EE	M	10/17/1975	FIRA	HDHP	PALM BCH GARDENS	FL	33418-0000
SP	F	08/16/1960	FIRA	HDHP	PALM BCH GARDENS	FL	33418-0000
CH	F	02/01/2006	FIRA	HDHP	PALM BCH GARDENS	FL	33418-0000
CH	F	02/13/2002	FIRA	HDHP	PALM BCH GARDENS	FL	33418-0000
EE	F	01/17/1975	CONA	HMO 1	PARKLAND	FL	33067-0000
CH	M	08/27/2004	CONA	HMO 1	PARKLAND	FL	33067-0000
CH	M	04/05/2012	CONA	HMO 1	PARKLAND	FL	33067-0000
EE	M	01/31/1959	PASA	HDHP	BOYNTON BEACH	FL	33472-0000
EE	M	05/05/1973	GENA	HDHP	PEMBROKE PINES	FL	33029-0000
CH	F	04/14/2004	GENA	HDHP	PEMBROKE PINES	FL	33029-0000
CH	M	04/17/2009	GENA	HDHP	PEMBROKE PINES	FL	33029-0000
CH	M	04/17/2010	GENA	HDHP	PEMBROKE PINES	FL	33029-0000
EE	M	02/25/1968	FIRA	HMO 2	MIAMI	FL	33178-0000
EE	F	08/18/1967	GENA	HMO 1	PLANTATION	FL	33324-0000
EE	M	01/19/1975	MGTA	HDHP	PEMBROKE PINES	FL	33029-0000
SP	F	08/09/1976	MGTA	HDHP	PEMBROKE PINES	FL	33029-0000
CH	F	03/31/2003	MGTA	HDHP	PEMBROKE PINES	FL	33029-0000

CH	F	12/01/2005	MGTA	HDHP	PEMBROKE PINES	FL	33029-0000
CH	F	05/11/2009	MGTA	HDHP	PEMBROKE PINES	FL	33029-0000
EE	M	08/29/1953	GENA	HMO 1	MIRAMAR	FL	33023-0000
EE	F	02/22/1964	MGTA	HDHP	PLANTATION	FL	33322-0000
SP	M	02/15/1969	MGTA	HDHP	PLANTATION	FL	33322-0000
CH	M	01/08/1999	MGTA	HDHP	PLANTATION	FL	33322-0000
EE	M	09/23/1958	GENA	HMO 1	DAVIE	FL	33314-0000
SP	F	04/25/1967	GENA	HMO 1	DAVIE	FL	33314-0000
EE	M	08/12/1993	GENA	HDHP	HOLLYWOOD	FL	33020-0000
EE	M	08/06/1966	GENA	HDHP	TAMARAC	FL	33321-0000
SP	F	03/05/1970	GENA	HDHP	TAMARAC	FL	33321-0000
CH	M	07/22/1991	GENA	HDHP	TAMARAC	FL	33321-0000
CH	M	03/24/1995	GENA	HDHP	TAMARAC	FL	33321-0000
CH	F	11/09/1993	GENA	HDHP	TAMARAC	FL	33321-0000
EE	M	04/12/1989	GENA	HMO 2	FORT LAUDERDALE	FL	33312-0000
EE	M	07/18/1985	FIRA	HDHP	HOLLYWOOD	FL	33024-0000
SP	F	05/12/1960	MGTA	HDHP	PARKLAND	FL	33067-0000
CH	F	07/30/1998	GENA	HMO 1	SUNRISE	FL	33322-0000
CH	M	04/29/1993	GENA	HMO 1	SUNRISE	FL	33322-0000
SP	F	11/30/1971	FIRA	HMO 1	PLANTATION	FL	33322-0000
EE	M	07/03/1956	FIRA	HMO 1	MIAMI	FL	33169-0000
CH	F	04/18/1996	FIRA	HMO 1	MIAMI	FL	33169-0000
CH	M	08/20/1998	FIRA	HMO 1	MIAMI	FL	33169-0000
EE	M	03/08/1941	PASA	HMO 1	FORT LAUDERDALE	FL	33311-0000
SP	F	04/20/1944	PASA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	05/02/1976	PASA	HMO 1	HOLLYWOOD	FL	33021-0000
EE	F	05/30/1960	CONA	HMO 1	HIALEAH	FL	33018-0000
EE	F	04/21/1980	MGTA	HMO 1	HOLLYWOOD	FL	33020-0000
EE	M	03/01/1963	FIRA	HDHP	PORT ST LUCIE	FL	34953-0000
SP	F	03/04/1964	FIRA	HDHP	PORT ST LUCIE	FL	34953-0000
CH	F	02/07/1995	PASA	HDHP	COCONUT CREEK	FL	33066-0000
EE	M	04/05/1983	FIRA	HMO 1	LAKE WORTH	FL	33449-0000
SP	F	02/20/1985	FIRA	HMO 1	LAKE WORTH	FL	33449-0000
CH	M	02/07/2015	FIRA	HMO 1	LAKE WORTH	FL	33449-0000
EE	F	09/22/1955	GENA	HDHP	MIRAMAR	FL	33025-0000
SP	M	05/30/1955	GENA	HDHP	MIRAMAR	FL	33025-0000
CH	M	02/20/1991	GENA	HDHP	MIRAMAR	FL	33025-0000
EE	M	12/24/1965	MGTA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	12/24/1958	MGTA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	04/28/1993	MGTA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	04/10/1995	MGTA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	F	06/13/1964	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
EE	F	11/20/1952	PASA	HDHP	HOLLYWOOD	FL	33023-0000

EE	M	01/04/1956	GENA	HDHP	WEST PARK	FL	33023-0000
EE	M	10/17/1982	FIRA	HMO 1	MIAMI	FL	33173-0000
SP	F	03/08/1983	FIRA	HMO 1	MIAMI	FL	33173-0000
CH	M	05/14/2013	FIRA	HMO 1	MIAMI	FL	33173-0000
CH	F	02/06/2015	FIRA	HMO 1	MIAMI	FL	33173-0000
EE	F	08/04/1975	MGTA	HMO 1	MIAMI LAKES	FL	33014-0000
EE	M	08/12/1970	PASA	HMO 2	NORTH MIAMI BEACH	FL	33162-0000
EE	M	06/11/1967	GENA	HDHP	MIRAMAR	FL	33025-0000
EE	F	12/10/1972	GENA	HMO 1	COCONUT CREEK	FL	33073-0000
CH	F	05/26/1990	GENA	HMO 1	PLANTATION	FL	33317-0000
EE	F	02/15/1957	GENA	HMO 1	MARGATE	FL	33063-0000
CH	F	10/16/1993	MGTA	HMO 1	CORAL SPRINGS	FL	33071-0000
EE	M	01/07/1960	FIRA	HMO 1	LAUDERDALE LAKES	FL	33311-0000
CH	F	03/15/1991	FIRA	HMO 1	LAUDERDALE LAKES	FL	33311-0000
CH	M	11/27/2000	FIRA	HMO 1	LAUDERDALE LAKES	FL	33311-0000
CH	M	11/03/1993	FIRA	HMO 1	LAUDERDALE LAKES	FL	33311-0000
SP	F	12/30/1965	GENA	HDHP	POMPANO BEACH	FL	33060-0000
EE	M	08/13/1952	GENU65	HMO 1	MARGATE	FL	33063-0000
EE	F	04/08/1963	PASA	HDHP	DAVIE	FL	33325-0000
SP	M	11/28/1965	PASA	HDHP	DAVIE	FL	33325-0000
CH	M	01/11/1994	PASA	HDHP	DAVIE	FL	33325-0000
CH	F	08/08/1997	PASA	HDHP	DAVIE	FL	33325-0000
SP	F	11/29/1971	GENA	HDHP	PLANTATION	FL	33324-0000
SP	F	08/07/1974	FIRA	HDHP	DAVIE	FL	33328-0000
EE	M	05/28/1981	GENA	HDHP	SUNRISE	FL	33322-0000
SP	F	08/09/1979	GENA	HDHP	SUNRISE	FL	33322-0000
CH	F	07/12/2007	GENA	HDHP	SUNRISE	FL	33322-0000
CH	F	02/09/2010	GENA	HDHP	SUNRISE	FL	33322-0000
CH	F	09/10/2004	GENA	HDHP	SUNRISE	FL	33322-0000
EE	M	07/15/1950	PASA	HMO 1	LAUDERHILL	FL	33319-0000
SP	F	12/19/1950	PASA	HMO 1	LAUDERHILL	FL	33319-0000
EE	F	05/18/1971	FIRA	HMO 1	COOPER CITY	FL	33328-0000
CH	M	12/14/2009	FIRA	HMO 1	COOPER CITY	FL	33328-0000
EE	M	10/30/1953	GENA	HDHP	CORAL SPRINGS	FL	33067-0000
EE	M	04/24/1988	FIRA	HDHP	PLANTATION	FL	33317-0000
EE	F	07/07/1966	MGTA	HMO 1	MIAMI	FL	33147-0000
EE	F	04/27/1982	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	M	03/26/1997	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	09/03/1959	PASA	HMO 1	MARGATE	FL	33063-0000
SP	F	03/17/1960	PASA	HMO 1	MARGATE	FL	33063-0000
CH	M	03/04/1999	PASA	HMO 1	MARGATE	FL	33063-0000
EE	M	08/27/1970	FIRA	HDHP	PEMBROKE PINES	FL	33026-0000
SP	F	10/28/1972	FIRA	HDHP	PEMBROKE PINES	FL	33026-0000

CH	M	10/27/2011	GENA	HDHP	LAUDERHILL	FL	33313-0000
EE	M	02/28/1982	GENA	HDHP	LAUDERHILL	FL	33313-0000
EE	M	08/16/1950	GENA	HMO 1	DANIA BEACH	FL	33312-0000
EE	M	05/30/1958	MGTA	HMO 1	MIAMI BEACH	FL	33139-0000
SP	F	03/01/1963	MGTA	HMO 1	MIAMI BEACH	FL	33139-0000
CH	M	06/15/1996	MGTA	HMO 1	WESTON	FL	33327-0000
EE	F	06/20/1957	PASA	HDHP	FORT LAUDERDALE	FL	33328-0000
EE	F	01/28/1976	GENA	HMO 2	LAUDERDALE LAKES	FL	33319-0000
EE	F	06/10/1967	MGTA	HMO 1	LAUDERHILL	FL	33319-0000
EE	M	05/06/1958	PASU65	HMO 1	FT LAUD	FL	33304-0000
EE	F	09/06/1963	GENA	HMO 1	CORAL SPRINGS	FL	33067-0000
SP	F	12/18/1990	GENA	HDHP	HOLLYWOOD	FL	33020-0000
EE	F	12/16/1986	GENA	HDHP	MIAMI	FL	33162-0000
EE	M	12/28/1967	PASA	HDHP	BOYNTON BEACH	FL	33435-0000
EE	M	12/01/1981	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
SP	F	05/06/1968	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	F	01/12/2006	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	04/23/1994	GENA	HMO 1	TAMARAC	FL	33321-0000
EE	M	04/20/1969	MGTA	HDHP	HOLLYWOOD	FL	33021-0000
SP	F	06/01/1971	MGTA	HDHP	HOLLYWOOD	FL	33021-0000
CH	F	02/27/2007	MGTA	HDHP	HOLLYWOOD	FL	33021-0000
CH	M	03/25/2009	MGTA	HDHP	HOLLYWOOD	FL	33021-0000
EE	M	10/13/1959	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	09/20/1962	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	10/18/1962	GENA	HMO 2	HOLLYWOOD	FL	33021-0000
SP	F	06/17/1966	GENA	HMO 2	HOLLYWOOD	FL	33021-0000
CH	F	02/26/1990	GENA	HMO 2	HOLLYWOOD	FL	33021-0000
CH	M	07/25/1999	GENA	HMO 2	HOLLYWOOD	FL	33021-0000
SP	M	05/01/1958	PASA	HDHP	HOLLYWOOD	FL	33019-0000
SP	F	11/29/1973	GENA	HMO 1	TAMARAC	FL	33319-0000
EE	M	01/12/1962	FIRA	HDHP	LAKE WORTH	FL	33463-0000
CH	F	08/01/1992	FIRA	HDHP	LAKE WORTH	FL	33463-0000
CH	F	01/15/1998	FIRA	HDHP	LAKE WORTH	FL	33463-0000
EE	M	12/05/1950	GENA	HDHP	HOLLYWOOD	FL	33024-0000
SP	F	10/24/1951	GENA	HDHP	HOLLYWOOD	FL	33024-0000
EE	M	07/09/1963	MGTA	HMO 1	PEMBROKE PINES	FL	33028-0000
EE	F	08/10/1982	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	M	11/21/1953	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
CH	F	08/27/1993	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
EE	F	11/08/1978	PASA	HMO 1	CORAL SPRINGS	FL	33071-0000
CH	F	10/27/1993	PASA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	F	10/29/1976	GENA	HDHP	MIRAMAR	FL	33023-0000
EE	M	09/07/1966	PASA	HDHP	FORT LAUDERDALE	FL	33309-0000

SP	F	02/26/1966	PASA	HDHP	FORT LAUDERDALE	FL	33308-0000
CH	M	02/23/1998	PASA	HDHP	FORT LAUDERDALE	FL	33308-0000
CH	M	01/15/1996	PASA	HDHP	GAINESVILLE	FL	32612-0000
EE	M	04/24/1961	MGTA	HMO 1	OAKLAND PARK	FL	33334-0000
EE	M	09/11/1958	MGTA	HDHP	FORT LAUDERDALE	FL	33315-0000
EE	F	05/31/1965	GENA	HMO 1	FORT LAUDERDALE	FL	33309-0000
SP	M	05/13/1960	GENA	HMO 1	FORT LAUDERDALE	FL	33309-0000
EE	F	09/12/1967	MGTA	HMO 1	LAUDERDALE LAKES	FL	33311-0000
SP	M	06/07/1967	MGTA	HMO 1	LAUDERDALE LAKES	FL	33311-0000
CH	F	11/11/1996	MGTA	HMO 1	LAUDERDALE LAKES	FL	33311-0000
CH	F	08/29/1991	MGTA	HMO 1	LAUDERDALE LAKES	FL	33311-0000
EE	M	09/07/1976	FIRA	HDHP	CORAL SPRINGS	FL	33067-0000
SP	F	07/07/1966	FIRA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	M	10/10/1955	MGTA	HMO 1	FORT LAUDERDALE	FL	33304-0000
EE	M	01/25/1964	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
EE	M	02/20/1987	FIRA	HDHP	LAKE WORTH	FL	33463-0000
SP	F	04/09/1981	FIRA	HDHP	LAKE WORTH	FL	33463-0000
CH	M	09/08/2011	FIRA	HDHP	LAKE WORTH	FL	33463-0000
CH	M	12/06/2012	FIRA	HDHP	LAKE WORTH	FL	33463-0000
SP	M	06/11/1953	GENA	HMO 1	PLANTATION	FL	33324-0000
CH	M	07/11/1991	GENA	HMO 1	PLANTATION	FL	33324-0000
CH	M	05/19/1996	GENA	HMO 1	PLANTATION	FL	33324-0000
EE	M	01/07/1964	GENA	HMO 2	FORT LAUDERDALE	FL	33316-0000
EE	M	01/19/1970	GENA	HMO 1	FORT LAUDERDALE	FL	33304-0000
SP	F	10/15/1978	GENA	HDHP	MIRAMAR	FL	33023-0000
EE	M	02/13/1968	FIRA	HDHP	ROYAL PALM BCH	FL	33411-0000
SP	F	02/26/1967	FIRA	HDHP	ROYAL PALM BCH	FL	33411-0000
CH	M	09/23/2003	FIRA	HDHP	ROYAL PALM BCH	FL	33411-0000
CH	M	01/13/2005	FIRA	HDHP	ROYAL PALM BCH	FL	33411-0000
SP	M	03/19/1973	MGTA	HMO 1	LAUDERDALE LAKES	FL	33309-0000
CH	F	11/22/2004	MGTA	HMO 1	LAUDERDALE LAKES	FL	33309-0000
CH	F	09/10/2003	MGTA	HMO 1	LAUDERDALE LAKES	FL	33309-0000
EE	F	10/01/1988	GENA	HDHP	POMPANO BEACH	FL	33060-0000
EE	F	11/23/1951	GENA	HDHP	FORT LAUDERDALE	FL	33302-0000
EE	M	05/05/1981	FIRA	HDHP	PALM CITY	FL	34990-0000
SP	F	10/22/1980	FIRA	HDHP	PALM CITY	FL	34990-0000
CH	F	12/09/2007	FIRA	HDHP	PALM CITY	FL	34990-0000
CH	F	03/27/2009	FIRA	HDHP	PALM CITY	FL	34990-0000
CH	M	04/20/2012	FIRA	HDHP	PALM CITY	FL	34990-0000
EE	F	12/02/1981	GENA	HDHP	BOYNTON BEACH	FL	33473-0000
CH	F	11/14/2012	GENA	HDHP	BOYNTON BEACH	FL	33473-0000
EE	M	11/27/1958	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
SP	F	08/16/1962	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000

CH	M	04/05/1993	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
SP	F	10/24/1973	PASA	HMO 1	MIRAMAR	FL	33027-0000
EE	F	06/04/1964	GENA	HMO 1	POMPANO BEACH	FL	33069-0000
SP	M	09/09/1960	GENA	HMO 1	POMPANO BEACH	FL	33069-0000
CH	M	02/07/1986	GENA	HMO 1	POMPANO BEACH	FL	33069-0000
EE	M	10/11/1968	MGTA	HMO 1	SUNRISE	FL	33351-0000
SP	F	10/02/1972	MGTA	HMO 1	SUNRISE	FL	33351-0000
CH	F	06/02/2005	MGTA	HMO 1	SUNRISE	FL	33351-0000
CH	M	09/11/2000	MGTA	HMO 1	SUNRISE	FL	33351-0000
CH	M	12/15/1994	MGTA	HMO 1	SUNRISE	FL	33351-0000
EE	F	03/11/1958	GENA	HMO 1	HOLLYWOOD	FL	33023-0000
CH	F	02/10/1994	GENA	HMO 1	HOLLYWOOD	FL	33023-0000
EE	M	01/26/1979	FIRA	HDHP	DAVIE	FL	33328-0000
SP	F	01/10/1974	FIRA	HDHP	DAVIE	FL	33328-0000
CH	F	12/16/2009	FIRA	HDHP	DAVIE	FL	33328-0000
CH	M	07/21/2012	FIRA	HDHP	DAVIE	FL	33328-0000
EE	M	02/26/1962	GENA	HMO 1	POMPANO BEACH	FL	33064-0000
EE	F	05/07/1977	PASA	HDHP	CORAL SPRINGS	FL	33076-0000
SP	M	10/08/1973	PASA	HDHP	CORAL SPRINGS	FL	33076-0000
CH	F	10/05/2006	PASA	HDHP	CORAL SPRINGS	FL	33076-0000
CH	F	07/31/2008	PASA	HDHP	CORAL SPRINGS	FL	33076-0000
EE	M	11/24/1970	GENA	HMO 1	COCONUT CREEK	FL	33073-0000
CH	F	05/23/2003	GENA	HMO 1	COCONUT CREEK	FL	33073-0000
CH	F	10/20/2000	GENA	HMO 1	COCONUT CREEK	FL	33073-0000
EE	M	02/16/1953	GENA	HMO 2	FORT LAUDERDALE	FL	33348-0000
EE	F	10/03/1955	CONU65	HMO 1	FT LAUD	FL	33334-0000
EE	M	11/11/1963	FIRA	HDHP	FORT LAUDERDALE	FL	33315-0000
EE	M	11/06/1989	MGTA	HDHP	OAKLAND PARK	FL	33309-0000
EE	M	01/09/1986	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	12/13/1952	PASC	HMO 1	WILTON MANORS	FL	33311-0000
CH	M	08/04/1992	SPEC	HMO 1	LIGHTHOUSE POINT	FL	33064-0000
CH	M	03/18/1995	SPEC	HMO 1	LIGHTHOUSE POINT	FL	33064-0000
EE	F	02/12/1962	GENA	HMO 1	LIGHTHOUSE POINT	FL	33074-0000
EE	F	09/23/1959	SPEC	HMO 1	LIGHTHOUSE POINT	FL	33064-0000
SP	M	07/31/1985	GENA	HMO 2	WESTON	FL	33331-0000
EE	F	11/29/1984	GENA	HMO 2	WESTON	FL	33331-0000
EE	M	08/19/1971	GENA	HMO 2	POMPANO BEACH	FL	33064-0000
CH	F	12/13/2000	GENA	HMO 2	POMPANO BEACH	FL	33064-0000
CH	F	03/24/1997	GENA	HMO 2	POMPANO BEACH	FL	33064-0000
CH	M	08/25/2004	GENA	HMO 2	POMPANO BEACH	FL	33064-0000
EE	M	03/01/1953	MGTU65	HMO 1	FLAT ROCK	NC	28731-0000
EE	M	01/14/1976	PASA	HDHP	NORTH LAUDERDALE	FL	33068-0000
EE	M	01/14/1981	PASA	HMO 1	DAVIE	FL	33314-0000

EE	M	07/22/1950	MGTA	HMO 1	PLANTATION	FL	33317-0000
SP	F	04/17/1953	MGTA	HMO 1	PLANTATION	FL	33317-0000
SP	F	12/13/1953	GENA	HMO 2	DAVIE	FL	33324-0000
SP	M	10/06/1953	PASA	HMO 1	MIAMI BEACH	FL	33141-0000
EE	M	09/28/1982	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	09/30/2004	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	F	09/30/1972	GENA	HMO 1	SUNRISE	FL	33345-0000
EE	M	09/03/1966	GENA	HMO 2	LAUDERHILL	FL	33311-0000
SP	F	09/03/1969	GENA	HMO 2	LAUDERHILL	FL	33311-0000
EE	M	05/12/1973	FIRA	HDHP	MIRAMAR	FL	33029-0000
CH	F	03/21/2001	FIRA	HDHP	MIRAMAR	FL	33029-0000
EE	F	12/21/1958	MGTA	HDHP	DAVIE	FL	33324-0000
EE	M	12/29/1941	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
EE	F	11/03/1945	CONA	HDHP	TAMARAC	FL	33321-0000
EE	M	02/02/1954	MGTU65	HMO 1	PALMETTO BAY	FL	33157-0000
EE	M	06/12/1965	PASA	HDHP	TAMARAC	FL	33319-0000
CH	M	05/09/2000	PASA	HDHP	TAMARAC	FL	33319-0000
CH	M	12/05/1994	PASA	HDHP	TAMARAC	FL	33319-0000
EE	M	03/07/1972	GENA	HDHP	COOPER CITY	FL	33328-0000
SP	F	02/16/1974	GENA	HDHP	COOPER CITY	FL	33328-0000
CH	M	06/01/2000	GENA	HDHP	COOPER CITY	FL	33328-0000
CH	M	03/07/2002	GENA	HDHP	COOPER CITY	FL	33328-0000
EE	M	06/09/1982	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
EE	M	07/22/1966	MGTA	HMO 1	WESTON	FL	33327-0000
SP	F	01/07/1978	MGTA	HMO 1	WESTON	FL	33327-0000
CH	M	01/31/1996	MGTA	HMO 1	WESTON	FL	33327-0000
CH	F	07/29/2011	MGTA	HMO 1	WESTON	FL	33327-0000
SP	M	03/23/1979	PASA	HMO 1	WEST PALM BEACH	FL	33406-0000
CH	M	06/15/2006	PASA	HMO 1	WEST PALM BEACH	FL	33406-0000
CH	F	03/12/2014	PASA	HMO 1	WEST PALM BEACH	FL	33406-0000
EE	F	04/03/1971	GENA	HMO 2	PLANTATION	FL	33324-0000
CH	M	11/07/1995	FIRA	HDHP	BOCA RATON	FL	33431-0000
EE	M	09/14/1979	FIRA	HDHP	POMPANO BEACH	FL	33062-0000
SP	F	06/25/1982	FIRA	HDHP	POMPANO BEACH	FL	33062-0000
CH	M	12/25/2015	FIRA	HDHP	POMPANO BEACH	FL	33062-0000
EE	M	03/09/1961	FIRA	HDHP	PORT ST LUCIE	FL	34953-0000
SP	F	07/31/1958	FIRA	HDHP	PORT ST LUCIE	FL	34953-0000
CH	M	05/18/1995	FIRA	HDHP	PORT ST LUCIE	FL	34953-0000
EE	F	07/19/1951	GENU65	HDHPR	POWDER SPRINGS	GA	30127-0000
CH	M	07/17/2006	FIRA	HDHP	COOPER CITY	FL	33328-0000
EE	M	10/27/1974	MGTA	HMO 1	PLANTATION	FL	33323-0000
CH	F	06/01/2006	MGTA	HMO 1	PLANTATION	FL	33323-0000
CH	F	02/28/2011	MGTA	HMO 1	PLANTATION	FL	33323-0000

EE	M	12/06/1957	MGTU65	HMO 1	CAROGA LAKE	NY	12032-0000
CH	F	10/17/1993	MGTU65	HMO 1	CAROGA LAKE	NY	12032-0000
EE	F	10/09/1957	MGTU65	HMO 1	CAROGA LAKE	NY	12032-0000
EE	M	11/30/1969	MGTA	HMO 1	BOCA RATON	FL	33498-0000
EE	M	11/18/1958	FIRA	HMO 1	STUART	FL	34997-0000
EE	M	04/04/1990	PASA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	06/21/1983	FIRA	HMO 1	FORT LAUDERDALE	FL	33304-0000
SP	F	05/03/1987	FIRA	HMO 1	FORT LAUDERDALE	FL	33304-0000
EE	F	07/26/1973	MGTA	HMO 1	CORAL SPRINGS	FL	33065-0000
CH	F	12/19/2008	MGTA	HMO 1	CORAL SPRINGS	FL	33065-0000
CH	M	06/28/2006	MGTA	HMO 1	CORAL SPRINGS	FL	33065-0000
EE	F	06/01/1971	CONA	HMO 1	SUNRISE	FL	33351-0000
CH	M	08/27/1994	PASA	HDHP	MIAMI	FL	33185-0000
EE	F	06/26/1972	GENA	HMO 1	TAMARAC	FL	33321-0000
EE	M	03/19/1987	FIRA	HDHP	DELRAY BEACH	FL	33483-0000
EE	M	05/13/1985	MGTA	HDHP	FORT LAUDERDALE	FL	33306-0000
SP	F	04/02/1985	MGTA	HDHP	FORT LAUDERDALE	FL	33306-0000
CH	F	02/27/2016	MGTA	HDHP	FORT LAUDERDALE	FL	33306-0000
EE	M	01/05/1988	MGTA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	F	02/21/1956	MGTU65	HMO 1	VERO BEACH	FL	32964-0000
EE	M	06/03/1982	GENA	HDHP	TAMARAC	FL	33321-0000
CH	F	07/19/2015	FIRA	HDHP	LOXAHATCHEE	FL	33470-0000
CH	F	09/24/1997	FIRA	HDHP	LOXAHATCHEE	FL	33470-0000
EE	F	12/22/1974	PASA	HMO 1	BOYNTON BEACH	FL	33437-0000
EE	M	02/18/1983	GENA	HMO 2	ROYAL PALM BEACH	FL	33411-0000
CH	F	07/28/2007	GENA	HMO 2	ROYAL PALM BEACH	FL	33411-0000
EE	M	12/15/1962	GENA	HDHP	MIRAMAR	FL	33027-0000
SP	F	01/01/1966	GENA	HDHP	MIRAMAR	FL	33027-0000
EE	M	03/08/1981	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	12/29/1998	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	10/01/2002	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	10/27/1997	PASA	HMO 1	COOPER CITY	FL	33328-0000
EE	F	05/29/1960	SPEC	HMO 1	HERMITAGE	TN	37076-0000
CH	F	07/02/1996	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	07/04/1976	GENA	HMO 1	FORT LAUDERDALE	FL	33308-0000
EE	M	12/17/1975	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	F	02/06/1957	CONU65	HMO 1	BOCA RATON	FL	33428-0000
EE	F	01/15/1973	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	F	01/13/1944	GENA	HMO 1	LAUDERHILL	FL	33351-0000
CH	M	12/30/2000	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	04/14/1975	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	F	11/04/1952	MGTU65	HMO 1	PLTN	FL	33317-0000
EE	M	10/06/1967	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000

CH	M	06/06/1996	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
CH	M	05/05/1998	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
EE	M	09/02/1966	PASA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
SP	F	06/19/1980	PASA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
CH	F	02/05/2010	PASA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
CH	M	12/16/2010	PASA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	M	09/21/1954	GENU65	HMO 1	FT LAUDERDALE	FL	33311-0000
EE	F	02/28/1965	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	06/21/1962	GENA	HMO 1	LAUDERHILL	FL	33313-0000
SP	F	03/17/1956	GENA	HMO 1	LAUDERHILL	FL	33313-0000
EE	M	01/02/1973	MGTA	HMO 1	WELLINGTON	FL	33414-0000
SP	F	12/19/1973	MGTA	HMO 1	WELLINGTON	FL	33414-0000
CH	F	04/23/2001	MGTA	HMO 1	WELLINGTON	FL	33414-0000
EE	M	04/18/1943	GENA	HMO 1	PLANTATION	FL	33317-0000
EE	F	08/30/1968	GENA	HDHP	DANIA	FL	33312-0000
SP	M	04/26/1965	GENA	HDHP	DANIA	FL	33312-0000
CH	F	10/30/1994	GENA	HDHP	DANIA	FL	33312-0000
CH	M	05/23/1997	GENA	HDHP	DANIA	FL	33312-0000
EE	M	01/16/1963	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
SP	F	06/30/1961	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	10/27/1996	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	08/28/1962	GENA	HMO 1	POMPANO BEACH	FL	33060-0000
EE	M	04/05/1964	GENA	HMO 1	POMPANO BEACH	FL	33073-0000
SP	F	09/26/1971	GENA	HMO 1	POMPANO BEACH	FL	33073-0000
CH	M	09/30/2007	GENA	HMO 1	POMPANO BEACH	FL	33073-0000
CH	M	09/30/2007	GENA	HMO 1	POMPANO BEACH	FL	33073-0000
SP	F	03/16/1976	GENA	HDHP	OAKLAND PARK	FL	33309-0000
CH	M	11/03/1998	GENA	HDHP	OAKLAND PARK	FL	33309-0000
CH	M	01/01/1993	PASA	HDHP	POMPANO BEACH	FL	33064-0000
EE	M	04/30/1969	GENA	HDHP	MARGATE	FL	33063-0000
SP	F	11/07/1971	GENA	HDHP	MARGATE	FL	33063-0000
CH	F	08/01/2005	GENA	HDHP	MARGATE	FL	33063-0000
CH	F	01/26/2001	GENA	HDHP	MARGATE	FL	33063-0000
CH	M	12/21/1993	GENA	HDHP	MARGATE	FL	33063-0000
EE	M	07/17/1975	GENA	HDHP	LAUDERHILL	FL	33311-0000
CH	F	03/12/2003	GENA	HDHP	LAUDERHILL	FL	33311-0000
CH	M	10/11/2004	GENA	HDHP	LAUDERHILL	FL	33311-0000
CH	F	06/24/1996	GENA	HDHP	LAUDERHILL	FL	33311-0000
CH	M	12/22/2001	GENA	HDHP	LAUDERHILL	FL	33311-0000
EE	M	03/31/1988	GENA	HDHP	LAUDERHILL	FL	33311-0000
EE	M	08/23/1969	GENA	HMO 2	LAUDERHILL	FL	33311-0000
EE	M	09/04/1976	GENA	HDHP	POMPANO BEACH	FL	33069-0000
CH	M	11/25/2005	GENA	HDHP	POMPANO BEACH	FL	33069-0000

CH	F	11/14/2000	GENA	HDHP	POMPANO BEACH	FL	33069-0000
CH	F	10/03/2015	GENA	HDHP	POMPANO BEACH	FL	33069-0000
CH	M	06/22/2012	GENA	HDHP	POMPANO BEACH	FL	33069-0000
EE	F	12/04/1955	GENA	HDHP	LAUDERHILL	FL	33351-0000
EE	F	07/19/1967	MGTA	HDHP	PEMBROKE PINES	FL	33029-0000
EE	M	06/12/1986	FIRA	HDHP	DANIA BEACH	FL	33004-0000
CH	M	09/09/2014	FIRA	HDHP	DANIA BEACH	FL	33004-0000
EE	M	07/12/1954	CONU65	HMO 1	MARGATE	FL	33063-0000
EE	F	03/11/1963	SPEC	HMO 1	FORT MYERS	FL	33901-0000
EE	M	01/04/1982	GENA	HMO 2	FORT LAUDERDALE	FL	33316-0000
CH	F	09/19/2000	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	F	01/18/2005	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	F	11/07/1952	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	11/30/1952	MGTU65	HMO 1	CORAL SPRINGS	FL	33071-0000
EE	M	03/27/1943	MGTA	HMO 1	MIAMI	FL	33179-0000
SP	F	06/18/1944	MGTA	HMO 1	MIAMI	FL	33179-0000
CH	M	10/12/1999	GENA	HDHP	FORT LAUDERDALE	FL	33304-0000
EE	M	08/01/1953	MGTA	HMO 1	LIGHTHOUSE POINT	FL	33064-0000
EE	M	06/23/1965	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	M	03/31/1999	GENA	HDHP	FORT LAUDERDALE	FL	33310-0000
CH	M	11/13/1997	GENA	HDHP	FORT LAUDERDALE	FL	33310-0000
EE	F	01/21/1989	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	09/03/2012	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	10/29/1957	GENA	HMO 1	FORT LAUDERDALE	FL	33309-0000
SP	F	12/03/1960	GENA	HMO 1	FORT LAUDERDALE	FL	33309-0000
CH	M	01/23/2005	MGTA	HDHP	PLANTATION	FL	33322-0000
EE	M	07/24/1961	PASA	HMO 1	PLANTATION	FL	33317-0000
SP	F	09/10/1962	PASA	HMO 1	PLANTATION	FL	33317-0000
EE	F	10/10/1964	CONA	HMO 1	LAUDERHILL	FL	33313-0000
EE	F	05/29/1986	FIRA	HDHP	LIGHTHOUSE POINT	FL	33064-0000
EE	F	09/16/1950	PASA	HMO 1	DAVIE	FL	33314-0000
EE	F	10/03/1981	GENA	HDHP	OAKLAND PARK	FL	33309-0000
EE	M	07/15/1969	FIRA	HDHP	POMPANO BEACH	FL	33062-0000
EE	M	09/06/1970	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	F	01/13/1999	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
SP	F	07/28/1964	FIRA	HDHP	COOPER CITY	FL	33328-0000
CH	F	04/23/2002	FIRA	HDHP	COOPER CITY	FL	33328-0000
EE	M	02/11/1972	FIRA	HDHP	COOPER CITY	FL	33328-0000
EE	F	10/27/1964	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	06/11/1963	PASA	HDHP	PEMBROKE PINES	FL	33025-0000
EE	M	04/18/1972	GENA	HDHP	FORT LAUDERDALE	FL	33302-0000
EE	M	03/13/1974	GENA	HMO 1	CORAL SPRINGS	FL	33065-0000
EE	M	09/11/1968	FIRA	HDHP	WILTON MANORS	FL	33334-0000

SP	F	10/09/1968	FIRA	HDHP	WILTON MANORS	FL	33334-0000
CH	M	09/05/2000	FIRA	HDHP	WILTON MANORS	FL	33334-0000
CH	F	07/13/2002	FIRA	HDHP	WILTON MANORS	FL	33334-0000
EE	M	09/06/1976	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	M	02/28/2000	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	M	04/02/1959	FIRA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	F	02/16/1958	PASA	HMO 1	FORT LAUDERDALE	FL	33334-0000
SP	M	09/06/1953	PASA	HMO 1	FORT LAUDERDALE	FL	33334-0000
EE	M	01/15/1971	GENA	HMO 1	PLANTATION	FL	33317-0000
CH	F	07/13/1990	GENA	HMO 1	PLANTATION	FL	33317-0000
CH	M	01/30/2000	GENA	HMO 1	PLANTATION	FL	33317-0000
CH	M	04/02/1992	MGTA	HMO 1	BOYNTON BCH	FL	33435-0000
EE	M	09/30/1989	FIRA	HMO 2	PEMBROKE PINES	FL	33028-0000
EE	F	11/02/1957	PASA	HMO 1	CORAL SPRINGS	FL	33076-0000
CH	M	10/23/1995	PASA	HMO 1	CORAL SPRINGS	FL	33076-0000
CH	M	10/09/2000	PASA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	F	09/02/1966	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
SP	M	08/31/1959	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	10/05/1968	FIRA	HDHP	ROYAL PALM BCH	FL	33414-0000
EE	M	08/12/1970	MGTA	HMO 1	TAMARAC	FL	33319-0000
CH	F	10/14/1999	MGTA	HMO 1	TAMARAC	FL	33319-0000
EE	M	09/09/1974	GENA	HMO 2	COCONUT CREEK	FL	33073-0000
EE	F	02/05/1957	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
SP	M	10/27/1956	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	F	01/05/1990	MGTA	HMO 1	LAUDERHILL	FL	33319-0000
SP	F	12/19/1960	GENA	HMO 1	CORAL SPRINGS	FL	33065-0000
EE	F	01/13/1964	GENA	HDHP	LAUDERDALE LAKES	FL	33309-0000
EE	M	01/03/1956	GENA	HMO 1	COOPER CITY	FL	33026-0000
SP	F	06/24/1955	GENA	HMO 1	COOPER CITY	FL	33026-0000
CH	F	07/24/2008	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	M	01/24/2013	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	09/21/1967	PASA	HMO 1	FORT LAUDERDALE	FL	33334-0000
CH	M	09/07/2001	PASA	HMO 1	FORT LAUDERDALE	FL	33334-0000
CH	M	01/05/2015	GENA	HMO 1	POMPANO BEACH	FL	33069-0000
EE	F	02/09/1977	GENA	HDHP	POMPANO BEACH	FL	33069-0000
EE	M	04/03/1988	GENA	HMO 1	MIAMI	FL	33145-0000
CH	M	02/24/2016	GENA	HMO 1	MIAMI	FL	33145-0000
EE	M	06/06/1978	PASA	HMO 2	HOLLYWOOD	FL	33020-0000
SP	F	05/05/1962	GENA	HDHP	TAMARAC	FL	33321-0000
EE	M	10/09/1968	GENA	HMO 2	WILTON MANORS	FL	33311-0000
SP	F	12/04/1970	GENA	HMO 2	WILTON MANORS	FL	33311-0000
CH	F	02/27/2004	GENA	HMO 2	WILTON MANORS	FL	33311-0000
CH	M	07/25/2006	GENA	HMO 2	WILTON MANORS	FL	33311-0000

EE	M	08/11/1962	GENA	HMO 2	COOPER CITY	FL	33328-0000
EE	M	12/22/1971	FIRA	HDHP	DAVIE	FL	33325-0000
SP	F	07/24/1953	GENA	HDHP	PLANTATION	FL	33322-0000
SP	F	03/13/1964	PASA	HMO 2	FORT LAUDERDALE	FL	33304-0000
CH	F	04/19/1995	PASA	HMO 2	FORT LAUDERDALE	FL	33304-0000
EE	F	12/25/1953	PASU65	HMO 1	DANIA BEACH	FL	33004-0000
SP	M	11/28/1962	MGTA	HMO 1	DAVIE	FL	33328-0000
EE	M	12/29/1972	GENA	HDHP	MIRAMAR	FL	33025-0000
SP	F	08/20/1984	FIRA	HDHP	COOPER CITY	FL	33328-0000
CH	F	08/01/2013	FIRA	HDHP	COOPER CITY	FL	33328-0000
EE	M	08/05/1965	FIRA	HDHP	PORT ST LUCIE	FL	34953-0000
SP	F	08/03/1962	FIRA	HDHP	PORT ST LUCIE	FL	34953-0000
CH	F	02/20/1998	FIRA	HDHP	PORT ST LUCIE	FL	34953-0000
EE	M	12/24/1954	GENA	HDHP	TAMARAC	FL	33321-0000
SP	F	02/14/1963	GENA	HDHP	TAMARAC	FL	33321-0000
CH	M	12/10/1998	GENA	HDHP	TAMARAC	FL	33321-0000
EE	M	12/01/1966	MGTA	HDHP	WESTON	FL	33331-0000
EE	F	07/21/1989	GENA	HDHP	POMPANO BEACH	FL	33069-0000
EE	M	11/12/1960	FIRA	HDHP	FORT LAUDERDALE	FL	33312-0000
SP	F	05/12/1963	FIRA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	05/14/1991	FIRA	HDHP	FORT LAUDERDALE	FL	33308-0000
CH	F	10/16/1992	FIRA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	05/22/1992	GENA	HMO 2	DANIA	FL	33004-0000
EE	F	03/17/1958	GENA	HMO 1	NO MIAMI BEACH	FL	33179-0000
EE	M	05/30/1968	GENA	HMO 1	LAUDERHILL	FL	33313-0000
EE	M	01/26/1981	GENA	HMO 1	DEERFIELD BEACH	FL	33442-0000
CH	M	07/18/2013	GENA	HMO 1	DEERFIELD BEACH	FL	33442-0000
EE	F	12/27/1968	GENA	HMO 1	PEMBROKE PINES	FL	33024-0000
CH	M	10/10/1999	GENA	HMO 1	PEMBROKE PINES	FL	33024-0000
CH	M	08/13/2004	GENA	HMO 1	PEMBROKE PINES	FL	33024-0000
EE	M	03/03/1960	GENU65	HMO 1	FT LAUD	FL	33311-0000
EE	M	07/17/1958	MGTA	HMO 1	POMPANO BEACH	FL	33069-0000
EE	M	04/26/1981	FIRA	HMO 1	BOYNTON BEACH	FL	33426-0000
SP	F	11/11/1988	FIRA	HMO 1	BOYNTON BEACH	FL	33426-0000
CH	M	01/20/2014	FIRA	HMO 1	BOYNTON BEACH	FL	33426-0000
EE	M	09/23/1963	GENA	HDHP	FORT LAUDERDALE	FL	33301-0000
EE	M	07/13/1974	GENA	HDHP	PEMBROKE PINES	FL	33025-0000
SP	F	10/16/1968	GENA	HDHP	PEMBROKE PINES	FL	33025-0000
EE	M	06/30/1969	MGTA	HMO 1	DEERFIELD BEACH	FL	33442-0000
SP	F	12/23/1970	MGTA	HMO 1	DEERFIELD BEACH	FL	33442-0000
CH	M	01/13/1991	MGTA	HMO 1	DEERFIELD BEACH	FL	33442-0000
CH	F	03/30/1995	GENA	HMO 1	POMPANO BEACH	FL	33064-0000
EE	M	12/05/1979	GENA	HDHP	LAUDERHILL	FL	33311-0000

CH	F	11/03/2005	GENA	HDHP	LAUDERHILL	FL	33311-0000
CH	F	05/20/2000	GENA	HDHP	LAUDERHILL	FL	33311-0000
CH	F	07/23/2001	GENA	HDHP	LAUDERHILL	FL	33311-0000
EE	M	02/23/1958	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	M	08/16/1962	PASA	HDHP	DELRAY BEACH	FL	33484-0000
SP	F	03/12/1960	PASA	HDHP	DELRAY BEACH	FL	33484-0000
CH	F	03/17/1995	PASA	HDHP	DELRAY BEACH	FL	33484-0000
CH	M	07/11/2000	PASA	HDHP	DELRAY BEACH	FL	33484-0000
CH	M	07/04/2003	PASA	HDHP	DELRAY BEACH	FL	33484-0000
EE	F	10/27/1972	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	M	03/06/1949	GENA	HMO 1	FORT LAUDERDALE	FL	33308-0000
EE	M	11/18/1960	PASA	HDHP	PLANTATION	FL	33324-0000
SP	F	01/13/1962	PASA	HDHP	PLANTATION	FL	33324-0000
CH	F	07/25/1991	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
CH	M	11/14/1992	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
CH	F	04/20/1995	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
CH	M	11/13/2009	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
CH	M	01/19/2000	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	08/25/1998	PASA	HMO 2	MIRAMAR	FL	33025-0000
CH	F	11/04/2003	PASA	HMO 2	MIRAMAR	FL	33025-0000
EE	M	09/19/1976	GENA	HMO 2	LAUDERDALE LAKES	FL	33311-0000
EE	M	08/09/1954	GENA	HMO 1	COCONUT CREEK	FL	33066-0000
SP	F	09/24/1953	GENA	HMO 1	COCONUT CREEK	FL	33066-0000
EE	M	01/05/1957	GENA	HDHP	OAKLAND PARK	FL	33334-0000
SP	F	10/29/1969	GENA	HDHP	OAKLAND PARK	FL	33334-0000
CH	M	10/06/2000	GENA	HDHP	OAKLAND PARK	FL	33334-0000
CH	F	06/22/2003	GENA	HDHP	OAKLAND PARK	FL	33334-0000
CH	M	10/03/1997	GENA	HDHP	OAKLAND PARK	FL	33334-0000
EE	M	08/09/1955	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	06/24/1957	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	12/29/1957	GENA	HDHP	DEERFIELD BEACH	FL	33442-0000
SP	F	04/10/1980	GENA	HDHP	BOCA RATON	FL	33486-0000
EE	M	05/30/1973	GENA	HDHP	WESTON	FL	33326-0000
CH	M	07/29/2001	GENA	HDHP	WESTON	FL	33326-0000
CH	M	07/10/2003	GENA	HDHP	WESTON	FL	33326-0000
EE	M	10/18/1984	FIRA	HDHP	BOCA RATON	FL	33434-0000
SP	F	12/14/1985	FIRA	HDHP	BOCA RATON	FL	33434-0000
CH	F	12/07/2015	FIRA	HDHP	BOCA RATON	FL	33434-0000
EE	M	10/27/1985	FIRA	HDHP	SUNNY ISLES	FL	33160-0000
EE	F	02/20/1955	CONA	HMO 1	DAVIE	FL	33324-0000
EE	M	01/25/1965	GENA	HMO 2	OAKLAND PARK	FL	33334-0000
CH	M	12/15/2003	GENA	HMO 2	OAKLAND PARK	FL	33334-0000
CH	F	11/11/2001	GENA	HMO 2	OAKLAND PARK	FL	33334-0000

CH	M	10/13/1995	MGTA	HMO 1	LAUDERHILL	FL	33319-0000
CH	F	06/21/2012	PASA	HDHP	DEERFIELD BEACH	FL	33442-0000
EE	F	05/07/1986	GENA	HDHP	HOLLYWOOD	FL	33020-0000
EE	M	08/19/1959	GENA	HDHP	LAUDERDALE LAKES	FL	33309-0000
SP	F	01/15/1967	GENA	HDHP	LAUDERDALE LAKES	FL	33309-0000
CH	M	04/27/1995	GENA	HDHP	LAUDERDALE LAKES	FL	33309-0000
CH	M	09/22/1997	GENA	HDHP	LAUDERDALE LAKES	FL	33309-0000
CH	M	04/12/1992	GENA	HDHP	LAUDERDALE LAKES	FL	33309-0000
SP	F	06/16/1970	GENA	HMO 1	LAUDERHILL	FL	33319-0000
EE	F	10/30/1957	PASA	HMO 1	PEMBROKE PINES	FL	33024-0000
EE	M	07/08/1975	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	08/16/2007	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	06/08/2003	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	09/16/1971	GENA	HMO 2	LAUDERHILL	FL	33319-0000
CH	M	06/13/2003	GENA	HMO 2	LAUDERHILL	FL	33319-0000
EE	F	03/02/1979	GENA	HMO 1	DEERFIELD BEACH	FL	33442-0000
EE	F	04/05/1958	MGTU65	HMO 1	FORT LAUDERDALE	FL	33308-0000
EE	F	01/28/1959	PASU65	HMO 1	CORAL SPRINGS	FL	33071-0000
EE	M	07/23/1973	GENA	HDHP	HALLANDALE BEACH	FL	33009-0000
CH	M	12/17/1994	GENA	HDHP	HALLANDALE BEACH	FL	33009-0000
EE	M	09/18/1978	MGTA	HDHP	HOLLYWOOD	FL	33024-0000
EE	M	05/24/1958	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
SP	F	12/10/1959	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	02/03/1969	FIRA	HDHP	PEMBROKE PINES	FL	33026-0000
CH	M	05/24/2001	FIRA	HDHP	PEMBROKE PINES	FL	33026-0000
CH	M	04/10/2004	FIRA	HDHP	PEMBROKE PINES	FL	33026-0000
CH	M	08/15/2007	FIRA	HDHP	PEMBROKE PINES	FL	33026-0000
EE	M	12/29/1970	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
SP	F	07/14/1961	FIRA	HDHP	LAKE WORTH	FL	33463-0000
EE	F	06/28/1987	GENA	HDHP	NORTH MIAMI BEACH	FL	33162-0000
EE	M	08/23/1969	GENA	HDHP	DAVIE	FL	33024-0000
CH	M	01/29/1994	GENA	HDHP	DAVIE	FL	33024-0000
EE	F	12/06/1953	CONU65	HMO 1	TAMARAC	FL	33321-0000
EE	F	01/16/1964	MGTA	HMO 1	FORT LAUDERDALE	FL	33305-0000
SP	M	06/05/1955	MGTA	HMO 1	FORT LAUDERDALE	FL	33305-0000
EE	M	03/03/1974	FIRA	HDHP	DAVIE	FL	33325-0000
SP	F	10/10/1972	FIRA	HDHP	DAVIE	FL	33325-0000
CH	M	03/08/2001	FIRA	HDHP	DAVIE	FL	33325-0000
CH	M	11/29/2007	FIRA	HDHP	DAVIE	FL	33325-0000
EE	M	12/23/1986	FIRA	HDHP	BOCA RATON	FL	33433-0000
SP	F	06/23/1988	FIRA	HDHP	BOCA RATON	FL	33433-0000
CH	F	03/03/2012	FIRA	HDHP	BOCA RATON	FL	33433-0000
CH	F	04/24/2014	FIRA	HDHP	BOCA RATON	FL	33433-0000

EE	F	05/28/1963	MGTA	HDHP	PLANTATION	FL	33325-0000
EE	F	06/12/1982	CONA	HDHP	MARGATE	FL	33063-0000
EE	M	11/25/1993	GENA	HDHP	LAUDERHILL	FL	33313-0000
EE	F	11/14/1958	CONA	HDHP	LOXAHATCHEE	FL	33470-0000
CH	F	10/16/2004	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	11/03/2012	GENA	HDHP	CORAL SPRINGS	FL	33067-0000
CH	M	06/28/2010	GENA	HDHP	CORAL SPRINGS	FL	33067-0000
EE	F	08/06/1992	CONA	HMO 1	NORTH MIAMI BEACH	FL	33162-0000
CH	M	03/18/1990	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
EE	M	09/13/1967	GENA	HMO 2	SUNRISE	FL	33351-0000
SP	F	03/20/1965	GENA	HMO 2	SUNRISE	FL	33351-0000
EE	M	04/11/1956	GENA	HMO 1	CORAL SPRINGS	FL	33092-0000
SP	F	09/25/1955	GENA	HMO 1	CORAL SPRINGS	FL	33092-0000
EE	M	03/10/1974	FIRA	HDHP	LAKE WORTH	FL	33463-0000
SP	F	05/21/1976	FIRA	HDHP	LAKE WORTH	FL	33463-0000
CH	F	01/11/1996	FIRA	HDHP	LAKE WORTH	FL	33463-0000
CH	F	02/16/1999	FIRA	HDHP	LAKE WORTH	FL	33463-0000
CH	M	03/16/2001	FIRA	HDHP	LAKE WORTH	FL	33463-0000
EE	M	06/04/1958	FIRA	HMO 1	WILTON MANORS	FL	33305-0000
SP	F	10/07/1962	FIRA	HMO 1	WILTON MANORS	FL	33305-0000
EE	M	11/04/1963	GENA	HDHP	LAUDERDALE LAKES	FL	33311-0000
SP	F	01/12/1965	GENA	HDHP	LAUDERDALE LAKES	FL	33311-0000
CH	M	11/03/2005	GENA	HDHP	LAUDERDALE LAKES	FL	33311-0000
EE	M	10/05/1981	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
SP	F	03/22/1985	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	M	08/03/2007	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	12/25/2001	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	M	04/16/2004	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	08/06/2005	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	09/09/1965	FIRA	HMO 1	PLANTATION	FL	33318-0000
SP	F	01/28/1962	FIRA	HMO 1	PLANTATION	FL	33318-0000
CH	M	02/08/1996	FIRA	HMO 1	SUNRISE	FL	33321-0000
CH	F	04/16/1997	FIRA	HMO 1	SUNRISE	FL	33321-0000
CH	M	07/12/2005	FIRA	HMO 1	SUNRISE	FL	33321-0000
EE	M	06/12/1946	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
SP	F	09/28/1963	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	12/28/1967	FIRA	HMO 1	PEMBROKE PINES	FL	33026-0000
CH	M	02/04/2008	FIRA	HMO 1	PEMBROKE PINES	FL	33026-0000
CH	F	02/04/2008	FIRA	HMO 1	PEMBROKE PINES	FL	33026-0000
EE	F	02/20/1954	PASA	HMO 1	MARGATE	FL	33063-0000
EE	F	06/18/1977	GENA	HMO 1	PEMBROKE PINES	FL	33029-0000
EE	F	05/13/1978	GENA	HMO 1	PEMBROKES PINES	FL	33023-0000
SP	M	05/18/1979	GENA	HMO 1	PEMBROKES PINES	FL	33023-0000

CH	F	11/15/2007	GENA	HMO 1	PEMBROKES PINES	FL	33023-0000
CH	F	05/05/2010	GENA	HMO 1	PEMBROKES PINES	FL	33023-0000
CH	F	08/22/2014	GENA	HMO 1	PEMBROKES PINES	FL	33023-0000
EE	M	07/30/1973	MGTA	HDHP	BOYNTON BCH	FL	33436-0000
SP	F	10/25/1973	MGTA	HDHP	BOYNTON BCH	FL	33436-0000
CH	M	05/26/2000	MGTA	HDHP	BOYNTON BCH	FL	33436-0000
CH	M	04/03/2002	MGTA	HDHP	BOYNTON BCH	FL	33436-0000
EE	M	02/18/1971	GENA	HDHP	LAUDERHILL	FL	33351-0000
CH	M	09/14/2004	GENA	HDHP	LAUDERHILL	FL	33351-0000
EE	M	08/21/1981	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	11/04/1984	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	10/04/2002	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	07/19/2012	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	10/06/2008	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	03/20/1969	GENA	HMO 2	LAUDERHILL	FL	33319-0000
EE	M	09/30/1983	MGTA	HDHP	WESTON	FL	33326-0000
CH	M	07/20/2010	MGTA	HDHP	WESTON	FL	33326-0000
CH	M	04/25/2012	MGTA	HDHP	WESTON	FL	33326-0000
EE	M	11/19/1982	GENA	HDHP	LAUDERHILL	FL	33313-0000
CH	F	03/16/2009	GENA	HDHP	LAUDERHILL	FL	33313-0000
EE	M	03/01/1968	GENA	HMO 1	PEMBROKE PINES	FL	33029-0000
CH	F	08/31/1999	GENA	HMO 1	PEMBROKE PINES	FL	33029-0000
EE	F	08/14/1968	GENA	HDHP	DAVIE	FL	33325-0000
EE	M	06/02/1972	GENA	HMO 1	HALLANDALE	FL	33009-0000
CH	F	12/24/1998	FIRA	HDHP	PLANTATION	FL	33322-0000
CH	F	08/15/2004	FIRA	HDHP	PLANTATION	FL	33322-0000
CH	M	12/25/2007	FIRA	HDHP	PLANTATION	FL	33322-0000
EE	M	05/24/1982	FIRA	HDHP	HOLLYWOOD	FL	33020-0000
SP	F	03/03/1978	FIRA	HDHP	HOLLYWOOD	FL	33020-0000
CH	M	08/08/2011	FIRA	HDHP	HOLLYWOOD	FL	33020-0000
EE	M	11/09/1972	FIRA	HDHP	BOYNTON BEACH	FL	33437-0000
SP	F	05/03/1973	FIRA	HDHP	BOYNTON BEACH	FL	33437-0000
CH	M	08/03/2009	FIRA	HDHP	BOYNTON BEACH	FL	33437-0000
CH	F	08/03/2009	FIRA	HDHP	BOYNTON BEACH	FL	33437-0000
CH	F	02/02/2006	FIRA	HDHP	BOYNTON BEACH	FL	33437-0000
EE	F	04/06/1971	GENA	HDHP	COCONUT CREEK	FL	33073-0000
CH	M	09/20/1991	GENA	HDHP	COCONUT CREEK	FL	33073-0000
CH	M	04/22/1997	GENA	HDHP	COCONUT CREEK	FL	33073-0000
EE	M	05/15/1965	GENA	HDHP	FORT LAUDERDALE	FL	33306-0000
CH	F	09/12/1998	GENA	HDHP	FORT LAUDERDALE	FL	33306-0000
CH	F	09/28/2000	GENA	HDHP	FORT LAUDERDALE	FL	33306-0000
CH	F	06/18/2004	GENA	HMO 1	MIAMI GARDENS	FL	33054-0000
SP	F	07/02/1985	GENA	HMO 1	MIAMI GARDENS	FL	33054-0000

EE	M	10/28/1974	GENA	HMO 2	HOLLYWOOD	FL	33024-0000
SP	F	04/11/1979	GENA	HMO 2	HOLLYWOOD	FL	33024-0000
EE	M	12/22/1986	GENA	HDHP	COOPER CITY	FL	33026-0000
EE	M	10/03/1992	FIRA	HDHP	COOPER CITY	FL	33026-0000
EE	M	12/01/1983	FIRA	HDHP	BOCA RATON	FL	33486-0000
CH	M	05/31/2013	FIRA	HDHP	BOCA RATON	FL	33486-0000
EE	F	09/01/1963	GENA	HMO 1	MARGATE	FL	33063-0000
SP	M	02/08/1967	GENA	HMO 1	MARGATE	FL	33063-0000
CH	F	11/09/1998	GENA	HMO 1	MARGATE	FL	33063-0000
CH	F	05/03/1996	GENA	HMO 1	MARGATE	FL	33063-0000
CH	F	01/03/1994	GENA	HMO 1	MARGATE	FL	33063-0000
EE	F	08/12/1957	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
EE	M	02/07/1966	PASA	HMO 1	PLANTATION	FL	33324-0000
EE	F	02/17/1966	MGTA	HDHP	FORT LAUDERDALE	FL	33301-0000
EE	F	10/13/1965	GENA	HMO 1	POMPANO BEACH	FL	33069-0000
EE	F	09/10/1961	GENA	HDHP	FORT LAUDERDALE	FL	33346-0000
EE	F	12/16/1969	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
SP	M	07/03/1965	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	03/24/1998	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	F	07/07/1957	GENA	HMO 1	TAMARAC	FL	33321-0000
SP	M	09/21/1966	PASA	HMO 1	PLANTATION	FL	33324-0000
CH	F	07/24/2001	PASA	HMO 1	PLANTATION	FL	33324-0000
CH	F	12/04/1999	PASA	HMO 1	PLANTATION	FL	33324-0000
EE	M	06/09/1953	GENA	HMO 1	CORAL SPRINGS	FL	33071-0000
SP	F	07/03/1958	GENA	HMO 1	CORAL SPRINGS	FL	33071-0000
CH	M	03/17/2000	MGTA	HDHP	PLANTATION	FL	33324-0000
EE	M	09/24/1970	PASA	HDHP	LAUDERHILL	FL	33313-0000
EE	F	08/01/1962	GENA	HMO 1	PLANTATION	FL	33325-0000
CH	F	03/18/1995	MGTA	HMO 1	POMPANO BCH	FL	33062-0000
CH	F	08/21/1997	MGTA	HMO 1	POMPANO BCH	FL	33062-0000
CH	F	12/07/1999	MGTA	HMO 1	POMPANO BCH	FL	33062-0000
EE	F	04/26/1951	MGTU65	HMO 1	SEBRING	FL	33876-0000
EE	M	11/05/1970	GENA	HDHP	DANIA BEACH	FL	33004-0000
CH	M	08/24/2006	GENA	HDHP	DANIA BEACH	FL	33004-0000
CH	F	05/18/2009	GENA	HDHP	DANIA BEACH	FL	33004-0000
EE	M	10/05/1967	MGTA	HDHP	DAVIE	FL	33328-0000
SP	F	03/10/1979	MGTA	HDHP	DAVIE	FL	33328-0000
CH	F	08/24/2008	MGTA	HDHP	DAVIE	FL	33328-0000
CH	F	03/11/2010	MGTA	HDHP	DAVIE	FL	33328-0000
CH	M	08/13/2013	MGTA	HDHP	DAVIE	FL	33328-0000
EE	F	07/07/1971	GENA	HDHP	COCONUT CREEK	FL	33073-0000
EE	M	09/22/1968	GENA	HDHP	OAKLAND PARK	FL	33309-0000
EE	M	03/31/1959	GENA	HMO 1	LAUDERDALE LAKES	FL	33319-0000

EE	M	04/07/1968	GENA	HDHP	HOLLYWOOD	FL	33020-0000
SP	F	12/31/1970	GENA	HDHP	HOLLYWOOD	FL	33020-0000
EE	M	10/14/1958	PASA	HMO 2	HALLANDALE	FL	33009-0000
SP	M	05/26/1974	PASA	HDHP	FORT LAUDERDALE	FL	33305-0000
CH	M	01/17/2012	PASA	HDHP	FORT LAUDERDALE	FL	33305-0000
EE	M	08/31/1982	FIRA	HMO 2	FORT LAUDERDALE	FL	33334-0000
SP	M	11/22/1956	PASA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	F	07/31/1966	FIRA	HMO 2	CORAL SPRINGS	FL	33071-0000
SP	M	12/24/1953	FIRA	HMO 2	CORAL SPRINGS	FL	33071-0000
CH	F	07/22/2003	FIRA	HMO 2	CORAL SPRINGS	FL	33071-0000
SP	M	10/04/1954	GENA	HDHP	SOUTHWEST RANCHES	FL	33330-0000
CH	M	09/05/1992	GENA	HDHP	SOUTHWEST RANCHES	FL	33330-0000
EE	M	01/11/1982	GENA	HDHP	DAVIE	FL	33328-0000
SP	F	06/02/1983	GENA	HDHP	DAVIE	FL	33328-0000
CH	M	07/24/2009	GENA	HDHP	DAVIE	FL	33328-0000
EE	F	10/25/1957	GENA	HMO 1	LAUDERHILL	FL	33311-0000
EE	M	10/05/1961	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	10/29/1955	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	04/02/1951	GENA	HMO 1	PLANTATION	FL	33322-0000
EE	M	09/15/1955	PASA	HDHP	MIRAMAR	FL	33023-0000
SP	F	09/16/1973	PASA	HDHP	MIRAMAR	FL	33023-0000
CH	M	03/05/1994	PASA	HDHP	MIRAMAR	FL	33023-0000
CH	M	11/06/2008	PASA	HDHP	MIRAMAR	FL	33023-0000
CH	F	02/17/2010	PASA	HDHP	MIRAMAR	FL	33023-0000
CH	M	02/22/1993	PASA	HDHP	MIRAMAR	FL	33023-0000
EE	F	04/12/1979	MGTA	HMO 1	BOCA RATON	FL	33428-0000
EE	M	07/03/1984	FIRA	HDHP	CORAL SPRINGS	FL	33071-0000
CH	F	04/05/2010	FIRA	HDHP	CORAL SPRINGS	FL	33071-0000
CH	M	03/08/2013	FIRA	HDHP	CORAL SPRINGS	FL	33071-0000
CH	M	06/22/1998	FIRU65	HDHP retiree	DANIA	FL	33004-0000
CH	M	09/12/2002	FIRA	HDHP	PORT ST LUCIE	FL	34983-0000
CH	F	06/07/1998	FIRA	HDHP	PORT ST LUCIE	FL	34983-0000
SP	F	04/12/1978	FIRA	HDHP	PORT ST LUCIE	FL	34983-0000
CH	M	07/10/2011	FIRA	HDHP	PORT ST LUCIE	FL	34983-0000
CH	F	08/15/2006	FIRA	HDHP	PORT ST LUCIE	FL	34983-0000
EE	F	10/23/1964	PASA	HMO 1	HOLLYWOOD	FL	33024-0000
EE	M	07/01/1985	PASA	HMO 1	COCONUT CREEK	FL	33073-0000
EE	M	09/25/1991	GENA	HDHP	PEMBROKE PINES	FL	33029-0000
EE	M	03/09/1971	FIRA	HDHP	MIAMI	FL	33168-0000
SP	F	02/20/1973	FIRA	HDHP	MIAMI	FL	33168-0000
CH	F	12/19/2000	FIRA	HDHP	MIAMI	FL	33168-0000
CH	F	02/13/2002	FIRA	HDHP	MIAMI	FL	33168-0000
CH	M	10/17/2005	FIRA	HDHP	MIAMI	FL	33168-0000

EE	M	05/23/1968	GENA	HMO 2	PEMBROKE PINES	FL	33026-0000
SP	F	01/18/1964	GENA	HMO 2	PEMBROKE PINES	FL	33026-0000
CH	M	09/13/1994	GENA	HMO 2	PEMBROKE PINES	FL	33026-0000
CH	M	11/26/1998	GENA	HMO 2	PEMBROKE PINES	FL	33026-0000
SP	F	10/01/1961	GENA	HMO 1	FORT LAUDERDALE	FL	33308-0000
EE	M	03/30/1967	GENA	HMO 2	OAKLAND PARK	FL	33309-0000
EE	M	08/27/1961	GENA	HMO 2	LAUDERHILL	FL	33313-0000
EE	M	02/28/1964	MGTA	HDHP	LAUDERDALE LAKES	FL	33313-0000
CH	M	05/08/2000	MGTA	HDHP	LAUDERDALE LAKES	FL	33313-0000
EE	F	10/11/1978	MGTA	HDHP	CORAL SPRINGS	FL	33065-0000
CH	F	06/16/2006	MGTA	HDHP	CORAL SPRINGS	FL	33065-0000
CH	M	01/23/1999	MGTA	HDHP	CORAL SPRINGS	FL	33065-0000
CH	F	11/01/2015	MGTA	HDHP	CORAL SPRINGS	FL	33065-0000
EE	M	10/06/1971	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	M	08/05/1982	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	05/13/1972	GENA	HMO 2	POMPANO	FL	33060-0000
EE	M	09/13/1984	FIRA	HDHP	ROYAL PALM BEACH	FL	33411-0000
EE	M	01/15/1965	MGTA	HMO 1	WILTON MANORS	FL	33311-0000
EE	M	09/09/1970	FIRA	HDHP	DAVIE	FL	33325-0000
SP	F	06/16/1967	FIRA	HDHP	DAVIE	FL	33325-0000
CH	M	07/02/1999	FIRA	HDHP	DAVIE	FL	33325-0000
CH	F	12/19/2001	FIRA	HDHP	DAVIE	FL	33325-0000
SP	F	05/25/1967	PASA	HDHP	BOCA RATON	FL	33428-0000
EE	M	09/10/1981	FIRA	HDHP	DEERFIELD BEACH	FL	33442-0000
SP	F	04/07/1984	FIRA	HDHP	DEERFIELD BEACH	FL	33442-0000
CH	M	02/06/2014	FIRA	HDHP	DEERFIELD BEACH	FL	33442-0000
EE	M	05/27/1949	MGTA	HMO 1	FORT LAUDERDALE	FL	33309-0000
EE	F	11/05/1980	FIRA	HMO 1	BOYNTON BEACH	FL	33436-0000
SP	M	03/19/1979	GENA	HDHP	TAMARAC	FL	33309-0000
EE	M	09/06/1989	FIRA	HMO 2	WEST PALM BEACH	FL	33405-0000
EE	M	08/02/1987	FIRA	HMO 2	COCONUT CREEK	FL	33073-0000
SP	F	11/04/1989	FIRA	HMO 2	COCONUT CREEK	FL	33073-0000
EE	M	07/19/1960	GENA	HMO 2	LAUDERHILL	FL	33313-0000
EE	M	07/01/1983	PASA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	M	04/25/2009	PASA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	F	02/24/1983	GENA	HDHP	OAKLAND PARK	FL	33334-0000
EE	M	09/06/1977	FIRA	HDHP	PLANTATION	FL	33374-0000
SP	F	01/29/1985	FIRA	HDHP	PLANTATION	FL	33374-0000
CH	F	09/07/2011	FIRA	HDHP	PLANTATION	FL	33374-0000
CH	M	09/24/2013	FIRA	HDHP	PLANTATION	FL	33374-0000
EE	F	03/24/1990	GENA	HMO 2	PLANTATION	FL	33324-0000
EE	M	08/01/1970	GENA	HDHP	PLANTATION	FL	33324-0000
EE	F	12/02/1959	GENA	HMO 1	DAVIE	FL	33314-0000

EE	M	03/04/1962	MGTA	HMO 2	PLANTATION	FL	33322-0000
CH	M	04/12/1999	MGTA	HMO 2	PLANTATION	FL	33322-0000
CH	M	04/12/1999	MGTA	HMO 2	PLANTATION	FL	33322-0000
EE	M	02/17/1959	MGTA	HDHP	HOLLYWOOD	FL	33021-0000
SP	F	02/02/1962	MGTA	HDHP	HOLLYWOOD	FL	33021-0000
EE	M	05/04/1980	FIRA	HDHP	LAKE WORTH	FL	33467-0000
SP	F	11/09/1978	FIRA	HDHP	LAKE WORTH	FL	33467-0000
CH	F	04/14/2010	FIRA	HDHP	LAKE WORTH	FL	33467-0000
CH	F	11/27/2011	FIRA	HDHP	LAKE WORTH	FL	33467-0000
CH	F	07/15/2014	FIRA	HDHP	LAKE WORTH	FL	33467-0000
EE	M	03/09/1957	PASA	HMO 1	COOPER CITY	FL	33328-0000
CH	M	11/06/1996	PASA	HMO 1	COOPER CITY	FL	33328-0000
CH	M	02/20/2000	PASA	HMO 1	COOPER CITY	FL	33328-0000
EE	M	06/29/1988	FIRA	HDHP	BOYNTON BEACH	FL	33472-0000
SP	F	09/23/1975	FIRA	HMO 1	BOYNTON BEACH	FL	33472-0000
EE	M	03/04/1957	GENA	HMO 1	DAVIE	FL	33325-0000
EE	M	08/19/1983	GENA	HMO 1	FT LAUDERDALE	FL	33311-0000
EE	M	10/08/1974	FIRA	HMO 1	KEY LARGO	FL	33037-0000
CH	F	11/08/2003	FIRA	HMO 1	KEY LARGO	FL	33037-0000
CH	F	11/28/2008	FIRA	HMO 1	KEY LARGO	FL	33037-0000
EE	M	04/17/1966	PASA	HDHP	POMPANO BEACH	FL	33069-0000
CH	M	01/04/2010	CONA	HMO 1	SUNRISE	FL	33351-0000
CH	M	08/09/2001	GENA	HDHP	FORT LAUDERDALE	FL	33306-0000
SP	F	03/07/1972	GENA	HMO 2	LAUDERDALE LAKES	FL	33311-0000
EE	M	07/04/1954	GENA	HMO 2	FORT LAUDERDALE	FL	33315-0000
CH	M	01/06/1998	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
CH	M	01/09/2012	PASA	HDHP	LAUDERHILL	FL	33351-0000
EE	F	08/22/1965	GENA	HDHP	PORT ST LUCIE	FL	34953-0000
EE	M	07/24/1965	GENA	HDHP	FORT LAUDERDALE	FL	33316-0000
EE	M	07/24/1965	PASA	HDHP	PLANTATION	FL	33317-0000
SP	F	05/11/1965	PASA	HDHP	PLANTATION	FL	33317-0000
CH	F	10/05/1992	PASA	HDHP	PLANTATION	FL	33317-0000
CH	M	06/03/1998	PASA	HDHP	PLANTATION	FL	33317-0000
EE	M	01/05/1965	GENA	HMO 1	SUNRISE	FL	33322-0000
SP	F	01/21/1966	GENA	HMO 1	SUNRISE	FL	33322-0000
CH	F	11/23/1997	GENA	HMO 1	SUNRISE	FL	33322-0000
EE	F	09/25/1967	CONA	HMO 2	COCONUT CREEK	FL	33073-0000
EE	F	10/15/1962	GENA	HMO 1	COCONUT CREEK	FL	33073-0000
EE	M	05/07/1971	PASA	HDHP	BOCA RATON	FL	33428-0000
CH	M	10/31/2007	PASA	HDHP	BOCA RATON	FL	33428-0000
CH	M	10/31/2007	PASA	HDHP	BOCA RATON	FL	33428-0000
EE	M	01/22/1958	MGTU65	HMO 1	INVERNESS	FL	34450-0000
EE	M	01/01/1976	FIRA	HDHP	BOCA RATON	FL	33486-0000

EE	M	08/28/1970	GENA	HMO 1	FORT LAUDERDALE	FL	33304-0000
EE	M	02/11/1961	GENA	HMO 1	MARGATE	FL	33063-0000
EE	F	06/02/1979	PASA	HDHP	DAVIE	FL	33324-0000
SP	M	11/11/1976	PASA	HDHP	DAVIE	FL	33324-0000
CH	F	09/09/2008	PASA	HDHP	DAVIE	FL	33324-0000
CH	F	08/29/2010	PASA	HDHP	DAVIE	FL	33324-0000
EE	M	08/02/1957	PASU65	HMO 1	TAMARAC	FL	33321-0000
EE	F	02/19/1961	GENA	HMO 1	LANTANA	FL	33465-0000
EE	M	06/25/1965	MGTA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	F	01/29/1992	MGTA	HMO 1	AMHERST	MA	01002-0000
EE	M	07/14/1956	GENA	HMO 1	HALLANDALE	FL	33009-0000
SP	F	08/29/1956	GENA	HMO 1	HALLANDALE	FL	33009-0000
EE	M	04/20/1970	FIRA	HDHP	LIGHTHOUSE PT	FL	33064-0000
SP	F	05/27/1970	FIRA	HDHP	LIGHTHOUSE PT	FL	33064-0000
CH	M	11/19/2002	FIRA	HDHP	LIGHTHOUSE PT	FL	33064-0000
CH	M	02/25/2006	FIRA	HDHP	LIGHTHOUSE PT	FL	33064-0000
CH	M	02/25/2006	FIRA	HDHP	LIGHTHOUSE PT	FL	33064-0000
EE	F	10/19/1957	PASA	HDHP	MIAMI	FL	33167-0000
SP	M	12/13/1955	PASA	HDHP	MIAMI	FL	33167-0000
EE	M	05/24/1988	ADCH	HDHP	MIAMI	FL	33167-0000
EE	F	07/28/1982	FIRA	HMO 1	TAMARAC	FL	33321-0000
CH	F	09/29/2009	FIRA	HMO 1	TAMARAC	FL	33321-0000
EE	M	10/07/1971	FIRA	HDHP	COOPER CITY	FL	33331-0000
CH	M	03/17/2003	FIRA	HDHP	COOPER CITY	FL	33331-0000
EE	F	08/04/1980	MGTA	HMO 1	OAKLAND PARK	FL	33334-0000
EE	M	01/07/1963	MGTA	HDHP	WESTON	FL	33331-0000
SP	F	03/28/1967	MGTA	HDHP	WESTON	FL	33331-0000
CH	M	02/26/2000	MGTA	HDHP	WESTON	FL	33331-0000
CH	F	11/24/2005	MGTA	HDHP	WESTON	FL	33331-0000
EE	M	11/30/1962	GENA	HDHP	BOCA RATON	FL	33428-0000
EE	F	08/29/1961	PASA	HMO 1	SUNRISE	FL	33323-0000
SP	M	07/21/1959	PASA	HMO 1	SUNRISE	FL	33323-0000
CH	F	07/17/2008	PASA	HMO 2	CORAL SPRINGS	FL	33065-0000
EE	M	03/13/1965	MGTA	HDHP	SUNRISE	FL	33323-0000
SP	F	04/13/1965	MGTA	HDHP	SUNRISE	FL	33323-0000
CH	M	12/19/1998	MGTA	HDHP	SUNRISE	FL	33323-0000
CH	M	09/29/1996	MGTA	HDHP	SUNRISE	FL	33323-0000
EE	F	06/09/1963	MGTA	HMO 1	MIAMI SHORES	FL	33150-0000
EE	M	02/12/1952	GENA	HMO 2	LAKE WORTH	FL	33467-0000
SP	F	07/08/1952	GENA	HMO 2	LAKE WORTH	FL	33467-0000
EE	M	09/25/1967	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	07/26/1993	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	11/04/1971	PASA	HMO 1	PEMBROKE PINES	FL	33026-0000

CH	M	01/21/1997	PASA	HMO 1	PEMBROKE PINES	FL	33026-0000
EE	F	11/28/1952	MGTA	HMO 1	OAKLAND PARK	FL	33334-0000
EE	M	05/29/1956	GENA	HMO 1	COCONUT CREEK	FL	33073-0000
SP	F	02/19/1976	GENA	HMO 1	COCONUT CREEK	FL	33073-0000
CH	M	06/29/2007	GENA	HMO 1	COCONUT CREEK	FL	33073-0000
CH	F	06/18/2014	GENA	HMO 1	COCONUT CREEK	FL	33073-0000
EE	M	03/21/1965	MGTA	HMO 1	PEMBROKE PINES	FL	33026-0000
SP	F	02/03/1965	MGTA	HMO 1	PEMBROKE PINES	FL	33026-0000
CH	M	02/18/1991	MGTA	HMO 1	PEMBROKE PINES	FL	33026-0000
EE	M	06/08/1969	FIRA	HDHP	CORAL SPRINGS	FL	33071-0000
EE	F	10/25/1961	GENA	HMO 1	DAVIE	FL	33325-0000
CH	F	06/28/1993	GENA	HMO 1	FORT LAUDERDALE	FL	33334-0000
EE	M	01/11/1968	GENA	HDHP	FORT LAUDERDALE	FL	33317-0000
EE	M	06/09/1957	MGTA	HMO 2	MIRAMAR	FL	33025-0000
EE	M	04/10/1992	GENA	HMO 2	DANIA	FL	33004-0000
EE	M	11/27/1948	MGTA	HMO 1	FORT LAUDERDALE	FL	33305-0000
SP	F	09/22/1950	MGTA	HMO 1	FORT LAUDERDALE	FL	33305-0000
EE	M	05/17/1975	FIRA	HMO 1	COOPER CITY	FL	33328-0000
CH	M	09/17/2010	FIRA	HMO 1	COOPER CITY	FL	33328-0000
CH	M	01/17/2013	FIRA	HMO 1	COOPER CITY	FL	33328-0000
EE	M	01/02/1980	FIRA	HDHP	FORT LAUDERDALE	FL	33308-0000
SP	F	12/17/1984	FIRA	HDHP	FORT LAUDERDALE	FL	33308-0000
CH	M	11/05/2015	FIRA	HDHP	FORT LAUDERDALE	FL	33308-0000
CH	M	11/05/2015	FIRA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	F	09/30/1982	GENA	HDHP	LAUDERDALE LAKES	FL	33319-0000
EE	F	01/28/1959	CONA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	F	11/16/1994	PASA	HDHP	WILTON MANORS	FL	33334-0000
EE	M	02/13/1960	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	04/16/1957	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	04/16/1991	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	F	06/28/1952	MGTU65	HMO 1	PLANTATION	FL	33317-0000
EE	M	02/25/1974	MGTA	HMO 1	MIAMI	FL	33136-0000
SP	F	07/15/1977	MGTA	HMO 1	MIAMI	FL	33136-0000
EE	F	07/01/1967	GENA	HMO 1	PEMBROKE PINES	FL	33028-0000
CH	F	01/16/1999	GENA	HMO 1	PEMBROKE PINES	FL	33028-0000
CH	M	10/12/1994	GENA	HMO 1	PEMBROKE PINES	FL	33028-0000
CH	M	07/10/2002	GENA	HMO 1	PEMBROKE PINES	FL	33028-0000
EE	M	08/05/1953	PASA	HMO 1	FORT LAUDERDALE	FL	33305-0000
EE	F	10/21/1962	GENA	HDHP	WEST PARK	FL	33023-0000
CH	M	01/31/1995	GENA	HDHP	WEST PARK	FL	33023-0000
CH	F	05/13/1990	MGTA	HDHP	FORT LAUDERDALE	FL	33301-0000
CH	M	02/02/1993	MGTA	HDHP	FORT LAUDERDALE	FL	33301-0000
EE	M	11/27/1970	PASA	HMO 1	POMPANO BEACH	FL	33064-0000

SP	F	02/10/1972	PASA	HMO 1	POMPANO BEACH	FL	33064-0000
CH	M	10/21/2003	PASA	HMO 1	POMPANO BEACH	FL	33064-0000
CH	M	10/05/2007	PASA	HMO 1	POMPANO BEACH	FL	33064-0000
EE	M	06/22/1952	MGTU65	HMO 1	BELLEFONTE	PA	16823-0000
EE	M	10/14/1984	FIRA	HDHP	COCONUT CREEK	FL	33073-0000
EE	M	11/30/1972	GENA	HMO 1	SUNRISE	FL	33351-0000
CH	F	09/19/2006	GENA	HMO 1	SUNRISE	FL	33351-0000
EE	M	07/26/1960	GENU65	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	M	03/04/1952	GENA	HMO 1	CORAL SPRINGS	FL	33065-0000
CH	F	09/02/1995	GENA	HMO 1	CORAL SPRINGS	FL	33065-0000
EE	M	04/18/1964	GENA	HMO 2	LAUDERHILL	FL	33311-0000
CH	M	03/29/1997	GENA	HMO 2	LAUDERHILL	FL	33311-0000
EE	M	04/09/1955	PASA	HMO 1	LAUDERHILL	FL	33313-0000
EE	F	05/11/1975	PASA	HMO 1	OAKLAND PARK	FL	33334-0000
SP	F	11/01/1968	PASA	HMO 1	FORT LAUDERDALE	FL	33334-0000
EE	M	08/01/1965	GENA	HDHP	PLANTATION	FL	33317-0000
SP	F	03/12/1972	GENA	HDHP	PLANTATION	FL	33317-0000
CH	F	05/29/2009	GENA	HDHP	PLANTATION	FL	33317-0000
CH	F	08/24/2006	GENA	HDHP	PLANTATION	FL	33317-0000
EE	M	07/09/1982	FIRA	HMO 2	TALLAHASSEE	FL	32312-0000
EE	M	05/09/1977	GENA	HDHP	HOLLYWOOD	FL	33021-0000
SP	F	10/14/1962	GENA	HDHP	COCONUT CREEK	FL	33073-0000
EE	M	02/25/1956	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	01/17/1997	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	10/02/1999	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	08/26/2000	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	05/31/2002	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	03/17/2007	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	10/01/2011	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	F	06/15/1954	GENU65	HMO 1	TAMARAC	FL	33321-0000
EE	F	03/06/1965	MGTA	HDHP	LAUDERHILL	FL	33313-0000
EE	M	02/28/1988	ADCH	HDHP	FORT LAUDERDALE	FL	33316-0000
SP	M	03/13/1977	MGTA	HDHP	MIAMI	FL	33179-0000
EE	M	08/26/1980	GENA	HDHP	OAKLAND PARK	FL	33334-0000
EE	M	08/02/1982	PASA	HDHP	FT LAUDERDALE	FL	33316-0000
SP	M	03/09/1947	MGTA	HDHP	DAVIE	FL	33324-0000
EE	F	09/23/1987	GENA	HDHP	PLANTATION	FL	33324-0000
EE	M	02/13/1986	FIRA	HDHP	TAMARAC	FL	33321-0000
EE	M	02/07/1959	PASU65	HMO 2	SUNRISE	FL	33323-0000
SP	F	04/05/1953	PASU65	HMO 2	SUNRISE	FL	33323-0000
EE	F	01/10/1962	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	01/29/1965	PASA	HMO 1	LAUDERDALE LAKES	FL	33319-0000
SP	F	09/23/1959	PASA	HMO 1	LAUDERDALE LAKES	FL	33319-0000

CH	M	03/02/1993	PASA	HMO 1	LAUDERDALE LAKES	FL	33319-0000
EE	M	08/26/1989	GENA	HMO 2	NORTH LAUDERDALE	FL	33068-0000
EE	M	03/06/1996	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	10/30/1960	GENA	HMO 2	SUNRISE	FL	33313-0000
SP	F	03/30/1956	PASU65	HMO 1	TAVARES	FL	32778-0000
EE	M	11/29/1963	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
EE	F	02/27/1990	MGTA	HDHP	FORT LAUDERDALE	FL	33304-0000
EE	F	02/28/1958	MGTA	HDHP	FORT LAUDERDALE	FL	33304-0000
EE	M	10/04/1962	PASA	HDHP	BOYNTON BEACH	FL	33424-0000
SP	F	03/02/1970	PASA	HDHP	BOYNTON BEACH	FL	33424-0000
CH	M	12/30/1996	PASA	HDHP	BOYNTON BEACH	FL	33424-0000
CH	F	12/30/1999	PASA	HDHP	BOYNTON BEACH	FL	33424-0000
EE	M	03/11/1988	GENA	HDHP	NORTH MIAMI	FL	33161-0000
CH	F	07/04/2013	GENA	HDHP	NORTH MIAMI	FL	33161-0000
EE	F	08/08/1961	GENA	HMO 2	COCONUT CREEK	FL	33066-0000
CH	F	05/13/1994	GENA	HMO 2	COCONUT CREEK	FL	33066-0000
CH	F	09/22/1991	GENA	HMO 2	COCONUT CREEK	FL	33066-0000
EE	M	05/12/1967	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	M	04/15/1991	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	11/26/1971	MGTA	HDHP	OAKLAND PARK	FL	33334-0000
EE	M	08/04/1970	FIRA	HDHP	FORT LAUDERDALE	FL	33305-0000
CH	M	11/14/1996	FIRA	HDHP	FORT LAUDERDALE	FL	33305-0000
CH	F	03/31/1998	FIRA	HDHP	FORT LAUDERDALE	FL	33305-0000
SP	F	08/25/1971	FIRA	HDHP	FORT LAUDERDALE	FL	33305-0000
EE	M	01/29/1982	GENA	HMO 1	FORT LAUDERDALE	FL	33304-0000
EE	M	12/02/1983	GENA	HDHP	HOLLYWOOD	FL	33024-0000
EE	F	11/29/1974	GENA	HDHP	POMPANO BEACH	FL	33060-0000
CH	F	03/07/2005	GENA	HDHP	POMPANO BEACH	FL	33060-0000
EE	F	05/26/1977	PASA	HDHP	FORT LAUDERDALE	FL	33304-0000
SP	M	05/03/1976	PASA	HDHP	FORT LAUDERDALE	FL	33304-0000
CH	M	08/16/2006	PASA	HDHP	FORT LAUDERDALE	FL	33304-0000
CH	M	02/09/2011	PASA	HDHP	FORT LAUDERDALE	FL	33304-0000
CH	M	03/04/2008	PASA	HDHP	FORT LAUDERDALE	FL	33304-0000
EE	M	07/28/1953	GENA	HMO 1	MIRAMAR	FL	33023-0000
SP	F	05/19/1952	GENA	HMO 1	MIRAMAR	FL	33023-0000
SP	F	06/22/1987	PASA	HMO 1	AVENTURA	FL	33180-0000
EE	M	11/16/1965	FIRA	HDHP	JENSEN BEACH	FL	34957-0000
SP	F	06/09/1965	FIRA	HDHP	JENSEN BEACH	FL	34957-0000
CH	M	04/04/1994	FIRA	HDHP	JENSEN BEACH	FL	34957-0000
EE	M	05/30/1963	GENA	HMO 1	FORT LAUDERDALE	FL	33309-0000
SP	F	12/31/1969	GENA	HMO 1	FORT LAUDERDALE	FL	33309-0000
EE	F	12/18/1964	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
EE	M	07/10/1963	GENA	HMO 1	DAVIE	FL	33325-0000

SP	F	12/06/1964	GENA	HMO 1	DAVIE	FL	33325-0000
EE	M	09/06/1949	GENA	HMO 1	NORTH MIAMI BEACH	FL	33179-0000
SP	F	07/10/1955	GENA	HMO 1	NORTH MIAMI BEACH	FL	33179-0000
EE	F	10/31/1962	PASA	HDHP	MARGATE	FL	33063-0000
EE	M	11/03/1952	GENA	HMO 2	DAVIE	FL	33324-0000
EE	M	09/18/1961	GENA	HMO 1	TAMARAC	FL	33321-0000
EE	F	01/26/1978	GENA	HMO 1	PORT SAINT LUCIE	FL	34983-0000
SP	F	10/04/1969	GENA	HDHP	SUNRISE	FL	33323-0000
EE	F	09/03/1970	GENA	HDHP	HOLLYWOOD	FL	33020-0000
SP	M	02/26/1969	GENA	HDHP	HOLLYWOOD	FL	33020-0000
EE	M	09/01/1982	PASA	HMO 1	PEMBROKE PINES	FL	33026-0000
EE	F	12/16/1964	PASA	HMO 1	TAMARAC	FL	33319-0000
EE	M	01/17/1996	GENA	HDHP	MIAMI LAKES	FL	33014-0000
EE	M	02/03/1964	FIRA	HDHP	PALM CITY	FL	34990-0000
CH	M	05/30/1998	FIRA	HDHP	PALM CITY	FL	34990-0000
CH	F	12/18/1999	FIRA	HDHP	PALM CITY	FL	34990-0000
EE	F	02/24/1971	CONA	HDHP	COCONUT CREEK	FL	33066-0000
SP	M	05/20/1958	CONA	HDHP	COCONUT CREEK	FL	33066-0000
EE	M	01/11/1989	MGTA	HDHP	LAKE WORTH	FL	33467-0000
EE	M	02/28/1969	FIRA	HMO 1	PORT ST LUCIE	FL	34986-0000
SP	F	04/15/1971	FIRA	HMO 1	PORT ST LUCIE	FL	34986-0000
CH	F	10/04/2004	FIRA	HMO 1	PORT ST LUCIE	FL	34986-0000
CH	F	10/04/2004	FIRA	HMO 1	PORT ST LUCIE	FL	34986-0000
CH	M	11/25/2007	FIRA	HMO 1	PORT ST LUCIE	FL	34986-0000
SP	M	06/13/1977	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	F	08/01/2006	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	F	07/02/1954	GENA	HMO 2	FORT LAUDERDALE	FL	33305-0000
EE	M	04/05/1972	PASA	HDHP	GREENACRES	FL	33463-0000
CH	M	12/13/2002	PASA	HDHP	GREENACRES	FL	33463-0000
EE	M	06/16/1981	FIRA	HDHP	COOPER CITY	FL	33328-0000
EE	M	04/27/1986	FIRA	HDHP	COCONUT CREEK	FL	33063-0000
SP	F	09/09/1987	FIRA	HDHP	COCONUT CREEK	FL	33063-0000
EE	M	05/26/1966	GENA	HMO 1	POMPANO BEACH	FL	33064-0000
EE	M	11/19/1972	GENA	HMO 2	COCONUT CREEK	FL	33066-0000
SP	F	01/31/1975	GENA	HMO 2	COCONUT CREEK	FL	33066-0000
EE	F	09/14/1965	PASA	HDHP	FORT LAUDERDALE	FL	33313-0000
EE	M	01/07/1991	FIRA	HMO 1	DELRAY BEACH	FL	33445-0000
EE	M	11/03/1956	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
SP	F	01/25/1967	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
CH	M	01/13/1994	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
EE	F	10/23/1974	GENA	HMO 2	MIRAMAR	FL	33027-0000
EE	F	02/21/1974	MGTA	HDHP	SUNRISE	FL	33322-0000
EE	F	11/16/1957	MGTA	HMO 1	FORT LAUDERDALE	FL	33305-0000

EE	F	01/13/1955	GENA	HDHP	LAUDERHILL	FL	33313-0000
CH	F	07/28/1996	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
EE	F	06/20/1970	GENA	HMO 2	TAMARAC	FL	33321-0000
EE	M	10/07/1963	FIRA	HDHP	JENSEN BEACH	FL	34957-0000
SP	F	07/08/1966	FIRA	HDHP	JENSEN BEACH	FL	34957-0000
CH	M	08/12/1997	FIRA	HDHP	JENSEN BEACH	FL	34957-0000
EE	F	06/19/1959	MGTU65	HMO 1	POMPANO BEACH	FL	33062-0000
EE	F	09/17/1963	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	12/31/1959	GENA	HMO 1	DELRAY BEACH	FL	33446-0000
SP	F	11/07/1960	GENA	HMO 1	DELRAY BEACH	FL	33446-0000
CH	M	05/30/1994	GENA	HMO 1	DELRAY BEACH	FL	33446-0000
CH	F	12/26/1991	GENA	HMO 1	DELRAY BEACH	FL	33446-0000
EE	M	01/21/1963	PASA	HDHP	TAMARAC	FL	33321-0000
CH	F	01/25/1995	PASA	HDHP	TAMARAC	FL	33321-0000
EE	M	07/29/1990	FIRA	HDHP	BOCA RATON	FL	33433-0000
EE	F	11/21/1963	MGTA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	05/18/1964	GENA	HMO 1	POMPANO BEACH	FL	33069-0000
EE	M	04/16/1988	ADCH	HMO 1	POMPANO BEACH	FL	33069-0000
EE	M	05/29/1958	GENA	HDHP	FORT LAUDERDALE	FL	33304-0000
EE	M	02/01/1970	FIRA	HMO 2	JUPITER	FL	33478-0000
SP	F	08/26/1979	FIRA	HMO 2	JUPITER	FL	33478-0000
CH	M	02/17/2005	FIRA	HMO 2	JUPITER	FL	33478-0000
CH	M	01/22/2008	FIRA	HMO 2	JUPITER	FL	33478-0000
EE	M	07/25/1989	FIRA	HDHP	WEST PALM BEACH	FL	33412-0000
EE	F	02/22/1978	CONA	HDHP	WILTON MANORS	FL	33311-0000
EE	M	12/17/1981	FIRA	HMO 1	SOUTHWEST RANCHES	FL	33332-0000
SP	F	07/19/1980	FIRA	HMO 1	SOUTHWEST RANCHES	FL	33332-0000
EE	F	12/14/1972	PASA	HMO 1	MARGATE	FL	33063-0000
CH	M	02/14/2007	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	12/10/1970	FIRA	HDHP	WINTER GARDEN	FL	34787-0000
SP	F	02/18/1977	FIRA	HDHP	WINTER GARDEN	FL	34787-0000
CH	M	06/28/2007	FIRA	HDHP	WINTER GARDEN	FL	34787-0000
CH	M	12/06/2009	FIRA	HDHP	WINTER GARDEN	FL	34787-0000
EE	M	05/03/1976	MGTA	HMO 1	BOYNTON BCH	FL	33435-0000
CH	F	08/10/2006	MGTA	HMO 1	BOYNTON BCH	FL	33435-0000
CH	M	03/31/2008	MGTA	HMO 1	BOYNTON BCH	FL	33435-0000
CH	F	01/15/2010	MGTA	HMO 1	BOYNTON BCH	FL	33435-0000
CH	M	09/13/2011	MGTA	HMO 1	BOYNTON BCH	FL	33435-0000
CH	M	04/08/2014	MGTA	HMO 1	BOYNTON BCH	FL	33435-0000
EE	F	03/13/1977	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	08/27/1952	PASA	HDHP	POMPANO BEACH	FL	33060-0000
EE	M	05/24/1982	GENA	HDHP	POMPANO BEACH	FL	33060-0000
EE	M	07/27/1960	PASA	HDHP	TAMARAC	FL	33321-0000

SP	F	06/06/1961	PASA	HDHP	TAMARAC	FL	33321-0000
EE	M	12/27/1967	FIRA	HDHP	PORT ST LUCIE	FL	34983-0000
SP	F	06/21/1971	PASA	HDHP	TAMARAC	FL	33321-0000
EE	M	04/09/1963	GENA	HMO 1	SUNRISE	FL	33323-0000
CH	M	07/16/2003	GENA	HMO 1	SUNRISE	FL	33323-0000
EE	F	03/16/1952	GENA	HMO 1	SUNRISE	FL	33326-0000
EE	F	12/13/1962	GENA	HMO 1	LIGHTHOUSE PT	FL	33064-0000
SP	M	05/25/1956	GENA	HMO 1	LIGHTHOUSE PT	FL	33064-0000
EE	M	01/17/1985	FIRA	HMO 1	PLANTATION	FL	33323-0000
EE	M	09/30/1964	GENA	HMO 1	POMPANO BEACH	FL	33064-0000
SP	F	06/18/1967	GENA	HMO 1	POMPANO BEACH	FL	33064-0000
EE	M	08/28/1971	FIRA	HDHP	WESTON	FL	33331-0000
SP	F	08/06/1967	FIRA	HDHP	WESTON	FL	33331-0000
CH	F	05/06/1999	FIRA	HDHP	WESTON	FL	33331-0000
CH	M	11/08/2002	FIRA	HDHP	WESTON	FL	33331-0000
EE	F	03/07/1964	MGTA	HDHP	MARGATE	FL	33063-0000
EE	M	05/22/1957	GENA	HMO 1	POMPANO BCH	FL	33060-0000
SP	F	11/14/1952	GENA	HMO 1	POMPANO BCH	FL	33060-0000
CH	F	12/05/1996	FIRA	HDHP	OAKLAND PARK	FL	33309-0000
CH	F	07/14/1999	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	01/17/1996	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	F	10/23/1964	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	12/04/1974	GENA	HDHP	LAUDERHILL	FL	33313-0000
EE	M	08/14/1982	GENA	HDHP	OPA LOCKA	FL	33054-0000
EE	F	05/17/1973	MGTA	HMO 2	CORAL SPRINGS	FL	33065-0000
SP	M	05/18/1954	GENA	HMO 2	COCONUT CREEK	FL	33066-0000
EE	M	08/29/1971	FIRA	HDHP	SOUTHWEST RANCHES	FL	33332-0000
SP	F	03/04/1975	FIRA	HDHP	SOUTHWEST RANCHES	FL	33332-0000
CH	F	01/09/2002	FIRA	HDHP	SOUTHWEST RANCHES	FL	33332-0000
CH	F	02/03/2003	FIRA	HDHP	SOUTHWEST RANCHES	FL	33332-0000
CH	F	06/24/2004	FIRA	HDHP	SOUTHWEST RANCHES	FL	33332-0000
CH	F	03/17/2007	FIRA	HDHP	SOUTHWEST RANCHES	FL	33332-0000
EE	M	04/20/1950	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
SP	F	04/19/1963	PASA	HDHP	BOYNTON BEACH	FL	33435-0000
CH	M	05/07/1990	GENA	HMO 1	MIAMI	FL	33179-0000
CH	M	02/01/1994	GENA	HMO 1	MIAMI	FL	33179-0000
EE	M	10/18/1967	GENA	HMO 2	PORT ST LUCIE	FL	34953-0000
EE	M	07/07/1966	CONA	HMO 2	OAKLAND PARK	FL	33309-0000
CH	M	06/23/1993	PASA	HMO 1	FORT LAUDERDALE	FL	33334-0000
EE	F	07/27/1963	MGTA	HMO 1	HOLLYWOOD	FL	33021-0000
EE	M	07/07/1969	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	03/13/2000	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	10/09/1970	GENA	HMO 1	POMPANO BEACH	FL	33062-0000

EE	F	07/27/1956	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	M	07/28/1990	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	04/13/1993	GENA	HDHP	MORRISTOWN	NJ	07960-0000
EE	M	05/28/1977	FIRA	HDHP	LAKE WORTH	FL	33467-0000
SP	F	09/23/1979	FIRA	HDHP	LAKE WORTH	FL	33467-0000
CH	M	06/29/2010	FIRA	HDHP	LAKE WORTH	FL	33467-0000
CH	F	04/27/2013	FIRA	HDHP	LAKE WORTH	FL	33467-0000
EE	M	02/09/1989	GENA	HDHP	OAKLAND PARK	FL	33309-0000
EE	M	02/05/1965	GENA	HMO 1	DAVIE	FL	33328-0000
CH	M	11/08/2000	GENA	HMO 1	DAVIE	FL	33328-0000
CH	M	08/11/2002	GENA	HMO 1	DAVIE	FL	33328-0000
CH	F	08/11/2002	GENA	HMO 1	DAVIE	FL	33328-0000
EE	F	11/08/1959	PASA	HMO 1	OAKLAND PARK	FL	33309-0000
EE	M	04/12/1960	GENA	HMO 1	MIAMI	FL	33169-0000
SP	F	06/10/1976	GENA	HMO 1	MIAMI	FL	33169-0000
EE	M	11/11/1955	PASA	HDHP	FORT LAUDERDALE	FL	33312-0000
SP	F	01/07/1960	PASA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	M	02/27/1992	PASA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	10/19/1959	FIRU65	HMO 1	JENSEN BEACH	FL	34957-0000
EE	F	09/29/1976	PASA	HMO 1	OAKLAND PARK	FL	33334-0000
EE	F	11/20/1957	GENA	HMO 1	FORT LAUDERDALE	FL	33317-0000
SP	M	11/01/1952	GENA	HMO 1	FORT LAUDERDALE	FL	33317-0000
CH	F	12/02/1991	GENA	HMO 1	FORT LAUDERDALE	FL	33317-0000
EE	M	08/24/1987	GENA	HMO 1	COOPER CITY	FL	33328-0000
SP	F	11/17/1980	GENA	HMO 1	COOPER CITY	FL	33328-0000
CH	F	12/22/2014	GENA	HMO 1	COOPER CITY	FL	33328-0000
EE	M	09/13/1955	FIRA	HDHP	HOBE SOUND	FL	33455-0000
SP	F	07/08/1955	FIRA	HDHP	HOBE SOUND	FL	33455-0000
CH	F	01/29/1994	FIRA	HDHP	HOBE SOUND	FL	33455-0000
EE	F	03/04/1993	GENA	HMO 1	PLANTATION	FL	33324-0000
EE	M	09/23/1986	FIRA	HDHP	PLANTATION	FL	33322-0000
EE	F	10/11/1967	GENA	HDHP	SUNRISE	FL	33351-0000
CH	M	11/14/1994	GENA	HDHP	SUNRISE	FL	33351-0000
CH	M	07/21/2005	GENA	HDHP	SUNRISE	FL	33351-0000
EE	M	01/09/1971	FIRA	HMO 1	WEST PALM BEACH	FL	33406-0000
SP	F	06/27/1967	FIRA	HMO 1	WEST PALM BEACH	FL	33406-0000
CH	M	02/24/2001	FIRA	HMO 1	WEST PALM BEACH	FL	33406-0000
CH	M	04/21/2004	FIRA	HMO 1	WEST PALM BEACH	FL	33406-0000
EE	F	07/10/1955	GENA	HMO 1	FORT LAUDERDALE	FL	33304-0000
EE	M	10/18/1956	GENA	HMO 2	TAMARAC	FL	33309-0000
SP	F	01/22/1969	GENA	HMO 2	TAMARAC	FL	33309-0000
CH	F	01/18/1993	GENA	HMO 2	TAMARAC	FL	33309-0000
CH	F	01/18/1993	GENA	HMO 2	TAMARAC	FL	33309-0000

CH	F	08/20/2004	GENA	HMO 2	TAMARAC	FL	33309-0000
EE	M	04/27/1958	GENA	HMO 1	COOPER CITY	FL	33330-0000
SP	F	02/03/1971	GENA	HMO 1	COOPER CITY	FL	33330-0000
CH	M	06/29/1991	GENA	HMO 1	COOPER CITY	FL	33330-0000
EE	M	05/12/1960	GENA	HMO 2	PORT ST LUCIE	FL	34953-0000
SP	F	07/07/1962	GENA	HMO 2	PORT ST LUCIE	FL	34953-0000
SP	M	07/16/1968	GENA	HMO 1	LAKE WORTH	FL	33463-0000
EE	F	02/21/1983	PASA	HMO 1	POMPANO BEACH	FL	33060-0000
EE	M	04/24/1978	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	F	12/13/1990	PASA	HMO 1	OAKLAND PARK	FL	33309-0000
CH	M	10/04/2012	PASA	HMO 1	OAKLAND PARK	FL	33309-0000
EE	F	03/26/1965	GENA	HMO 2	DAVIE	FL	33328-0000
SP	M	08/31/1968	GENA	HMO 2	DAVIE	FL	33328-0000
CH	F	11/21/2000	GENA	HMO 2	DAVIE	FL	33328-0000
EE	F	04/24/1957	MGTA	HMO 1	HOLLYWOOD	FL	33020-0000
SP	M	02/18/1957	MGTA	HMO 1	HOLLYWOOD	FL	33020-0000
EE	M	01/23/1954	GENA	HDHP	SUNRISE	FL	33322-0000
SP	F	01/25/1978	GENA	HDHP	SUNRISE	FL	33322-0000
CH	M	01/19/2012	GENA	HDHP	SUNRISE	FL	33322-0000
EE	F	03/25/1974	PASA	HMO 1	WEST PALM BEACH	FL	33406-0000
EE	F	02/12/1963	PASA	HMO 1	TAMARAC	FL	33321-0000
SP	M	08/24/1958	PASA	HMO 1	TAMARAC	FL	33321-0000
CH	M	11/19/1990	PASA	HMO 1	TAMARAC	FL	33321-0000
EE	M	01/20/1972	PASA	HDHP	MIAMI	FL	33179-0000
CH	F	11/16/2004	PASA	HDHP	AVENTURA	FL	33180-0000
EE	M	05/10/1986	GENA	HDHP	TAMARAC	FL	33309-0000
EE	M	11/21/1978	GENA	HDHP	SOUTHWEST RANCHES	FL	33332-0000
SP	F	11/27/1978	GENA	HDHP	SOUTHWEST RANCHES	FL	33332-0000
CH	F	09/22/2006	GENA	HDHP	SOUTHWEST RANCHES	FL	33332-0000
CH	M	09/17/2008	GENA	HDHP	SOUTHWEST RANCHES	FL	33332-0000
CH	M	04/04/2000	GENA	HDHP	SOUTHWEST RANCHES	FL	33332-0000
CH	M	11/09/2002	GENA	HDHP	SOUTHWEST RANCHES	FL	33332-0000
CH	M	01/29/1995	GENA	HMO 1	PLANTATION	FL	33317-0000
CH	M	01/10/1997	GENA	HMO 1	PLANTATION	FL	33317-0000
EE	F	04/04/1964	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	02/06/1995	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	F	01/18/1966	GENA	HMO 1	MIRAMAR	FL	33025-0000
SP	M	01/10/1965	GENA	HMO 1	MIRAMAR	FL	33025-0000
CH	F	01/09/1992	GENA	HMO 1	MIRAMAR	FL	33025-0000
EE	F	01/19/1978	GENA	HDHP	LAUDERHILL	FL	33313-0000
SP	M	07/29/1971	GENA	HDHP	LAUDERHILL	FL	33313-0000
EE	M	06/02/1969	GENA	HDHP	PLANTATION	FL	33322-0000
EE	F	07/23/1968	GENA	HDHP	OAKLAND PARK	FL	33309-0000

EE	M	03/01/1975	FIRA	HDHP	MIRAMAR	FL	33029-0000
CH	F	02/10/2004	FIRA	HDHP	MIRAMAR	FL	33029-0000
CH	F	05/14/2010	FIRA	HDHP	MIRAMAR	FL	33029-0000
EE	F	08/26/1963	CONA	HDHP	DAVIE	FL	33325-0000
EE	M	11/28/1954	GENA	HDHP	FORT LAUDERDALE	FL	33304-0000
EE	M	01/12/1978	GENA	HMO 1	OAKLAND PARK	FL	33309-0000
CH	F	11/16/2011	GENA	HMO 1	OAKLAND PARK	FL	33309-0000
EE	F	09/14/1967	GENA	HDHP	MIAMI GARDENS	FL	33055-0000
EE	M	11/07/1953	FIRU65	HMO 1	DANIA BEACH	FL	33004-0000
EE	F	07/20/1963	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	M	09/13/1993	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	F	05/19/2001	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	F	11/02/1982	MGTA	HMO 1	SUNRISE	FL	33351-0000
EE	M	02/26/1985	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	M	09/28/1987	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	F	12/31/2008	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	08/04/1966	GENA	HMO 1	PEMBROKE PINES	FL	33028-0000
CH	F	09/02/1999	GENA	HMO 1	PEMBROKE PINES	FL	33028-0000
EE	M	11/05/1965	GENA	HDHP	LAUDERDALE LAKES	FL	33309-0000
CH	M	09/15/2006	GENA	HDHP	LAUDERDALE LAKES	FL	33309-0000
CH	M	09/25/2000	GENA	HDHP	LAUDERDALE LAKES	FL	33309-0000
EE	M	08/06/1965	GENA	HDHP	FORT LAUDERDALE	FL	33313-0000
CH	F	05/29/2009	GENA	HDHP	FORT LAUDERDALE	FL	33313-0000
CH	F	02/21/1999	GENA	HDHP	FORT LAUDERDALE	FL	33313-0000
CH	F	11/03/1992	GENA	HDHP	FORT LAUDERDALE	FL	33313-0000
EE	F	12/17/1971	FIRA	HDHP	FORT LAUDERDALE	FL	33308-0000
SP	M	12/08/1978	FIRA	HDHP	FORT LAUDERDALE	FL	33308-0000
CH	F	08/22/2010	FIRA	HDHP	FORT LAUDERDALE	FL	33308-0000
CH	M	05/25/2012	FIRA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	F	01/08/1988	PASA	HDHP	LAUDERHILL	FL	33351-0000
EE	M	01/23/1960	GENA	HMO 1	LAUDERHILL	FL	33313-0000
SP	F	12/23/1961	GENA	HMO 1	LAUDERHILL	FL	33313-0000
EE	M	10/31/1954	MGTA	HMO 1	LAUDERHILL	FL	33319-0000
EE	M	07/28/1976	FIRA	HMO 2	CORAL SPRINGS	FL	33065-0000
SP	F	03/16/1974	FIRA	HMO 2	CORAL SPRINGS	FL	33065-0000
CH	F	12/30/1996	FIRA	HMO 2	CORAL SPRINGS	FL	33065-0000
CH	F	01/30/2009	FIRA	HMO 2	CORAL SPRINGS	FL	33065-0000
EE	M	02/15/1972	FIRA	HDHP	WEST PALM BEACH	FL	33406-0000
CH	M	04/16/1997	FIRA	HDHP	WEST PALM BEACH	FL	33406-0000
EE	M	01/07/1980	PASA	HMO 1	POMPANO BEACH	FL	33062-0000
SP	F	09/03/1977	PASA	HMO 1	POMPANO BEACH	FL	33062-0000
CH	F	11/25/2013	PASA	HMO 1	POMPANO BEACH	FL	33062-0000
CH	M	02/06/2016	PASA	HMO 1	POMPANO BEACH	FL	33062-0000

EE	F	03/19/1984	GENA	HMO 1	PEMBROKE PINES	FL	33027-0000
EE	M	08/03/1973	MGTA	HDHP	CORAL SPRINGS	FL	33067-0000
EE	F	04/27/1963	GENA	HDHP	SUNRISE	FL	33313-0000
EE	M	08/16/1952	MGTU65	HDHPR	MARGATE	FL	33063-0000
EE	M	09/08/1955	GENA	HDHP	LAUDERHILL	FL	33313-0000
EE	F	10/28/1974	PASA	HMO 1	FORT LAUDERDALE	FL	33311-0000
SP	M	10/26/1975	GENA	HMO 1	PEMBROKE PINES	FL	33027-0000
CH	M	07/24/2013	GENA	HMO 1	PEMBROKE PINES	FL	33027-0000
EE	M	09/22/1961	FIRA	HMO 1	PLANTATION	FL	33317-0000
SP	F	09/12/1969	FIRA	HMO 1	PLANTATION	FL	33317-0000
CH	M	09/11/2003	FIRA	HMO 1	PLANTATION	FL	33317-0000
CH	M	03/18/2006	FIRA	HMO 1	PLANTATION	FL	33317-0000
EE	F	04/15/1969	MGTA	HMO 1	MIAMI	FL	33183-0000
EE	F	09/28/1971	FIRA	HDHP	MARGATE	FL	33068-0000
EE	F	07/25/1960	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
SP	M	01/03/1958	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	M	11/28/1989	ADCH	HMO 1	NORTH LAUDERDALE	FL	33068-0000
CH	F	01/09/1998	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	05/07/1999	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	08/04/1983	FIRA	HMO 1	SANFORD	FL	32773-0000
CH	F	07/20/2014	FIRA	HMO 1	SANFORD	FL	32773-0000
EE	F	01/16/1966	GENA	HMO 1	HOLLYWOOD	FL	33021-0000
EE	F	03/26/1964	GENA	HMO 1	HOLLYWOOD	FL	33019-0000
EE	M	04/24/1969	FIRA	HDHP	LOXAHATCHEE	FL	33470-0000
EE	F	09/05/1966	FIRA	HDHP	LOXAHATCHEE	FL	33470-0000
EE	M	12/04/1959	FIRA	HDHP	PLANTATION	FL	33317-0000
CH	F	05/04/1994	FIRA	HDHP	PLANTATION	FL	33317-0000
CH	M	07/25/1996	FIRA	HDHP	PLANTATION	FL	33317-0000
EE	M	04/27/1966	MGTA	HMO 1	DORAL	FL	33178-0000
SP	F	04/01/1969	MGTA	HMO 1	DORAL	FL	33178-0000
CH	F	11/30/1999	MGTA	HMO 1	DORAL	FL	33178-0000
CH	F	03/18/2002	MGTA	HMO 1	DORAL	FL	33178-0000
EE	F	03/11/1951	GENA	HMO 2	SUNRISE	FL	33323-0000
SP	F	01/07/1983	PASA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	M	10/16/1978	PASA	HDHP	POMPANO BEACH	FL	33060-0000
EE	F	04/19/1961	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
EE	F	03/30/1972	GENA	HDHP	LAUDERHILL	FL	33351-0000
SP	M	04/21/1974	GENA	HDHP	LAUDERHILL	FL	33351-0000
CH	F	07/27/2008	GENA	HDHP	LAUDERHILL	FL	33351-0000
CH	M	05/08/2001	GENA	HDHP	LAUDERHILL	FL	33351-0000
CH	M	06/03/2004	GENA	HDHP	LAUDERHILL	FL	33351-0000
EE	M	12/07/1954	PASU65	HMO 1	PLANTATION	FL	33313-0000
EE	F	07/09/1992	GENA	HMO 2	PLANTATION	FL	33313-0000

EE	M	07/17/1980	FIRA	HDHP	COOPER CITY	FL	33026-0000
SP	F	02/25/1982	FIRA	HDHP	COOPER CITY	FL	33026-0000
CH	F	12/08/2004	FIRA	HDHP	COOPER CITY	FL	33026-0000
CH	F	02/25/2008	FIRA	HDHP	COOPER CITY	FL	33026-0000
CH	F	10/23/2015	FIRA	HDHP	COOPER CITY	FL	33026-0000
EE	F	12/17/1978	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	09/02/1963	GENA	HDHP	CORAL SPRINGS	FL	33065-0000
SP	F	12/02/1959	GENA	HDHP	CORAL SPRINGS	FL	33065-0000
CH	F	12/29/1992	GENA	HDHP	CORAL SPRINGS	FL	33065-0000
EE	F	09/27/1962	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	09/27/1964	GENA	HMO 1	COCONUT CREEK	FL	33063-0000
EE	F	11/10/1957	MGTU65	HMO 1	POMPANO BCH	FL	33069-0000
EE	M	06/16/1951	GENU65	HMO 1	OAKLAND PK	FL	33309-0000
EE	F	08/16/1964	PASA	HDHP	MIRAMAR	FL	33025-0000
CH	F	06/03/1990	PASA	HDHP	MIRAMAR	FL	33025-0000
EE	M	07/16/1972	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	03/05/1994	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	04/16/1995	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	07/24/2000	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	03/18/1997	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	F	04/11/1963	GENA	HMO 1	TAMARAC	FL	33321-0000
EE	M	10/29/1955	GENA	HMO 1	FT LAUD	FL	33311-0000
SP	M	10/07/1956	GENA	HMO 1	FT LAUD	FL	33311-0000
CH	M	06/25/2015	PASA	HDHP	TAMARAC	FL	33319-0000
EE	M	12/31/1969	GENA	HDHP	FORT LAUDERDALE	FL	33316-0000
CH	M	01/25/2003	GENA	HDHP	FORT LAUDERDALE	FL	33316-0000
EE	M	06/16/1974	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
SP	F	01/12/1977	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
CH	F	02/15/2000	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
EE	F	09/29/1973	GENA	HMO 1	LAUDERHILL	FL	33319-0000
SP	F	07/24/1953	PASA	HMO 2	HALLANDALE	FL	33009-0000
EE	M	10/28/1973	MGTA	HMO 1	CORAL SPRINGS	FL	33071-0000
SP	F	11/30/1976	MGTA	HMO 1	CORAL SPRINGS	FL	33071-0000
CH	F	08/04/2011	MGTA	HMO 1	CORAL SPRINGS	FL	33071-0000
CH	M	09/17/2007	MGTA	HMO 1	CORAL SPRINGS	FL	33071-0000
EE	F	06/21/1988	PASA	HDHP	PLANTATION	FL	33317-0000
EE	M	08/22/1989	GENA	HDHP	CORAL GABLES	FL	33134-0000
EE	M	05/28/1952	PASU65	HMO 1	TAVARES	FL	32778-0000
EE	M	06/23/1992	GENA	HDHP	DAVIE	FL	33314-0000
EE	M	03/23/1963	GENA	HMO 1	TAMARAC	FL	33319-0000
SP	F	08/27/1972	GENA	HMO 1	TAMARAC	FL	33319-0000
EE	M	12/30/1974	GENA	HDHP	DAVIE	FL	33312-0000
EE	M	12/03/1960	MGTA	HMO 1	CORAL SPRINGS	FL	33071-0000

SP	F	05/13/1959	MGTA	HMO 1	CORAL SPRINGS	FL	33071-0000
CH	F	10/30/1992	MGTA	HMO 1	CORAL SPRINGS	FL	33071-0000
EE	M	02/05/1962	PASA	HMO 1	OAKLAND PARK	FL	33309-0000
CH	M	07/13/2000	MGTA	HMO 1	BOCA RATON	FL	33428-0000
EE	F	11/30/1964	MGTA	HMO 1	DAVIE	FL	33330-0000
SP	M	07/11/1970	MGTA	HMO 1	DAVIE	FL	33330-0000
CH	F	08/02/2005	MGTA	HMO 1	DAVIE	FL	33330-0000
EE	M	05/16/1958	GENA	HDHP	COCONUT CREEK	FL	33073-0000
SP	F	04/23/1960	GENA	HDHP	COCONUT CREEK	FL	33073-0000
CH	M	06/14/1991	GENA	HDHP	COCONUT CREEK	FL	33073-0000
EE	F	09/27/1953	GENU65	HMO 1	PLANTATION	FL	33317-0000
EE	F	02/06/1964	GENA	HDHP	PORT ST LUCIE	FL	34953-0000
EE	M	12/18/1970	MGTA	HMO 1	FORT LAUDERDALE	FL	33308-0000
EE	M	08/18/1961	PASA	HMO 2	WELLINGTON	FL	33414-0000
SP	F	03/28/1967	PASA	HMO 2	WELLINGTON	FL	33414-0000
CH	F	11/04/2000	PASA	HMO 2	WELLINGTON	FL	33414-0000
CH	M	12/01/2002	PASA	HMO 2	WELLINGTON	FL	33414-0000
EE	M	01/21/1964	GENA	HMO 1	DEERFIELD BEACH	FL	33441-0000
CH	M	01/17/1991	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	11/15/1960	MGTA	HDHP	FORT LAUDERDALE	FL	33316-0000
EE	F	06/10/1970	PASA	HMO 1	FORT LAUDERDALE	FL	33311-0000
SP	M	07/25/1963	GENA	HDHP	LAUDERDALE LAKES	FL	33309-0000
CH	M	03/30/1992	GENA	HDHP	LAUDERDALE LAKES	FL	33309-0000
SP	M	02/10/1951	CONA	HDHP	FORT LAUDERDALE	FL	33304-0000
EE	M	12/07/1963	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	09/04/1987	GENA	HDHP	BOCA RATON	FL	33433-0000
EE	M	11/20/1970	GENA	HDHP	OAKLAND PARK	FL	33311-0000
CH	M	04/20/1992	GENA	HDHP	OAKLAND PARK	FL	33311-0000
CH	M	10/04/1996	GENA	HDHP	OAKLAND PARK	FL	33311-0000
SP	F	09/30/1981	FIRA	HMO 1	SUNRISE	FL	33351-0000
CH	F	04/06/2000	FIRA	HMO 1	SUNRISE	FL	33351-0000
EE	M	04/07/1966	FIRA	HMO 1	LAKE WORTH	FL	33460-0000
EE	M	05/17/1968	MGTA	HMO 1	PLANTATION	FL	33317-0000
SP	F	01/22/1971	MGTA	HMO 1	PLANTATION	FL	33317-0000
SP	F	04/29/1962	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	05/23/1965	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	F	01/31/1965	CONA	HMO 1	FORT LAUDERDALE	FL	33308-0000
CH	M	05/06/2003	CONA	HMO 1	FORT LAUDERDALE	FL	33308-0000
CH	M	11/21/1994	CONA	HMO 1	FORT LAUDERDALE	FL	33308-0000
EE	M	08/25/1959	PASA	HMO 1	HOLLYWOOD	FL	33020-0000
SP	F	05/31/1963	PASA	HMO 1	HOLLYWOOD	FL	33020-0000
EE	M	05/14/1987	MGTA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	08/15/1957	GENA	HDHP	SUNRISE	FL	33351-0000

EE	M	04/25/1958	PASA	HMO 1	LAUD BY THE SEA	FL	33308-0000
SP	F	11/03/1988	GENA	HMO 1	PEMBROKE PINES	FL	33028-0000
EE	M	12/16/1976	FIRA	HDHP	PALM CITY	FL	34990-0000
SP	F	01/07/1980	FIRA	HDHP	PALM CITY	FL	34990-0000
CH	M	10/19/2004	FIRA	HDHP	PALM CITY	FL	34990-0000
CH	M	11/09/2006	FIRA	HDHP	PALM CITY	FL	34990-0000
CH	F	12/20/2011	FIRA	HDHP	PALM CITY	FL	34990-0000
EE	M	04/13/1973	GENA	HDHP	POMPANO BEACH	FL	33064-0000
SP	F	08/15/1975	GENA	HDHP	POMPANO BEACH	FL	33064-0000
CH	M	10/18/2005	GENA	HDHP	POMPANO BEACH	FL	33064-0000
CH	M	08/22/2003	GENA	HDHP	POMPANO BEACH	FL	33064-0000
EE	M	02/14/1964	MGTA	HDHP	FORT LAUDERDALE	FL	33301-0000
EE	M	10/17/1949	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
SP	F	12/19/1957	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	M	02/16/1994	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	M	04/01/1990	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	M	01/09/2013	GENA	HMO 1	COOPER CITY	FL	33330-0000
EE	M	06/05/1986	GENA	HDHP	DAVIE	FL	33324-0000
EE	M	08/16/1965	MGTA	HMO 1	CORAL SPRINGS	FL	33065-0000
SP	F	10/21/1970	MGTA	HMO 1	CORAL SPRINGS	FL	33065-0000
CH	M	02/22/2007	MGTA	HMO 1	CORAL SPRINGS	FL	33065-0000
CH	F	12/17/1990	MGTA	HMO 1	CORAL SPRINGS	FL	33065-0000
EE	F	08/18/1968	PASA	HDHP	MIAMI BEACH	FL	33141-0000
CH	M	12/11/1990	PASA	HDHP	MIAMI BEACH	FL	33141-0000
CH	M	12/22/1992	PASA	HDHP	MIAMI BEACH	FL	33141-0000
EE	M	01/26/1983	FIRA	HMO 1	SUNRISE	FL	33322-0000
CH	M	12/03/2013	FIRA	HMO 1	SUNRISE	FL	33322-0000
EE	F	07/01/1976	GENA	HMO 1	DAVIE	FL	33317-0000
CH	F	09/06/1991	GENA	HMO 1	DAVIE	FL	33317-0000
CH	F	07/28/2005	GENA	HMO 1	DAVIE	FL	33317-0000
CH	M	01/02/2010	GENA	HMO 1	DAVIE	FL	33317-0000
EE	M	02/27/1971	GENA	HMO 1	GOLDEN BEACH	FL	33160-0000
SP	F	04/14/1974	GENA	HMO 1	GOLDEN BEACH	FL	33160-0000
CH	M	11/30/1996	GENA	HMO 1	GOLDEN BEACH	FL	33160-0000
CH	F	07/07/1993	GENA	HMO 1	GOLDEN BEACH	FL	33160-0000
CH	F	08/17/1991	GENA	HMO 1	GOLDEN BEACH	FL	33160-0000
EE	M	09/17/1989	GENA	HMO 1	OAKLAND PARK	FL	33334-0000
EE	M	12/05/1973	PASA	HMO 2	OAKLAND PARK	FL	33334-0000
EE	M	05/13/1959	PASA	HDHP	LAUDERDALE LAKES	FL	33309-0000
SP	F	04/02/1957	PASA	HDHP	LAUDERDALE LAKES	FL	33309-0000
EE	M	08/01/1972	FIRA	HDHP	DAVIE	FL	33330-0000
SP	F	07/10/1974	FIRA	HDHP	DAVIE	FL	33330-0000
CH	F	11/12/2004	FIRA	HDHP	DAVIE	FL	33330-0000

CH	F	11/02/2007	FIRA	HDHP	DAVIE	FL	33330-0000
EE	F	02/25/1966	PASA	HDHP	DAVIE	FL	33328-0000
EE	M	12/07/1959	GENU65	HMO 1	LAKE PLACID	FL	33852-0000
EE	M	06/29/1973	GENA	HMO 2	FORT LAUDERDALE	FL	33309-0000
SP	F	10/05/1973	GENA	HMO 2	FORT LAUDERDALE	FL	33309-0000
SP	F	09/07/1952	GENA	HMO 1	POMPANO BEACH	FL	33060-0000
EE	M	09/12/1963	PASA	HMO 1	FORT LAUDERDALE	FL	33305-0000
EE	M	05/21/1965	MGTA	HDHP	FORT LAUDERDALE	FL	33301-0000
EE	F	08/21/1949	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	M	10/24/1971	MGTA	HDHP	SUNRISE	FL	33351-0000
SP	F	11/24/1971	MGTA	HDHP	SUNRISE	FL	33351-0000
CH	M	12/31/2003	MGTA	HDHP	SUNRISE	FL	33351-0000
CH	M	02/27/2006	MGTA	HDHP	SUNRISE	FL	33351-0000
CH	F	03/08/2008	MGTA	HDHP	SUNRISE	FL	33351-0000
EE	M	12/18/1957	GENA	HMO 1	MARGATE	FL	33063-0000
EE	M	07/13/1952	MGTU65	HMO 2	FORT PIERCE	FL	34949-0000
SP	F	05/17/1962	MGTU65	HMO 2	FORT PIERCE	FL	34949-0000
CH	M	03/08/1992	MGTU65	HMO 2	FORT PIERCE	FL	34949-0000
CH	F	04/13/1996	MGTU65	HMO 2	FORT PIERCE	FL	34949-0000
EE	M	09/05/1957	MGTA	HDHP	DELRAY BEACH	FL	33445-0000
SP	F	08/31/1963	MGTA	HDHP	DELRAY BEACH	FL	33445-0000
CH	F	05/30/1990	MGTA	HDHP	DELRAY BEACH	FL	33445-0000
CH	F	04/28/1994	MGTA	HDHP	DELRAY BEACH	FL	33445-0000
EE	M	10/23/1953	GENA	HDHP	HALLANDALE	FL	33009-0000
EE	F	06/15/1987	PASA	HDHP	FORT LAUDERDALE	FL	33308-0000
SP	M	01/06/1987	PASA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	F	01/27/1959	GENA	HMO 1	LAUDERHILL	FL	33313-0000
EE	M	09/26/1960	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	F	11/18/1966	MGTA	HDHP	PEMBROKE PINES	FL	33029-0000
EE	F	02/15/1956	GENA	HDHP	HOLLYWOOD	FL	33020-0000
EE	F	12/05/1974	GENA	HMO 1	FORT LAUDERDALE	FL	33302-0000
CH	F	08/08/1991	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	12/10/1986	GENA	HDHP	MIAMI	FL	33147-0000
EE	M	11/19/1963	GENA	HMO 2	LAUDERDALE LAKES	FL	33319-0000
CH	M	10/16/1990	GENA	HMO 2	LAUDERDALE LAKES	FL	33319-0000
CH	F	04/15/1993	GENA	HMO 2	LAUDERDALE LAKES	FL	33319-0000
CH	M	07/26/1999	GENA	HMO 2	LAUDERDALE LAKES	FL	33319-0000
CH	F	01/26/1996	GENA	HMO 2	LAUDERDALE LAKES	FL	33319-0000
EE	M	04/25/1962	PASA	HMO 1	OAKLAND PARK	FL	33308-0000
SP	F	04/23/1962	PASA	HMO 1	OAKLAND PARK	FL	33308-0000
CH	M	01/31/2008	GENA	HMO 1	COOPER CITY	FL	33328-0000
EE	F	04/11/1967	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
SP	F	01/30/1988	GENA	HDHP	HOLLYWOOD	FL	33024-0000

CH	F	06/02/2005	GENA	HMO 1	TAMARAC	FL	33321-0000
CH	F	01/03/2007	GENA	HMO 1	TAMARAC	FL	33321-0000
CH	M	10/23/2002	GENA	HMO 1	TAMARAC	FL	33321-0000
CH	F	06/22/2005	PASA	HDHP	HOLLYWOOD	FL	33023-0000
EE	M	05/23/1966	GENA	HDHP	LAUDERHILL	FL	33313-0000
CH	M	03/09/2004	GENA	HDHP	LAUDERHILL	FL	33313-0000
EE	M	06/21/1984	FIRA	HDHP	WEST PALM BEACH	FL	33413-0000
CH	M	08/24/1995	FIRA	HDHP	BOYNTON BEACH	FL	33437-0000
CH	M	04/19/1997	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	07/03/1956	PASA	HMO 1	PLANTATION	FL	33324-0000
EE	F	05/25/1951	PASA	HMO 2	LAUDERDALE LAKES	FL	33311-0000
SP	M	07/23/1946	PASA	HMO 2	LAUDERDALE LAKES	FL	33311-0000
EE	M	08/19/1964	MGTA	HDHP	FORT LAUDERDALE	FL	33316-0000
EE	M	03/07/1978	FIRA	HDHP	JUPITER	FL	33458-0000
SP	F	01/23/1973	FIRA	HDHP	JUPITER	FL	33458-0000
SP	M	08/09/1963	MGTA	HMO 1	POMPANO BEACH	FL	33069-0000
EE	M	08/07/1971	GENA	HMO 1	TAMARAC	FL	33321-0000
CH	F	04/13/2004	GENA	HMO 1	TAMARAC	FL	33321-0000
CH	M	10/15/1996	GENA	HMO 1	TAMARAC	FL	33321-0000
CH	M	02/16/2001	GENA	HMO 1	TAMARAC	FL	33321-0000
EE	F	04/08/1962	MGTA	HDHP	FORT LAUDERDALE	FL	33302-0000
EE	M	01/30/1960	PASA	HMO 1	DAVIE	FL	33325-0000
EE	F	11/04/1971	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
SP	M	12/04/1962	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
CH	M	08/21/2015	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
CH	M	06/17/1995	MGTA	HMO 1	WESTON	FL	33311-0000
EE	M	12/24/1973	PASA	HMO 1	PLANTATION	FL	33325-0000
CH	M	03/22/1998	PASA	HMO 1	PLANTATION	FL	33325-0000
EE	F	08/27/1974	GENA	HMO 2	COCONUT CREEK	FL	33066-0000
EE	M	01/11/1963	GENA	HMO 2	HOLLYWOOD	FL	33023-0000
EE	M	10/13/1964	MGTA	HDHP	BOYNTON BEACH	FL	33437-0000
SP	F	03/02/1970	MGTA	HDHP	BOYNTON BEACH	FL	33437-0000
CH	M	05/04/1992	MGTA	HDHP	BOYNTON BEACH	FL	33437-0000
CH	F	06/27/1993	MGTA	HDHP	BOYNTON BEACH	FL	33437-0000
EE	F	03/21/1977	PASA	HDHP	FORT LAUDERDALE	FL	33304-0000
CH	M	07/10/2004	PASA	HDHP	FORT LAUDERDALE	FL	33304-0000
CH	F	12/05/2005	PASA	HDHP	FORT LAUDERDALE	FL	33304-0000
EE	M	10/23/1976	GENA	HDHP	MARGATE	FL	33063-0000
EE	F	12/21/1957	GENA	HMO 1	FORT LAUDERDALE	FL	33334-0000
EE	M	11/18/1975	FIRA	HMO 1	BOYNTON BEACH	FL	33472-0000
CH	M	01/26/2006	FIRA	HMO 1	BOYNTON BEACH	FL	33472-0000
CH	M	02/12/2008	FIRA	HMO 1	BOYNTON BEACH	FL	33472-0000
EE	M	02/10/1975	FIRA	HDHP	FORT LAUDERDALE	FL	33315-0000

SP	F	04/23/1977	FIRA	HDHP	FORT LAUDERDALE	FL	33315-0000
CH	F	06/29/2000	FIRA	HDHP	FORT LAUDERDALE	FL	33315-0000
CH	M	09/02/2010	FIRA	HDHP	FORT LAUDERDALE	FL	33315-0000
CH	M	12/13/2012	FIRA	HDHP	FORT LAUDERDALE	FL	33315-0000
CH	M	02/12/1994	MGTU65	HMO 1	PLANTATION	FL	33317-0000
EE	F	09/30/1960	PASA	HDHP	DEERFIELD BEACH	FL	33442-0000
EE	M	03/31/1987	FIRA	HDHP	PLANTATION	FL	33324-0000
SP	F	08/26/1988	FIRA	HDHP	PLANTATION	FL	33324-0000
EE	M	04/06/1982	FIRA	HDHP	MIAMI	FL	33186-0000
SP	F	04/26/1985	FIRA	HDHP	MIAMI	FL	33186-0000
CH	F	02/28/2013	FIRA	HDHP	MIAMI	FL	33186-0000
CH	F	11/18/2012	PASA	HMO 1	HOLLYWOOD	FL	33021-0000
EE	M	11/13/1952	GENA	HMO 1	LAUDERDALE LAKES	FL	33309-0000
SP	F	11/11/1953	GENA	HMO 1	LAUDERDALE LAKES	FL	33309-0000
EE	M	10/12/1953	MGTU65	HMO 2	TAMARAC	FL	33321-0000
EE	M	04/21/1951	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
SP	F	07/18/1963	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	08/16/1994	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	F	12/02/2000	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	05/30/1980	MGTA	HDHP	MIAMI	FL	33179-0000
EE	F	08/09/1955	GENA	HMO 1	DAVIE	FL	33324-0000
EE	M	04/20/1961	FIRA	HMO 1	PEMBROKE PINES	FL	33027-0000
SP	F	07/30/1964	FIRA	HMO 1	PEMBROKE PINES	FL	33027-0000
CH	F	07/20/2003	FIRA	HMO 1	PEMBROKE PINES	FL	33027-0000
SP	F	10/22/1962	GENA	HMO 1	WILTON MANORS	FL	33334-0000
EE	M	03/04/1987	GENA	HMO 2	MIAMI GARDENS	FL	33056-0000
EE	M	02/11/1974	FIRA	HDHP	BOCA RATON	FL	33431-0000
SP	F	03/10/1956	MGTA	HMO 2	MIRAMAR	FL	33025-0000
EE	F	07/12/1968	GENA	HMO 1	OAKLAND PARK	FL	33334-0000
SP	M	04/04/1953	GENA	HMO 1	OAKLAND PARK	FL	33334-0000
EE	F	11/06/1968	PASA	HDHP	CORAL SPRINGS	FL	33065-0000
EE	M	08/02/1969	MGTA	HMO 1	SUNRISE	FL	33351-0000
CH	M	06/18/2004	MGTA	HMO 1	SUNRISE	FL	33351-0000
CH	M	09/14/2000	MGTA	HMO 1	SUNRISE	FL	33351-0000
EE	F	09/09/1976	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	11/09/1958	GENA	HMO 1	FORT LAUDERDALE	FL	33308-0000
SP	M	08/16/1975	CONA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	F	08/04/1998	CONA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	F	12/16/2013	CONA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	M	01/15/2016	CONA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	06/18/1962	PASA	HDHP	PEMBROKE PINES	FL	33025-0000
SP	F	10/06/1969	PASA	HDHP	PEMBROKE PINES	FL	33025-0000
CH	M	04/21/1999	PASA	HDHP	PEMBROKE PINES	FL	33025-0000

CH	F	10/18/2000	PASA	HDHP	PEMBROKE PINES	FL	33025-0000
CH	M	08/09/1996	FIRA	HDHP	MIAMI	FL	33168-0000
EE	F	06/02/1992	GENA	HMO 1	OPA LOCKA	FL	33054-0000
CH	F	09/20/1990	GENA	HDHP	LAUDERHILL	FL	33313-0000
SP	F	09/13/1962	GENA	HDHP	LAUDERHILL	FL	33313-0000
EE	F	01/06/1965	CONA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	F	12/10/1960	GENA	HMO 1	PEMBROKE PINES	FL	33029-0000
SP	F	07/17/1966	GENA	HMO 1	SUNRISE	FL	33323-0000
EE	M	06/18/1988	GENA	HDHP	PLANTATION	FL	33317-0000
EE	M	08/16/1968	GENA	HMO 1	LAUDERHILL	FL	33319-0000
EE	F	09/26/1958	PASA	HDHP	FORT LAUDERDALE	FL	33304-0000
EE	F	09/25/1959	CONA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	02/21/2004	GENA	HDHP	POMPANO BEACH	FL	33060-0000
EE	M	11/06/1960	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	05/01/1967	GENA	HMO 1	LAUDERHILL	FL	33319-0000
SP	F	11/07/1967	GENA	HMO 1	LAUDERHILL	FL	33319-0000
CH	M	06/10/1997	GENA	HMO 1	LAUDERHILL	FL	33319-0000
EE	M	03/09/1957	MGTA	HDHP	PLANTATION	FL	33317-0000
SP	F	05/13/1958	MGTA	HDHP	PLANTATION	FL	33317-0000
CH	F	03/10/1993	MGTA	HDHP	PLANTATION	FL	33317-0000
CH	M	08/24/2000	MGTA	HDHP	PLANTATION	FL	33317-0000
EE	M	08/25/1974	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	M	02/07/1995	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	M	03/25/1996	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	M	05/21/2001	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	M	06/04/1951	FIRU65	HMO 1	FORT LAUDERDALE	FL	33315-0000
SP	F	10/29/1951	FIRU65	HMO 1	FORT LAUDERDALE	FL	33315-0000
EE	M	02/08/1963	GENA	HDHP	FORT LAUDERDALE	FL	33315-0000
EE	F	05/25/1995	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	F	07/24/1987	GENA	HMO 1	MIAMI	FL	33127-0000
EE	M	07/05/1989	GENA	HDHP	HOLLYWOOD	FL	33024-0000
EE	M	01/15/1983	GENA	HDHP	OAKLAND PARK	FL	33309-0000
SP	F	12/13/1987	GENA	HDHP	OAKLAND PARK	FL	33309-0000
CH	F	09/15/2010	GENA	HDHP	OAKLAND PARK	FL	33309-0000
CH	F	05/29/2005	GENA	HDHP	OAKLAND PARK	FL	33309-0000
CH	M	02/04/2014	GENA	HDHP	OAKLAND PARK	FL	33309-0000
EE	M	04/17/1985	FIRA	HDHP	MIAMI	FL	33183-0000
CH	M	07/15/2009	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	M	03/19/1980	FIRA	HMO 1	LAKE WORTH	FL	33467-0000
SP	F	12/16/1974	FIRA	HMO 1	LAKE WORTH	FL	33467-0000
CH	F	09/13/2005	FIRA	HMO 1	LAKE WORTH	FL	33467-0000
CH	F	03/17/2007	FIRA	HMO 1	LAKE WORTH	FL	33467-0000
CH	F	04/03/2009	FIRA	HMO 1	LAKE WORTH	FL	33467-0000

EE	F	10/27/1963	PASA	HMO 1	LAUDERHILL	FL	33319-0000
EE	F	03/07/1963	PASA	HDHP	PLANTATION	FL	33322-0000
CH	F	11/30/2001	PASA	HDHP	JENSEN BEACH	FL	34957-0000
EE	M	01/20/1953	GENU65	HMO 1	FORT LAUDERDALET	FL	33311-0000
EE	F	11/05/1956	CONU65	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	02/06/1960	PASA	HDHP	LAUDERDALE LAKES	FL	33311-0000
CH	F	09/11/1996	PASA	HDHP	LAUDERDALE LAKES	FL	33311-0000
CH	F	06/09/1993	PASA	HDHP	LAUDERDALE LAKES	FL	33311-0000
EE	M	05/10/1959	GENA	HDHP	OPA LOCKA	FL	33054-0000
EE	F	02/24/1971	GENA	HDHP	CORAL SPRINGS	FL	33071-0000
EE	M	12/10/1969	FIRA	HDHP	POMPANO	FL	33062-0000
SP	F	09/25/1972	FIRA	HDHP	POMPANO	FL	33062-0000
EE	M	01/02/1984	FIRA	HMO 1	DEERFIELD BEACH	FL	33442-0000
EE	M	10/06/1984	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	M	12/01/1964	GENA	HMO 1	PLANTATION	FL	33317-0000
SP	F	09/08/1968	GENA	HMO 1	PLANTATION	FL	33317-0000
CH	M	05/04/1991	GENA	HMO 1	PLANTATION	FL	33317-0000
CH	M	08/29/1998	GENA	HMO 1	PLANTATION	FL	33317-0000
CH	M	06/25/2001	GENA	HMO 1	PLANTATION	FL	33317-0000
CH	F	06/10/1998	GENA	HMO 1	PLANTATION	FL	33317-0000
CH	M	08/09/1998	GENA	HMO 1	PLANTATION	FL	33317-0000
EE	M	10/07/1983	GENA	HDHP	HOLLYWOOD	FL	33024-0000
CH	F	11/17/2006	GENA	HDHP	HOLLYWOOD	FL	33024-0000
CH	M	09/24/2003	GENA	HDHP	HOLLYWOOD	FL	33024-0000
EE	M	03/13/1959	GENA	HMO 1	POMPANO BEACH	FL	33060-0000
CH	F	05/30/1996	GENA	HMO 1	POMPANO BEACH	FL	33060-0000
EE	M	11/13/1959	FIRA	HMO 1	TAMARAC	FL	33321-0000
CH	M	08/08/1994	FIRA	HMO 1	CORAL SPRINGS	FL	33321-0000
EE	F	10/05/1952	MGTU65	HMO 2	FORT LAUDERDALE	FL	33308-0000
EE	F	12/28/1980	PASA	HDHP	HOLLYWOOD	FL	33023-0000
EE	F	09/13/1968	PASA	HDHP	PLANTATION	FL	33317-0000
SP	M	10/10/1962	PASA	HDHP	PLANTATION	FL	33317-0000
CH	M	06/03/1996	PASA	HDHP	PLANTATION	FL	33317-0000
CH	F	03/25/1999	PASA	HDHP	PLANTATION	FL	33317-0000
EE	M	03/01/1963	GENA	HMO 2	NORTH LAUDERDALE	FL	33068-0000
CH	F	12/20/1996	FIRA	HMO 1	BOYNTON BEACH	FL	33426-0000
EE	M	07/15/1952	MGTU65	HDHP retiree	DEERFIELD BCH	FL	33441-0000
SP	F	07/13/1952	MGTU65	HDHP retiree	DEERFIELD BCH	FL	33441-0000
EE	M	10/14/1965	PASA	HMO 2	FORT LAUDERDALE	FL	33304-0000
CH	F	12/16/1994	PASA	HMO 2	FORT LAUDERDALE	FL	33304-0000
CH	M	05/07/1993	PASA	HMO 2	FORT LAUDERDALE	FL	33304-0000
EE	M	01/10/1956	GENA	HMO 1	DEERFIELD BCH	FL	33442-0000
SP	F	07/13/1955	GENA	HMO 1	DEERFIELD BCH	FL	33442-0000

EE	F	04/11/1974	MGTA	HDHP	DAVIE	FL	33331-0000
SP	M	06/26/1972	MGTA	HDHP	DAVIE	FL	33331-0000
CH	M	05/09/2008	MGTA	HDHP	DAVIE	FL	33331-0000
EE	M	03/31/1973	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	F	01/03/2000	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	10/22/2002	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	01/08/1959	FIRA	HDHP	WILTON MANORS	FL	33334-0000
SP	F	01/27/1960	FIRA	HDHP	WILTON MANORS	FL	33334-0000
CH	F	08/07/1996	FIRA	HDHP	WILTON MANORS	FL	33334-0000
CH	F	03/05/1997	FIRA	HDHP	WILTON MANORS	FL	33334-0000
EE	M	05/06/1983	GENA	HMO 1	PEMBROKE PINES	FL	33028-0000
EE	M	09/13/1956	GENA	HMO 1	MARGATE	FL	33063-0000
SP	F	05/19/1960	GENA	HMO 1	MARGATE	FL	33063-0000
CH	M	07/01/1994	GENA	HMO 1	MARGATE	FL	33063-0000
SP	M	03/08/1974	MGTA	HMO 1	MIAMI BEACH	FL	33139-0000
CH	M	12/29/2014	MGTA	HMO 1	MIAMI BEACH	FL	33139-0000
EE	M	02/28/1990	FIRA	HDHP	HOLLYWOOD	FL	33021-0000
EE	M	08/25/1986	GENA	HMO 1	TAMARAC	FL	33321-0000
SP	F	11/16/1986	GENA	HMO 1	TAMARAC	FL	33321-0000
CH	F	10/19/2011	GENA	HMO 1	TAMARAC	FL	33321-0000
CH	M	01/12/2016	GENA	HMO 1	TAMARAC	FL	33321-0000
SP	M	05/09/1980	GENA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	M	11/03/1962	MGTA	HDHP	FORT LAUDERDALE	FL	33308-0000
SP	F	07/28/1963	MGTA	HDHP	FORT LAUDERDALE	FL	33308-0000
CH	F	10/06/1995	MGTA	HDHP	FORT LAUDERDALE	FL	33308-0000
CH	M	07/06/1990	MGTA	HDHP	FORT LAUDERDALE	FL	33308-0000
CH	M	12/23/1992	MGTA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	M	11/07/1952	GENA	HMO 1	DAVIE	FL	33325-0000
SP	F	09/18/1950	GENA	HMO 1	DAVIE	FL	33325-0000
SP	F	12/19/1950	GENA	HMO 1	MIRAMAR	FL	33023-0000
EE	F	05/05/1948	GENA	HMO 1	TAMARAC	FL	33309-0000
EE	M	10/12/1963	GENA	HMO 1	FORT LAUDERDALE	FL	33309-0000
SP	F	02/14/1959	GENA	HMO 1	FORT LAUDERDALE	FL	33309-0000
CH	M	11/08/1995	GENA	HMO 1	FORT LAUDERDALE	FL	33309-0000
CH	M	11/08/1995	GENA	HMO 1	FORT LAUDERDALE	FL	33309-0000
EE	M	01/20/1955	MGTA	HMO 1	DAVIE	FL	33324-0000
EE	F	07/14/1959	FIRA	HMO 1	FORT LAUDERDALE	FL	33304-0000
CH	M	10/18/1991	FIRA	HMO 1	FORT LAUDERDALE	FL	33304-0000
EE	F	02/28/1973	PASA	HDHP	DAVIE	FL	33314-0000
SP	M	03/23/1949	PASA	HDHP	DAVIE	FL	33314-0000
CH	M	05/06/2000	PASA	HDHP	DAVIE	FL	33314-0000
CH	F	04/22/2002	PASA	HDHP	DAVIE	FL	33314-0000
EE	F	10/24/1957	GENA	HDHP	SUNRISE	FL	33322-0000

EE	M	02/14/1954	FIRU65	HMO 1	PLANTATION	FL	33317-0000
EE	M	01/12/1983	FIRA	HDHP	FORT LAUDERDALE	FL	33316-0000
EE	M	09/14/1985	FIRA	HDHP	DELRAY BEACH	FL	33444-0000
EE	F	10/06/1964	MGTA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	09/03/1960	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	10/10/1994	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	F	10/10/1953	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	M	08/24/1963	FIRA	HDHP	PEMBROKE PINES	FL	33024-0000
SP	F	10/04/1961	FIRA	HDHP	PEMBROKE PINES	FL	33024-0000
CH	F	12/22/1998	FIRA	HDHP	PEMBROKE PINES	FL	33024-0000
CH	M	01/07/1994	FIRA	HDHP	PEMBROKE PINES	FL	33024-0000
CH	F	08/25/1990	FIRA	HDHP	PEMBROKE PINES	FL	33024-0000
EE	F	04/30/1965	PASA	HMO 1	MIAMI BEACH	FL	33141-0000
EE	F	08/11/1956	CONU65	HMO 1	DANIA BEACH	FL	33004-0000
EE	M	06/25/1961	FIRA	HDHP	CORAL SPRINGS	FL	33071-0000
SP	F	03/10/1973	FIRA	HDHP	CORAL SPRINGS	FL	33071-0000
CH	M	03/28/2005	FIRA	HDHP	CORAL SPRINGS	FL	33071-0000
CH	M	10/06/2010	FIRA	HDHP	CORAL SPRINGS	FL	33071-0000
CH	M	07/18/1992	GENA	HMO 1	TAMARAC	FL	33319-0000
EE	M	12/03/1955	GENA	HMO 1	OAKLAND PARK	FL	33311-0000
EE	M	10/28/1961	FIRA	HMO 1	PLANTATION	FL	33317-0000
SP	F	10/20/1962	FIRA	HMO 1	PLANTATION	FL	33317-0000
EE	F	05/13/1968	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
SP	M	01/12/1965	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	F	10/06/1997	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	M	02/16/1991	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	F	03/20/1995	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	06/06/1988	GENA	HDHP	FORT LAUDERDALE	FL	33316-0000
EE	M	10/21/1973	MGTA	HMO 1	MIAMI SHORES	FL	33161-0000
SP	F	01/16/1976	MGTA	HMO 1	MIAMI SHORES	FL	33161-0000
CH	F	06/28/2005	MGTA	HMO 1	MIAMI SHORES	FL	33161-0000
CH	M	11/24/2010	MGTA	HMO 1	MIAMI SHORES	FL	33161-0000
EE	M	10/12/1973	GENA	HDHP	PLANTATION	FL	33317-0000
CH	F	05/18/1994	GENA	HDHP	COOPER CITY	FL	33328-0000
EE	M	03/15/1968	PASA	HMO 2	COOPER CITY	FL	33328-0000
EE	F	08/30/1969	GENA	HMO 1	POMPANO BEACH	FL	33064-0000
SP	M	10/15/1963	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	05/18/2005	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	05/07/2008	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	F	06/18/1957	PASU65	HMO 2	FORT LAUDERDALE	FL	33308-0000
EE	M	04/07/1961	GENA	HMO 1	FORT LAUDERDALE	FL	33334-0000
SP	F	08/18/2015	GENA	HMO 1	FORT LAUDERDALE	FL	33334-0000
EE	M	04/20/1982	FIRA	HDHP	DAVIE	FL	33330-0000

SP	F	08/14/1980	FIRA	HDHP	DAVIE	FL	33330-0000
CH	M	06/18/2012	FIRA	HDHP	DAVIE	FL	33330-0000
EE	M	06/30/1983	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	07/09/1966	GENA	HDHP	DEERFIELD BEACH	FL	33441-0000
SP	F	12/30/1956	GENA	HDHP	DEERFIELD BEACH	FL	33441-0000
EE	M	04/11/1959	PASA	HMO 2	SUNNY ISLES BCH	FL	33160-0000
CH	F	03/26/1990	PASA	HMO 2	SUNNY ISLES BCH	FL	33160-0000
CH	M	01/17/1997	PASA	HMO 2	SUNNY ISLES BCH	FL	33160-0000
EE	F	10/28/1963	GENA	HMO 1	FORT LAUDERDALE	FL	33306-0000
EE	M	12/01/1974	MGTA	HMO 1	FORT LAUDERDALE	FL	33304-0000
SP	F	03/15/1968	MGTA	HMO 1	FORT LAUDERDALE	FL	33304-0000
CH	M	08/19/2004	MGTA	HMO 1	FORT LAUDERDALE	FL	33304-0000
EE	F	11/05/1963	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	08/27/1988	FIRA	HMO 1	PLANTATION	FL	33325-0000
EE	F	07/11/1981	GENA	HMO 1	POMPANO BEACH	FL	33069-0000
EE	M	10/09/1968	GENA	HDHP	HIALEAH	FL	33010-0000
EE	F	07/30/1963	CONA	HDHP	FORT LAUDERDALE	FL	33309-0000
EE	M	12/05/1985	GENA	HDHP	TAMARAC	FL	33321-0000
SP	F	02/07/1990	GENA	HDHP	TAMARAC	FL	33321-0000
EE	M	03/12/1970	GENA	HDHP	LAUDERHILL	FL	33313-0000
EE	M	02/18/1966	FIRA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	11/08/1956	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	09/30/1965	GENA	HMO 1	POMPANO BEACH	FL	33060-0000
EE	F	10/19/1957	GENA	HDHP	POMPANO BEACH	FL	33062-0000
SP	F	07/12/1973	GENA	HMO 1	TAMARAC	FL	33321-0000
SP	F	11/03/1970	PASA	HDHP	GREENACRES	FL	33463-0000
EE	M	06/28/1968	GENA	HMO 2	WESTON	FL	33327-0000
EE	F	11/30/1976	CONA	HDHP	PLANTATION	FL	33324-0000
EE	M	04/15/1971	FIRU65	HMO 1	LAKE WORTH	FL	33467-0000
SP	F	10/07/1967	FIRU65	HMO 1	LAKE WORTH	FL	33467-0000
CH	F	04/08/1996	FIRU65	HMO 1	LAKE WORTH	FL	33467-0000
EE	M	08/07/1967	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	05/01/1975	GENA	HMO 2	MIRAMAR	FL	33023-0000
SP	F	03/12/1977	GENA	HMO 2	MIRAMAR	FL	33023-0000
EE	M	10/23/1971	FIRA	HDHP	JUPITER	FL	33478-0000
SP	F	04/16/1970	FIRA	HDHP	JUPITER	FL	33478-0000
CH	M	02/14/1991	FIRA	HDHP	JUPITER	FL	33478-0000
CH	F	10/13/1996	FIRA	HDHP	JUPITER	FL	33478-0000
EE	M	09/13/1963	GENA	HMO 2	LAUDERDALE LAKES	FL	33311-0000
CH	F	04/24/1997	GENA	HMO 2	LAUDERDALE LAKES	FL	33311-0000
EE	M	01/03/1965	PASA	HMO 1	PEMBROKE PINES	FL	33023-0000
SP	F	07/09/1973	GENA	HMO 1	LAUDERDALE LAKES	FL	33301-0000
CH	M	10/25/1989	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000

EE	F	06/20/1969	GENA	HDHP	MARGATE	FL	33063-0000
EE	F	10/06/1951	GENU65	HMO 2	LAUDERDALE LAKES	FL	33319-0000
EE	M	06/21/1972	GENA	HMO 1	PLANTATION	FL	33324-0000
CH	M	08/31/1990	MGTA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	F	01/09/1961	MGTA	HDHP	PLANTATION	FL	33324-0000
EE	M	04/29/1966	GENA	HDHP	MARGATE	FL	33063-0000
SP	F	03/13/1969	GENA	HDHP	MARGATE	FL	33063-0000
CH	M	06/10/2003	GENA	HDHP	MARGATE	FL	33063-0000
EE	F	01/17/1967	GENA	HMO 1	PEMBROKE PINES	FL	33025-0000
EE	M	06/13/1950	GENA	HMO 1	MARGATE	FL	33063-0000
EE	M	05/20/1977	PASA	HMO 2	MIRAMAR	FL	33025-0000
EE	M	01/18/1956	FIRU65	HMO 1	WELLINGTON	FL	33414-0000
EE	M	01/05/1959	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
SP	F	01/03/1967	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
CH	M	04/25/2002	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
CH	M	04/08/2000	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
CH	F	07/23/1994	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
CH	M	09/18/1991	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	M	05/04/1971	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	05/11/1998	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	06/07/1961	MGTA	HMO 1	PARKLAND	FL	33067-0000
SP	M	05/10/1959	MGTA	HMO 1	PARKLAND	FL	33067-0000
CH	F	10/18/1994	MGTA	HMO 1	PARKLAND	FL	33067-0000
CH	M	10/18/1994	MGTA	HMO 1	PARKLAND	FL	33067-0000
EE	F	03/13/1962	MGTA	HMO 2	PEMBROKE PINES	FL	33029-0000
EE	M	06/07/1980	FIRA	HDHP	MARGATE	FL	33063-0000
EE	F	12/09/1958	GENA	HDHP	COCONUT CREEK	FL	33073-0000
EE	M	12/17/1957	PASA	HMO 1	TAMARAC	FL	33321-0000
EE	F	03/01/1977	FIRA	HMO 1	COOPER CITY	FL	33338-0000
CH	F	08/14/2007	FIRA	HMO 1	COOPER CITY	FL	33338-0000
EE	M	01/07/1965	GENA	HMO 1	OAKLAND PARK	FL	33309-0000
EE	M	04/22/1960	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	08/03/1954	GENA	HDHP	POMPANO BEACH	FL	33060-0000
EE	M	09/04/1986	FIRA	HDHP	DAVIE	FL	33324-0000
SP	M	04/22/1988	FIRA	HDHP	DAVIE	FL	33324-0000
EE	F	11/23/1959	PASA	HDHP	NORTH LAUDERDALE	FL	33068-0000
EE	M	03/20/1987	FIRA	HMO 1	PEMBROKE PINES	FL	33026-0000
EE	F	03/04/1958	MGTA	HMO 1	CORAL SPRINGS	FL	33067-0000
EE	M	04/09/1958	GENA	HDHP	FORT LAUDERDALE	FL	33316-0000
SP	M	06/19/1958	PASA	HDHP	POMPANO BEACH	FL	33069-0000
EE	M	02/12/1992	GENA	HDHP	OAKLAND PARK	FL	33311-0000
EE	M	08/17/1989	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	10/16/1996	GENA	HDHP	POMPANO BEACH	FL	33064-0000

CH	M	11/27/1999	GENA	HDHP	POMPANO BEACH	FL	33064-0000
EE	M	02/03/1989	PASA	HDHP	CORAL SPRINGS	FL	33071-0000
CH	F	02/15/1994	GENA	HMO 1	COCONUT CREEK	FL	33063-0000
CH	F	01/29/1996	GENA	HMO 1	LEBANON	IN	46052-0000
CH	F	11/13/1997	GENA	HMO 1	LEBANON	IN	46052-0000
EE	M	02/04/1956	PASA	HMO 1	FORT LAUDERDALE	FL	33305-0000
EE	M	02/01/1970	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	07/21/2005	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	03/22/2002	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	09/01/1971	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	F	03/15/1983	GENA	HMO 1	LAUDERHILL	FL	33313-0000
EE	F	04/23/1991	GENA	HMO 2	LAUDERHILL	FL	33313-0000
EE	M	04/12/1987	PASA	HDHP	MIAMI	FL	33186-0000
EE	F	11/15/1951	GENA	HMO 1	DAVIE	FL	33314-0000
SP	M	11/18/1949	GENA	HMO 1	DAVIE	FL	33314-0000
EE	F	12/04/1972	MGTA	HMO 1	LAUDERHILL	FL	33319-0000
EE	M	03/31/1955	FIRA	HMO 1	LOXAHATCHEE	FL	33470-0000
SP	F	03/03/1955	FIRA	HMO 1	LOXAHATCHEE	FL	33470-0000
EE	M	08/26/1978	FIRA	HMO 1	LOXAHATCHEE	FL	33470-0000
SP	F	07/26/1978	FIRA	HMO 1	LOXAHATCHEE	FL	33470-0000
EE	M	04/06/1974	MGTA	HDHP	DEERFIELD BEACH	FL	33441-0000
SP	F	06/28/1979	MGTA	HDHP	DEERFIELD BEACH	FL	33441-0000
CH	F	06/14/2005	MGTA	HDHP	DEERFIELD BEACH	FL	33441-0000
CH	M	01/09/2007	MGTA	HDHP	DEERFIELD BEACH	FL	33441-0000
CH	F	06/24/2009	MGTA	HDHP	DEERFIELD BEACH	FL	33441-0000
CH	F	07/16/2011	MGTA	HDHP	DEERFIELD BEACH	FL	33441-0000
CH	M	09/25/2015	MGTA	HDHP	DEERFIELD BEACH	FL	33441-0000
SP	F	06/14/1967	GENA	HMO 1	DAVIE	FL	33314-0000
CH	M	11/18/1993	GENA	HMO 1	DAVIE	FL	33314-0000
CH	M	01/15/1996	GENA	HMO 1	DAVIE	FL	33314-0000
EE	M	01/20/1965	GENA	HMO 1	DAVIE	FL	33314-0000
EE	M	09/12/1991	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	12/25/1960	GENA	HDHP	FORT LAUDERDALE	FL	33316-0000
EE	M	01/22/1986	GENA	HMO 2	MIAMI	FL	33193-0000
EE	F	10/07/1963	MGTA	HDHP	OAKLAND PARK	FL	33309-0000
EE	M	06/24/1945	GEN65O	HMO 1	FT LAUDERDALE	FL	33311-0000
SP	F	03/25/1954	GEN65O	HMO 1	FT LAUDERDALE	FL	33311-0000
EE	M	08/24/1958	MGTA	HMO 1	FORT LAUDERDALE	FL	33304-0000
EE	F	02/18/1970	GENA	HMO 2	POMPANO BEACH	FL	33060-0000
EE	F	08/02/1974	GENA	HDHP	SUNRISE	FL	33313-0000
SP	M	10/04/1973	GENA	HDHP	SUNRISE	FL	33313-0000
CH	M	02/07/2004	GENA	HDHP	SUNRISE	FL	33313-0000
CH	F	06/12/2002	GENA	HDHP	SUNRISE	FL	33313-0000

CH	F	02/15/1993	GENA	HDHP	PEMBROKE PINES	FL	33025-0000
EE	M	08/06/1963	GENA	HDHP	OAKLAND PARK	FL	33309-0000
EE	M	05/20/1968	MGTA	HMO 1	POMPANO BCH	FL	33062-0000
SP	F	09/09/1976	MGTA	HMO 1	POMPANO BCH	FL	33062-0000
CH	M	11/26/1993	MGTA	HMO 1	POMPANO BCH	FL	33062-0000
CH	M	11/17/1994	MGTA	HMO 1	POMPANO BCH	FL	33062-0000
SP	F	04/08/1963	FIRA	HMO 1	STUART	FL	34997-0000
CH	M	12/25/2001	PASA	HMO 2	CORAL SPRINGS	FL	33065-0000
EE	M	12/19/1959	PASA	HDHP	JUPITER	FL	33478-0000
SP	F	10/20/1961	PASA	HDHP	JUPITER	FL	33478-0000
EE	F	03/19/1948	GENA	HMO 1	DELRAY BEACH	FL	33482-0000
EE	M	10/16/1960	GENA	HMO 1	FORT LAUDERDALE	FL	33316-0000
EE	M	11/01/1977	GENA	HDHP	LAUDERHILL	FL	33313-0000
EE	M	10/21/1984	FIRA	HDHP	GREENACRES	FL	33413-0000
EE	M	02/17/1989	FIRA	HMO 1	HIALEAH	FL	33015-0000
EE	F	08/30/1988	GENA	HDHP	PLANTATION	FL	33317-0000
EE	M	07/03/1954	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	09/24/1971	GENA	HMO 1	OAKLAND PARK	FL	33309-0000
EE	M	04/12/1964	MGTA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	F	09/23/1963	MGTU65	HMO 1	WRIGHTSTOWN	WI	54180-0000
CH	M	04/06/1995	MGTU65	HMO 1	WRIGHTSTOWN	WI	54180-0000
CH	F	10/26/1998	MGTU65	HMO 1	WRIGHTSTOWN	WI	54180-0000
CH	M	03/25/2002	MGTU65	HMO 1	WRIGHTSTOWN	WI	54180-0000
EE	M	07/31/1963	FIRA	HMO 1	PALM BCH GARDENS	FL	33412-0000
SP	F	12/21/1965	FIRA	HMO 1	PALM BCH GARDENS	FL	33412-0000
CH	F	10/13/1991	FIRA	HMO 1	PALM BCH GARDENS	FL	33412-0000
CH	M	04/23/1995	FIRA	HMO 1	PALM BCH GARDENS	FL	33412-0000
EE	F	09/17/1970	GENA	HMO 1	COCONUT CREEK	FL	33073-0000
CH	F	11/10/2008	GENA	HMO 1	COCONUT CREEK	FL	33073-0000
EE	M	12/27/1961	GENA	HMO 1	OAKLAND PARK	FL	33309-0000
EE	M	03/22/1973	GENA	HMO 1	PLANTATION	FL	33322-0000
EE	M	09/26/1952	MGTA	HMO 1	FORT PIERCE	FL	34949-0000
SP	F	10/23/1956	MGTA	HMO 1	FORT PIERCE	FL	34949-0000
EE	M	05/08/1961	GENA	HMO 2	MARGATE	FL	33068-0000
SP	F	11/27/1963	GENA	HMO 2	MARGATE	FL	33068-0000
CH	F	01/15/1991	FIRA	HDHP	BOCA RATON	FL	33428-0000
EE	F	07/24/1952	GENA	HMO 1	COOPER CITY	FL	33026-0000
EE	M	03/24/1989	FIRA	HMO 2	FORT LAUDERDALE	FL	33308-0000
EE	M	09/19/1970	FIRA	HDHP	JUPITER	FL	33478-0000
EE	M	02/03/1976	PASA	HMO 1	AVENTURA	FL	33180-0000
EE	F	03/23/1941	GENA	HMO 2	NORTH MIAMI BEACH	FL	33160-0000
EE	F	04/10/1960	MGTA	HMO 1	COCONUT CREEK	FL	33063-0000
EE	M	07/31/1981	PASA	HMO 1	NAPLES	FL	34120-0000

EE	M	09/09/1967	MGTA	HDHP	SUNRISE	FL	33351-0000
CH	M	11/20/2003	MGTA	HDHP	SUNRISE	FL	33351-0000
CH	M	09/27/1998	MGTA	HDHP	SUNRISE	FL	33351-0000
CH	F	02/12/1994	MGTA	HDHP	SUNRISE	FL	33351-0000
CH	M	04/03/2001	MGTA	HDHP	SUNRISE	FL	33351-0000
EE	M	01/07/1975	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	06/08/1965	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
SP	F	01/02/1965	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	F	08/04/1996	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	M	10/16/1998	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	01/19/1944	GENA	HMO 2	HALLANDALE	FL	33008-0000
EE	F	04/09/1963	PASA	HMO 1	KEY WEST	FL	33040-0000
EE	M	02/08/1960	GENU65	HMO 1	GAINSVILLE	FL	32609-0000
EE	M	11/30/1969	FIRA	HDHP	MIAMI	FL	33196-0000
SP	F	06/14/1975	FIRA	HDHP	MIAMI	FL	33196-0000
CH	F	12/29/1999	FIRA	HDHP	MIAMI	FL	33196-0000
CH	F	11/14/2003	FIRA	HDHP	MIAMI	FL	33196-0000
CH	F	11/12/2008	FIRA	HDHP	MIAMI	FL	33196-0000
EE	M	11/01/1954	GENA	HDHP	FORT LAUDERDALE	FL	33315-0000
EE	M	02/10/1982	PASA	HDHP	FORT LAUDERDALE	FL	33304-0000
EE	F	01/03/1968	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	04/14/1969	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	06/23/1955	GENU65	HMO 1	N LAUDERDALE	FL	33068-0000
EE	M	12/22/1986	GENA	HDHP	FORT LAUDERDALE	FL	33306-0000
EE	M	11/15/1958	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
SP	F	05/18/1954	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	12/18/1965	GENA	HDHP	PLANTATION	FL	33317-0000
SP	F	08/09/1964	GENA	HDHP	PLANTATION	FL	33317-0000
CH	M	05/29/1997	GENA	HDHP	PLANTATION	FL	33317-0000
CH	F	06/05/1999	GENA	HDHP	PLANTATION	FL	33317-0000
EE	M	08/27/1970	FIRA	HMO 1	JENSEN BEACH	FL	34957-0000
CH	M	01/23/2003	FIRA	HMO 1	JENSEN BEACH	FL	34957-0000
CH	F	08/01/2005	FIRA	HMO 1	JENSEN BEACH	FL	34957-0000
EE	M	08/08/1958	FIRU65	HMO 1	FORT LAUDERDALE	FL	33306-0000
CH	F	02/03/1993	FIRU65	HMO 1	FORT LAUDERDALE	FL	33306-0000
EE	M	11/28/1967	GENA	HDHP	SUNRISE	FL	33323-0000
CH	M	01/30/1993	GENA	HDHP	SUNRISE	FL	33323-0000
CH	M	04/05/1996	GENA	HDHP	SUNRISE	FL	33323-0000
SP	F	03/16/1962	GENA	HMO 1	HOLLYWOOD	FL	33019-0000
EE	F	07/05/1954	CONA	HDHP	LAUDERHILL	FL	33313-0000
SP	M	07/19/1969	PASA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	08/11/1976	GENA	HDHP	MARGATE	FL	33063-0000
CH	F	08/19/1997	FIRA	HDHP	COOPER CITY	FL	33026-0000

EE	F	04/19/1976	MGTA	HMO 1	MIRAMAR	FL	33027-0000
CH	F	05/09/2002	MGTA	HMO 1	MIRAMAR	FL	33027-0000
CH	F	12/01/2005	MGTA	HMO 1	MIRAMAR	FL	33027-0000
CH	M	09/03/2002	MGTA	HMO 1	MIAMI	FL	33183-0000
CH	F	10/06/2005	MGTA	HMO 1	MIAMI	FL	33183-0000
EE	F	06/27/1985	GENA	HDHP	N MIAMI	FL	33168-0000
EE	M	04/22/1972	FIRA	HMO 1	DAVIE	FL	33328-0000
CH	M	06/23/1997	FIRA	HMO 1	DAVIE	FL	33328-0000
SP	F	04/10/1964	GENA	HMO 1	FORT LAUDERDALE	FL	33334-0000
EE	F	06/10/1965	GENA	HDHP	SOUTHWEST RANCHES	FL	33330-0000
EE	M	01/30/1986	FIRA	HDHP	DAVIE	FL	33328-0000
EE	M	11/15/1968	GENA	HMO 2	FORT LAUDERDALE	FL	33308-0000
EE	F	06/26/1954	GENA	HDHP	SUNRISE	FL	33351-0000
EE	M	08/06/1956	PASA	HMO 1	POMPANO BEACH	FL	33064-0000
SP	F	06/18/1959	PASA	HMO 1	POMPANO BEACH	FL	33064-0000
EE	M	01/12/1971	FIRA	HDHP	OAKLAND PARK	FL	33309-0000
SP	F	06/18/1969	FIRA	HDHP	OAKLAND PARK	FL	33309-0000
CH	M	04/12/1993	FIRA	HDHP	OAKLAND PARK	FL	33309-0000
CH	M	03/08/2004	FIRA	HDHP	OAKLAND PARK	FL	33309-0000
CH	F	08/05/2008	FIRA	HDHP	OAKLAND PARK	FL	33309-0000
EE	F	09/29/1954	MGTA	HMO 1	FORT LAUDERDALE	FL	33315-0000
EE	F	11/04/1956	GENC	HMO 2	CHARLOTTE	NC	28214-0000
EE	M	08/16/1986	FIRA	HMO 1	MIRAMAR	FL	33025-0000
CH	M	10/28/2013	FIRA	HMO 1	MIRAMAR	FL	33025-0000
EE	M	02/10/1972	FIRA	HMO 1	BOCA RATON	FL	33428-0000
SP	F	07/05/1972	FIRA	HMO 1	BOCA RATON	FL	33428-0000
CH	M	12/12/2007	FIRA	HMO 1	BOCA RATON	FL	33428-0000
EE	M	02/20/1967	PASA	HMO 1	HOLLYWOOD	FL	33020-0000
CH	M	03/22/2005	PASA	HMO 1	HOLLYWOOD	FL	33020-0000
EE	M	11/18/1972	FIRA	HDHP	MIRAMAR	FL	33029-0000
SP	F	03/03/1975	FIRA	HDHP	MIRAMAR	FL	33029-0000
CH	F	08/07/1999	FIRA	HDHP	MIRAMAR	FL	33029-0000
CH	F	07/30/2009	FIRA	HDHP	MIRAMAR	FL	33029-0000
CH	M	03/11/2011	FIRA	HDHP	MIRAMAR	FL	33029-0000
EE	M	03/08/1961	GENA	HMO 1	DAVIE	FL	33314-0000
EE	M	09/13/1983	GENA	HDHP	POMPANO BEACH	FL	33062-0000
EE	F	08/23/1954	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
EE	F	02/01/1960	PASA	HMO 1	DEERFIELD	FL	33442-0000
EE	F	09/29/1967	CONA	HMO 1	SUNRISE	FL	33313-0000
EE	M	10/12/1971	PASA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	M	06/09/1969	GENA	HMO 2	FORT LAUDERDALE	FL	33304-0000
CH	F	09/15/1997	GENA	HMO 2	FORT LAUDERDALE	FL	33304-0000
CH	M	10/21/2002	GENA	HMO 2	FORT LAUDERDALE	FL	33304-0000

EE	M	03/26/1967	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	M	08/18/2004	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	F	05/28/1975	GENA	HDHP	FORT LAUDERDALE	FL	33310-0000
EE	F	07/22/1984	PASA	HDHP	TAMARAC	FL	33321-0000
EE	M	02/26/1963	PASA	HDHP	HOLLYWOOD	FL	33019-0000
CH	M	03/03/2006	GENA	HDHP	OAKLAND PARK	FL	33309-0000
EE	F	10/17/1968	PASA	HMO 1	SUNRISE	FL	33322-0000
SP	M	04/24/1958	PASA	HMO 1	SUNRISE	FL	33322-0000
EE	M	03/04/1977	GENA	HMO 2	FT LAUDERDALE	FL	33311-0000
CH	F	10/09/1997	GENA	HDHP	LAUDERHILL	FL	33351-0000
EE	M	11/01/1971	GENA	HMO 1	HOLLYWOOD	FL	33023-0000
EE	M	09/20/1990	MGTA	HDHP	FORT LAUDERDALE	FL	33304-0000
EE	M	01/02/1958	MGTA	HDHP	DAVIE	FL	33324-0000
EE	M	08/22/1967	FIRA	HMO 1	JUPITER	FL	33468-0000
EE	F	07/07/1970	CONA	HMO 2	DEERFIELD BEACH	FL	33441-0000
EE	F	12/04/1973	PASA	HDHP	POMPANO BEACH	FL	33064-0000
EE	M	11/08/1954	GENA	HMO 1	TAMARAC	FL	33319-0000
SP	F	06/06/1957	GENA	HMO 1	TAMARAC	FL	33319-0000
EE	F	07/13/1956	MGTA	HDHP	CORAL SPRINGS	FL	33065-0000
SP	M	10/10/1950	MGTA	HDHP	CORAL SPRINGS	FL	33065-0000
CH	M	07/20/2011	GENA	HMO 1	COOPER CITY	FL	33328-0000
EE	M	01/08/1962	MGTA	HMO 1	FORT LAUDERDALE	FL	33311-0000
SP	F	11/25/1988	GENA	HDHP	FORT LAUDERDALE	FL	33315-0000
EE	M	10/09/1971	MGTA	HMO 1	TAMARAC	FL	33321-0000
EE	F	06/09/1969	PASA	HDHP	OAKLAND PARK	FL	33309-0000
CH	F	03/15/2006	FIRA	HMO 1	SUNRISE	FL	33351-0000
CH	F	08/28/2007	FIRA	HMO 1	SUNRISE	FL	33351-0000
EE	M	01/04/1962	GENA	HDHP	PLANTATION	FL	33317-0000
SP	F	10/18/1972	GENA	HDHP	PLANTATION	FL	33317-0000
CH	M	03/18/2008	GENA	HDHP	PLANTATION	FL	33317-0000
EE	M	03/12/1968	FIRA	HDHP	OAKLAND PARK	FL	33334-0000
SP	F	02/16/1968	FIRA	HDHP	OAKLAND PARK	FL	33334-0000
CH	F	05/19/1998	FIRA	HDHP	OAKLAND PARK	FL	33334-0000
CH	M	07/09/2008	FIRA	HDHP	OAKLAND PARK	FL	33334-0000
EE	M	03/16/1966	FIRA	HDHP	LAKE WORTH	FL	33467-0000
EE	M	07/05/1956	GENA	HDHP	COCONUT CREEK	FL	33066-0000
SP	F	05/01/1956	GENA	HDHP	COCONUT CREEK	FL	33066-0000
CH	F	08/28/1998	GENA	HDHP	COCONUT CREEK	FL	33066-0000
CH	M	02/05/2001	GENA	HDHP	COCONUT CREEK	FL	33066-0000
EE	M	01/19/1960	PASA	HMO 1	FORT LAUDERDALE	FL	33308-0000
EE	F	06/18/1984	GENA	HMO 2	PEMBROKE PINES	FL	33026-0000
SP	M	06/28/1982	GENA	HMO 2	PEMBROKE PINES	FL	33026-0000
EE	F	12/29/1970	GENA	HMO 2	FORT LAUDERDALE	FL	33316-0000

EE	M	08/07/1986	FIRA	HDHP	BOYNTON BEACH	FL	33437-0000
EE	M	12/12/1982	FIRA	HMO 2	MIAMI	FL	33173-0000
EE	M	08/20/1959	GENA	HMO 1	POMPANO BEACH	FL	33064-0000
EE	F	04/11/1975	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	09/14/1966	FIRA	HDHP	ALTAMONTE SPRINGS	FL	32714-0000
SP	F	01/22/1967	FIRA	HDHP	ALTAMONTE SPRINGS	FL	32714-0000
CH	M	06/05/1994	FIRA	HDHP	ALTAMONTE SPRINGS	FL	32714-0000
EE	M	05/26/1955	GENA	HMO 2	LAUDERHILL	FL	33313-0000
EE	F	05/07/1972	GENA	HDHP	TAMARAC	FL	33319-0000
CH	M	08/19/2003	GENA	HDHP	TAMARAC	FL	33319-0000
CH	M	04/05/2002	GENA	HDHP	TAMARAC	FL	33319-0000
EE	M	10/04/1967	PASA	HDHP	DAVIE	FL	33314-0000
SP	F	04/29/1969	PASA	HDHP	DAVIE	FL	33314-0000
CH	F	09/08/2006	PASA	HDHP	DAVIE	FL	33314-0000
CH	M	04/23/2000	PASA	HMO 1	MIAMI BEACH	FL	33141-0000
CH	M	06/27/2002	PASA	HMO 1	MIAMI BEACH	FL	33141-0000
CH	M	01/04/2006	PASA	HMO 1	MIAMI BEACH	FL	33141-0000
EE	F	05/04/1960	FIRU65	HDHP retiree	DANIA	FL	33004-0000
CH	M	12/01/1995	MGTA	HMO 1	WELLINGTON	FL	33414-0000
EE	M	12/21/1956	GENU65	HMO 2	DAVIE	FL	33328-0000
EE	F	06/10/1963	GENA	HDHP	MIAMI	FL	33169-0000
EE	M	05/21/1989	PASA	HDHP	BOCA RATON	FL	33428-0000
SP	F	07/05/1988	PASA	HDHP	BOCA RATON	FL	33428-0000
CH	F	01/13/2012	PASA	HDHP	BOCA RATON	FL	33428-0000
CH	F	12/10/2014	PASA	HDHP	BOCA RATON	FL	33428-0000
EE	M	06/23/1982	FIRA	HMO 1	DAVIE	FL	33314-0000
SP	F	10/23/1986	GENA	HDHP	OAKLAND PARK	FL	33334-0000
EE	M	05/10/1969	GENA	HDHP	POMPANO BEACH	FL	33060-0000
EE	M	01/30/1955	GENA	HMO 1	HOLLYWOOD	FL	33024-0000
EE	M	11/19/1963	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	F	05/30/1996	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	04/12/1989	GENA	HDHP	FORT LAUDERDALE	FL	33314-0000
EE	M	01/31/1966	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	10/26/1983	FIRA	HDHP	DEERFIELD BCH	FL	33441-0000
CH	F	03/21/1993	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	08/18/1969	FIRA	HDHP	LIGHTHOUSE POINT	FL	33064-0000
CH	F	09/01/2004	FIRA	HDHP	LIGHTHOUSE POINT	FL	33064-0000
SP	F	05/31/1969	GENA	HMO 1	OAKLAND PARK	FL	33334-0000
EE	M	07/11/1954	FIRU65	HDHPR	HOBE SOUND	FL	33455-0000
EE	M	09/04/1969	GENA	HMO 2	POMPANO	FL	33060-0000
CH	F	01/20/2005	GENA	HMO 2	POMPANO	FL	33060-0000
CH	F	06/07/1997	GENA	HMO 2	POMPANO	FL	33060-0000
CH	M	05/04/1993	GENA	HMO 2	POMPANO	FL	33060-0000

EE	M	03/21/1990	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	F	03/18/1974	GENA	HDHP	DAVIE	FL	33324-0000
EE	M	05/07/1950	GEN65O	HMO 1	TAMARAC	FL	33319-0000
EE	M	04/16/1979	FIRA	HDHP	GREENACRES	FL	33463-0000
EE	F	12/30/1981	FIRA	HDHP	GREENACRES	FL	33463-0000
EE	M	01/19/1973	FIRA	HDHP	DAVIE	FL	33328-0000
CH	F	12/06/2006	FIRA	HDHP	DAVIE	FL	33328-0000
CH	F	12/06/2006	FIRA	HDHP	DAVIE	FL	33328-0000
EE	M	03/10/1967	MGTA	HDHP	FORT LAUDERDALE	FL	33334-0000
EE	F	07/22/1985	GENA	HMO 1	N LAUDERDALE	FL	33068-0000
EE	M	10/25/1982	GENA	HDHP	LAUDERHILL	FL	33319-0000
EE	F	05/12/1964	PASA	HDHP	CORAL SPRINGS	FL	33065-0000
SP	M	12/08/1955	PASA	HDHP	CORAL SPRINGS	FL	33065-0000
CH	M	05/23/1991	PASA	HDHP	CORAL SPRINGS	FL	33065-0000
CH	F	10/18/1996	PASA	HDHP	CORAL SPRINGS	FL	33065-0000
EE	F	01/14/1974	GENA	HDHP	MARGATE	FL	33063-0000
SP	M	04/28/1969	GENA	HDHP	MARGATE	FL	33063-0000
CH	M	07/18/2008	GENA	HDHP	MARGATE	FL	33063-0000
CH	F	09/09/2001	GENA	HDHP	MARGATE	FL	33063-0000
EE	M	01/23/1981	PASA	HDHP	TAMARAC	FL	33321-0000
EE	F	10/28/1963	PASA	HMO 1	POMPANO BEACH	FL	33060-0000
EE	M	07/31/1976	FIRA	HDHP	MIAMI GARDENS	FL	33015-0000
CH	F	05/05/2008	FIRA	HDHP	MIAMI GARDENS	FL	33015-0000
CH	F	12/14/2006	FIRA	HDHP	MIAMI GARDENS	FL	33015-0000
CH	F	03/18/2003	GENA	HMO 1	TAMARAC	FL	33319-0000
CH	M	06/24/2000	GENA	HMO 1	TAMARAC	FL	33319-0000
EE	M	01/01/1981	GENA	HDHP	MARGATE	FL	33063-0000
CH	F	10/01/2008	GENA	HDHP	MARGATE	FL	33063-0000
EE	M	10/29/1967	GENA	HMO 1	FORT LAUDERDALE	FL	33334-0000
CH	M	11/05/1993	GENA	HMO 1	FORT LAUDERDALE	FL	33334-0000
CH	F	08/23/1995	GENA	HMO 1	FORT LAUDERDALE	FL	33334-0000
CH	M	10/01/2001	GENA	HMO 1	FORT LAUDERDALE	FL	33334-0000
CH	F	10/31/2011	GENA	HMO 1	FORT LAUDERDALE	FL	33334-0000
SP	F	03/10/1978	GENA	HMO 1	FORT LAUDERDALE	FL	33334-0000
EE	M	11/08/1970	GENA	HDHP	MIRAMAR	FL	33023-0000
CH	M	03/05/2001	GENA	HDHP	MIRAMAR	FL	33023-0000
CH	F	04/24/1999	GENA	HDHP	MIRAMAR	FL	33023-0000
EE	M	10/25/1982	FIRA	HDHP	HOLLYWOOD	FL	33024-0000
SP	F	07/13/1986	FIRA	HDHP	HOLLYWOOD	FL	33024-0000
CH	M	11/17/1996	PASA	HDHP	GREENACRES	FL	33463-0000
EE	F	10/04/1961	SPEC	HMO 1	OKEECHOBEE	FL	34974-0000
EE	M	11/24/1965	GENA	HDHP	LAUDERHILL	FL	33313-0000
CH	M	08/09/1995	GENA	HDHP	LAUDERHILL	FL	33313-0000

EE	F	11/10/1962	GENA	HMO 1	DEERFIELD BCH	FL	33441-0000
CH	M	05/10/1995	GENA	HMO 1	DEERFIELD BCH	FL	33441-0000
EE	F	05/28/1965	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	02/13/1970	FIRA	HDHP	MIAMI	FL	33181-0000
CH	M	12/22/1994	FIRA	HDHP	PUEBLO	CO	81001-0000
CH	F	11/23/1996	FIRA	HDHP	MIAMI	FL	33181-0000
SP	F	12/07/1978	PASA	HMO 1	WILTON MANORS	FL	33305-0000
EE	M	11/23/1976	FIRA	HMO 1	PEMBROKE PINES	FL	33026-0000
CH	M	02/07/2006	FIRA	HMO 1	PEMBROKE PINES	FL	33026-0000
CH	M	09/12/2007	FIRA	HMO 1	PEMBROKE PINES	FL	33026-0000
CH	M	11/13/2013	FIRA	HMO 1	PEMBROKE PINES	FL	33026-0000
EE	F	04/02/1953	MGTU65	HMO 1	PLANTATION	FL	33317-0000
EE	M	09/02/1976	FIRA	HMO 1	LIGHTHOUSE POINT	FL	33064-0000
SP	F	12/22/1984	FIRA	HMO 1	LIGHTHOUSE POINT	FL	33064-0000
CH	F	10/28/2014	FIRA	HMO 1	LIGHTHOUSE POINT	FL	33064-0000
EE	F	09/18/1977	MGTA	HDHP	POMPANO BEACH	FL	33060-0000
SP	M	11/09/1966	MGTA	HDHP	POMPANO BEACH	FL	33060-0000
CH	M	10/31/2005	MGTA	HDHP	POMPANO BEACH	FL	33060-0000
CH	M	01/31/2008	MGTA	HDHP	POMPANO BEACH	FL	33060-0000
EE	M	05/07/1964	PASA	HMO 1	FORT LAUDERDALE	FL	33305-0000
EE	F	12/16/1976	GENA	HMO 1	HOLLYWOOD	FL	33023-0000
SP	F	09/17/1970	GENA	HDHP	BOCA RATON	FL	33498-0000
EE	M	10/31/1980	FIRA	HDHP	BOYNTON BEACH	FL	33426-0000
EE	M	02/02/1987	FIRA	HMO 1	LAKE WORTH	FL	33467-0000
SP	F	03/10/1985	FIRA	HMO 1	LAKE WORTH	FL	33467-0000
CH	M	05/20/2013	FIRA	HMO 1	LAKE WORTH	FL	33467-0000
EE	M	01/02/1966	FIRA	HDHP	BOCA RATON	FL	33486-0000
EE	F	04/26/1971	PASA	HMO 1	FORT LAUDERDALE	FL	33334-0000
CH	M	12/02/2000	PASA	HMO 1	FORT LAUDERDALE	FL	33334-0000
CH	M	07/14/2004	PASA	HMO 1	FORT LAUDERDALE	FL	33334-0000
EE	M	01/31/1970	GENA	HMO 2	FORT LAUDERDALE	FL	33334-0000
CH	F	08/23/1990	MGTA	HMO 1	SEFFNER	FL	33584-0000
CH	F	03/01/1999	GENA	HMO 1	COOPER CITY	FL	33328-0000
CH	M	09/17/2012	PASA	HDHP	HOLLYWOOD	FL	33019-0000
CH	M	04/13/2010	PASA	HDHP	HOLLYWOOD	FL	33019-0000
EE	M	04/21/1967	GENA	HDHP	PORT SAINT LUCIE	FL	34953-0000
SP	F	12/03/1976	GENA	HDHP	PORT SAINT LUCIE	FL	34953-0000
CH	F	05/03/2011	GENA	HDHP	PORT SAINT LUCIE	FL	34953-0000
CH	F	05/26/2014	GENA	HDHP	PORT SAINT LUCIE	FL	34953-0000
EE	F	09/10/1967	GENA	HDHP	TAMARAC	FL	33321-0000
SP	M	04/03/1956	MGTA	HDHP	POMPANO BEACH	FL	33062-0000
CH	F	11/01/2006	GENA	HDHP	SUNRISE	FL	33323-0000
CH	M	12/17/2008	GENA	HDHP	SUNRISE	FL	33323-0000

EE	M	07/30/1965	FIRA	HDHP	PORT ST LUCIE	FL	34987-0000
SP	F	02/16/1967	FIRA	HDHP	PORT ST LUCIE	FL	34987-0000
EE	M	03/25/1985	FIRA	HDHP	DAVIE	FL	33331-0000
EE	M	03/17/1987	FIRA	HDHP	BOYNTON BEACH	FL	33436-0000
EE	F	09/20/1962	GENA	HDHP	HOLLYWOOD	FL	33020-0000
SP	M	05/31/1958	GENA	HDHP	HOLLYWOOD	FL	33020-0000
CH	F	11/09/1995	GENA	HDHP	HOLLYWOOD	FL	33020-0000
CH	F	02/23/2000	GENA	HDHP	HOLLYWOOD	FL	33020-0000
EE	M	03/11/1960	GENA	HMO 1	HOLLYWOOD	FL	33021-0000
SP	F	05/28/1961	GENA	HMO 1	HOLLYWOOD	FL	33021-0000
EE	M	03/26/1980	PASA	HDHP	CORAL SPRINGS	FL	33065-0000
EE	M	07/21/1958	PASA	HMO 1	DAVIE	FL	33314-0000
EE	M	04/01/1963	MGTA	HDHP	DAVIE	FL	33314-0000
CH	M	07/07/2000	MGTA	HDHP	DAVIE	FL	33314-0000
CH	F	10/13/1998	MGTA	HDHP	DAVIE	FL	33314-0000
CH	F	11/06/1996	MGTA	HDHP	DAVIE	FL	33314-0000
EE	M	11/30/1959	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	11/03/1968	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	04/30/2007	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	04/21/2009	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	05/13/1965	GENA	HDHP	BOCA RATON	FL	33431-0000
SP	F	03/31/1969	GENA	HDHP	BOCA RATON	FL	33431-0000
CH	F	06/24/2004	GENA	HDHP	BOCA RATON	FL	33431-0000
CH	M	05/17/2002	GENA	HDHP	BOCA RATON	FL	33431-0000
EE	M	07/22/1971	GENA	HMO 2	DAVIE	FL	33325-0000
EE	M	06/01/1961	PASA	HDHP	MIAMI	FL	33185-0000
SP	F	02/06/1965	PASA	HDHP	MIAMI	FL	33185-0000
CH	M	04/07/1993	PASA	HDHP	MIAMI	FL	33185-0000
EE	M	07/15/1990	FIRA	HDHP	COOPER CITY	FL	33328-0000
EE	F	04/08/1971	GENA	HMO 1	TAMARAC	FL	33319-0000
EE	F	10/18/1953	GENC	HMO 1	DAVIE	FL	33314-0000
EE	M	01/12/1985	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	06/09/1965	MGTA	HMO 1	MIRAMAR	FL	33027-0000
SP	F	12/02/1964	MGTA	HMO 1	MIRAMAR	FL	33027-0000
CH	F	06/09/2000	MGTA	HMO 1	MIRAMAR	FL	33027-0000
EE	F	05/19/1982	PASA	HMO 2	CORAL SPRINGS	FL	33065-0000
EE	M	05/26/1951	GENA	HDHP	POMPANO BEACH	FL	33064-0000
EE	M	05/03/1952	MGTU65	HMO 1	LAUDERHILL	FL	33351-0000
EE	M	12/29/1970	FIRA	HMO 1	DAVIE	FL	33314-0000
EE	F	04/09/1970	FIRA	HMO 1	DAVIE	FL	33314-0000
CH	F	07/22/2006	FIRA	HMO 1	DAVIE	FL	33314-0000
EE	F	05/15/1969	FIRA	HDHP	FORT PIERCE	FL	34982-0000
SP	M	06/02/1969	FIRA	HDHP	FORT PIERCE	FL	34982-0000

CH	M	10/23/2001	FIRA	HDHP	FORT PIERCE	FL	34982-0000
EE	M	03/24/1971	PASA	HDHP	OAKLAND PARK	FL	33334-0000
SP	F	03/15/1972	PASA	HDHP	OAKLAND PARK	FL	33334-0000
CH	M	07/03/2004	PASA	HDHP	OAKLAND PARK	FL	33334-0000
CH	M	12/02/1998	PASA	HDHP	OAKLAND PARK	FL	33334-0000
CH	M	10/05/1992	PASA	HDHP	OAKLAND PARK	FL	33334-0000
EE	M	03/28/1961	GENA	HDHP	POMPANO BEACH	FL	33060-0000
CH	F	10/15/1999	GENA	HMO 1	PEMBROKE PINES	FL	33029-0000
EE	M	12/29/1975	FIRA	HDHP	COOPER CITY	FL	33026-0000
SP	F	11/14/1977	FIRA	HDHP	COOPER CITY	FL	33026-0000
CH	M	01/08/2005	FIRA	HDHP	COOPER CITY	FL	33026-0000
CH	M	10/14/2010	FIRA	HDHP	COOPER CITY	FL	33026-0000
CH	F	12/14/2012	FIRA	HDHP	COOPER CITY	FL	33026-0000
EE	M	12/22/1952	GENA	HMO 2	LAUDERHILL	FL	33313-0000
SP	F	03/12/1951	GENA	HMO 2	LAUDERHILL	FL	33313-0000
EE	F	02/13/1972	GENA	HMO 1	FORT LAUDERDALE	FL	33309-0000
EE	F	05/15/1967	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	03/25/1959	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
SP	F	07/07/1960	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
CH	F	07/06/1993	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
CH	F	02/05/1991	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
CH	M	11/16/1998	PASA	HMO 1	WEST PALM BEACH	FL	33406-0000
EE	M	04/29/1977	FIRA	HDHP	PEMBROKE PINES	FL	33024-0000
CH	F	03/11/2006	FIRA	HDHP	PEMBROKE PINES	FL	33024-0000
CH	M	02/12/2010	FIRA	HDHP	PEMBROKE PINES	FL	33024-0000
SP	F	08/21/1981	GENA	HDHP	MARGATE	FL	33063-0000
EE	F	02/19/1955	CONA	HDHP	FORT LAUDERDALE	FL	33304-0000
EE	F	06/19/1989	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	F	10/15/1952	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	F	11/15/1983	GENA	HMO 2	DEERFIELD BEACH	FL	33441-0000
EE	M	11/24/1968	GENA	HDHP	HOLLYWOOD	FL	33019-0000
SP	M	08/18/1973	PASA	HMO 1	MARGATE	FL	33063-0000
EE	F	06/27/1966	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
EE	M	03/10/1958	GENA	HMO 1	POMPANO BEACH	FL	33060-0000
CH	F	12/09/1998	GENA	HMO 1	POMPANO BEACH	FL	33060-0000
EE	M	07/20/1969	MGTA	HMO 1	BOCA RATON	FL	33432-0000
SP	F	08/06/1971	MGTA	HMO 1	BOCA RATON	FL	33432-0000
CH	M	05/19/2010	MGTA	HMO 1	BOCA RATON	FL	33432-0000
CH	F	03/06/2001	MGTA	HMO 1	BOCA RATON	FL	33432-0000
CH	F	06/26/2002	MGTA	HMO 1	BOCA RATON	FL	33432-0000
EE	M	01/22/1988	GENA	HMO 1	DEERFIELD BEACH	FL	33441-0000
SP	F	09/26/1990	GENA	HMO 1	DEERFIELD BEACH	FL	33441-0000
CH	M	10/14/2015	GENA	HMO 1	DEERFIELD BEACH	FL	33441-0000

EE	F	02/05/1976	PASA	HMO 1	PLANTATION	FL	33322-0000
EE	M	06/08/1977	GENA	HDHP	FORT LAUDERDALE	FL	33315-0000
CH	F	11/03/2005	GENA	HDHP	FORT LAUDERDALE	FL	33315-0000
EE	M	10/10/1954	MGTA	HDHP	PLANTATION	FL	33322-0000
EE	F	09/27/1955	GENA	HMO 1	FORT LAUDERDALE	FL	33302-0000
EE	M	08/26/1985	FIRA	HMO 2	DAVIE	FL	33314-0000
EE	F	08/01/1982	GENA	HDHP	TAMARAC	FL	33309-0000
EE	M	05/21/1965	FIRA	HDHP	CORAL SPRINGS	FL	33065-0000
CH	F	01/23/1995	FIRA	HDHP	CORAL SPRINGS	FL	33065-0000
CH	F	08/09/2000	FIRA	HDHP	CORAL SPRINGS	FL	33065-0000
CH	M	06/21/2002	GENA	HMO 1	POMPANO BEACH	FL	33069-0000
CH	M	08/25/2005	GENA	HMO 1	POMPANO BEACH	FL	33069-0000
EE	F	03/28/1979	GENA	HMO 1	COOPER CITY	FL	33328-0000
SP	M	01/18/1972	GENA	HMO 1	COOPER CITY	FL	33328-0000
CH	F	02/11/2009	GENA	HMO 1	COOPER CITY	FL	33328-0000
CH	F	07/13/2006	GENA	HMO 1	COOPER CITY	FL	33328-0000
CH	F	03/25/2005	GENA	HMO 1	COOPER CITY	FL	33328-0000
EE	M	04/03/1977	FIRA	HDHP	HOLLYWOOD	FL	33021-0000
EE	M	06/28/1977	MGTA	HDHP	PEMBROKE PINES	FL	33029-0000
EE	M	03/28/1974	GENA	HMO 1	PLANTATION	FL	33317-0000
EE	F	09/03/1967	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	F	04/29/1993	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	09/21/1958	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
SP	F	01/21/1961	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
SP	M	05/04/1957	PASU65	HMO 2	FORT LAUDERDALE	FL	33308-0000
SP	F	09/20/1968	GENA	HDHP	POMPANO BEACH	FL	33060-0000
EE	M	05/12/1969	GENA	HDHP	FORT LAUDERDALE	FL	33304-0000
EE	M	08/23/1955	GENA	HMO 2	CORAL SPRINGS	FL	33065-0000
EE	F	05/01/1958	MGTA	HMO 1	FORT LAUDERDALE	FL	33308-0000
SP	F	09/22/1976	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	12/10/1989	FIRA	HMO 1	FORT LAUDERDALE	FL	33408-0000
EE	M	01/19/1963	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
EE	M	06/26/1963	GENA	HMO 1	CORAL SPRINGS	FL	33071-0000
SP	F	07/13/1964	GENA	HMO 1	CORAL SPRINGS	FL	33071-0000
CH	M	06/03/1997	GENA	HMO 1	CORAL SPRINGS	FL	33071-0000
CH	F	05/01/1995	GENA	HMO 1	CORAL SPRINGS	FL	33071-0000
EE	F	01/09/1964	MGTA	HMO 1	BOYNTON BEACH	FL	33472-0000
SP	M	07/18/1945	GENA	HDHP	FORT LAUDERDALE	FL	33315-0000
EE	M	09/26/1969	FIRA	HMO 2	FORT LAUDERDALE	FL	33308-0000
SP	F	05/06/1970	FIRA	HMO 2	FORT LAUDERDALE	FL	33308-0000
CH	M	07/01/1996	FIRA	HMO 2	FORT LAUDERDALE	FL	33308-0000
CH	F	12/15/1998	FIRA	HMO 2	FORT LAUDERDALE	FL	33308-0000
CH	M	09/08/2006	FIRA	HMO 2	FORT LAUDERDALE	FL	33308-0000

EE	M	08/07/1962	PASA	HDHP	COCONUT CREEK	FL	33066-0000
SP	F	07/02/1971	PASA	HDHP	COCONUT CREEK	FL	33066-0000
EE	M	05/14/1953	GENA	HMO 1	CORAL SPRINGS	FL	33076-0000
SP	F	07/29/1954	GENA	HMO 1	CORAL SPRINGS	FL	33076-0000
EE	M	05/28/1986	GENA	HMO 1	CORAL SPRINGS	FL	33076-0000
EE	M	01/03/1975	FIRA	HDHP	COOPER CITY	FL	33330-0000
SP	F	12/27/1984	FIRA	HDHP	COOPER CITY	FL	33330-0000
CH	M	08/14/2007	FIRA	HDHP	COOPER CITY	FL	33330-0000
CH	M	06/17/2009	FIRA	HDHP	COOPER CITY	FL	33330-0000
CH	F	11/14/2012	FIRA	HDHP	COOPER CITY	FL	33330-0000
EE	F	07/03/1976	MGTA	HDHP	FORT LAUDERDALE	FL	33315-0000
EE	M	03/09/1959	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	06/12/1975	FIRA	HMO 1	BOCA RATON	FL	33486-0000
SP	F	10/23/1976	FIRA	HMO 1	BOCA RATON	FL	33486-0000
CH	M	09/18/2012	FIRA	HMO 1	BOCA RATON	FL	33486-0000
CH	M	06/03/2015	FIRA	HMO 1	BOCA RATON	FL	33486-0000
SP	F	12/03/1962	GENA	HMO 1	DAVIE	FL	33314-0000
EE	M	04/26/1972	PASA	HMO 1	WILTON MANORS	FL	33306-0000
SP	F	07/01/1970	PASA	HMO 1	WILTON MANORS	FL	33306-0000
CH	M	06/19/2005	PASA	HMO 1	WILTON MANORS	FL	33306-0000
EE	F	08/29/1978	FIRA	HDHP	MARGATE	FL	33063-0000
EE	M	10/14/1964	GENA	HDHP	FORT LAUDERDALE	FL	33306-0000
SP	F	11/26/1965	PASA	HDHP	SUNNY ISLES BEACH	FL	33160-0000
EE	F	02/05/1962	GENA	HDHP	SUNRISE	FL	33323-0000
SP	M	06/30/1961	GENA	HDHP	SUNRISE	FL	33323-0000
EE	M	04/03/1966	GENA	HMO 1	PEMBROKE PINES	FL	33028-0000
SP	F	10/08/1965	GENA	HMO 1	PEMBROKE PINES	FL	33028-0000
CH	F	10/18/1993	GENA	HMO 1	PEMBROKE PINES	FL	33028-0000
CH	F	04/09/1996	GENA	HMO 1	PEMBROKE PINES	FL	33028-0000
EE	M	03/05/1977	FIRA	HDHP	JUPITER	FL	33478-0000
SP	F	09/11/1984	FIRA	HDHP	JUPITER	FL	33478-0000
CH	F	11/03/2010	FIRA	HDHP	JUPITER	FL	33478-0000
CH	F	05/10/2012	FIRA	HDHP	JUPITER	FL	33478-0000
EE	F	02/18/1960	PASA	HMO 1	MARGATE	FL	33063-0000
CH	M	06/15/1990	PASA	HMO 1	MARGATE	FL	33063-0000
CH	F	06/15/1990	PASA	HMO 1	MARGATE	FL	33063-0000
EE	F	07/26/1965	CONA	HDHP	FORT LAUDERDALE	FL	33316-0000
SP	M	01/13/1964	CONA	HDHP	FORT LAUDERDALE	FL	33316-0000
CH	M	12/04/1991	CONA	HDHP	FORT LAUDERDALE	FL	33316-0000
CH	M	07/23/1999	CONA	HDHP	FORT LAUDERDALE	FL	33316-0000
CH	M	04/09/2001	CONA	HDHP	FORT LAUDERDALE	FL	33316-0000
EE	M	11/20/1987	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	07/22/1961	FIRA	HMO 2	PEMBROKE PINES	FL	33029-0000

EE	M	04/01/1979	GENA	HDHP	MARGATE	FL	33063-0000
CH	F	08/16/2007	GENA	HDHP	MARGATE	FL	33063-0000
CH	M	11/21/2008	GENA	HDHP	MARGATE	FL	33063-0000
CH	M	04/06/2015	GENA	HDHP	MARGATE	FL	33063-0000
EE	F	11/09/1969	PASA	HMO 1	FORT LAUDERDALE	FL	33308-0000
SP	M	05/13/1961	PASA	HMO 1	FORT LAUDERDALE	FL	33308-0000
CH	F	08/16/2001	PASA	HMO 1	FORT LAUDERDALE	FL	33308-0000
CH	M	05/17/2004	PASA	HMO 1	FORT LAUDERDALE	FL	33308-0000
EE	M	01/30/1960	MGTA	HDHP	OPA LOCKA	FL	33055-0000
EE	M	05/07/1974	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	M	07/21/1955	FIRU65	HMO 1	LAUDERHILL	FL	33313-0000
EE	M	04/14/1979	GENA	HDHP	POMPANO BEACH	FL	33069-0000
EE	M	11/08/1964	FIRA	HDHP	JUPITER	FL	33478-0000
SP	F	03/24/1975	FIRA	HDHP	JUPITER	FL	33478-0000
EE	F	08/17/1960	PASA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	F	05/03/1963	MGTA	HMO 1	PEMBROKE PINES	FL	33027-0000
SP	M	11/18/1962	MGTA	HMO 1	PEMBROKE PINES	FL	33027-0000
CH	M	07/30/1992	MGTA	HMO 1	PEMBROKE PINES	FL	33027-0000
EE	F	01/05/1972	PASA	HMO 1	MARGATE	FL	33063-0000
SP	M	09/04/1968	PASA	HMO 1	MARGATE	FL	33063-0000
CH	F	04/15/2004	PASA	HMO 1	MARGATE	FL	33063-0000
CH	F	09/11/1999	PASA	HMO 1	MARGATE	FL	33063-0000
EE	F	12/01/1965	MGTA	HDHP	POMPANO BEACH	FL	33062-0000
SP	F	10/24/1960	GENA	HDHP	PLANTATION	FL	33324-0000
EE	F	05/22/1960	PASA	HMO 1	FORT LAUDERDALE	FL	33308-0000
EE	M	03/28/1983	FIRA	HDHP	PLANTATION	FL	33322-0000
CH	F	11/18/2013	FIRA	HDHP	PLANTATION	FL	33322-0000
EE	M	04/04/1967	GENA	HDHP	HIALEAH	FL	33014-0000
SP	F	08/16/1960	GENA	HDHP	HIALEAH	FL	33014-0000
EE	M	01/05/1986	FIRA	HDHP	HIALEAH	FL	33015-0000
EE	M	07/12/1989	FIRA	HDHP	HOMESTEAD	FL	33031-0000
EE	M	01/25/1985	FIRA	HDHP	OAKLAND PARK	FL	33334-0000
SP	F	02/05/1985	FIRA	HDHP	OAKLAND PARK	FL	33334-0000
CH	M	10/21/2015	FIRA	HDHP	OAKLAND PARK	FL	33334-0000
EE	F	08/16/1975	GENA	HDHP	WILTON MANORS	FL	33305-0000
EE	M	12/22/1968	GENA	HDHP	SUNRISE	FL	33313-0000
SP	F	10/31/1979	GENA	HDHP	SUNRISE	FL	33313-0000
CH	M	08/31/1990	GENA	HDHP	SUNRISE	FL	33313-0000
CH	M	05/08/2007	GENA	HDHP	SUNRISE	FL	33313-0000
EE	F	05/04/1964	PASA	HDHP	DAVIE	FL	33317-0000
CH	M	11/22/1996	PASA	HDHP	DAVIE	FL	33317-0000
CH	F	04/06/2000	PASA	HDHP	DAVIE	FL	33317-0000
EE	F	01/01/1981	FIRA	HMO 1	DEERFIELD BEACH	FL	33442-0000

EE	F	10/24/1971	PASA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	M	01/02/1976	PASA	HMO 1	CORAL SPRINGS	FL	33065-0000
CH	F	11/15/2007	PASA	HMO 1	CORAL SPRINGS	FL	33065-0000
EE	M	01/27/1977	PASA	HDHP	PLANTATION	FL	33317-0000
EE	F	05/21/1964	GENA	HMO 1	HOLLYWOOD	FL	33021-0000
CH	M	09/26/1992	GENA	HMO 1	HOLLYWOOD	FL	33021-0000
EE	M	12/01/1974	GENA	HDHP	SUNRISE	FL	33323-0000
SP	F	02/01/1975	GENA	HDHP	SUNRISE	FL	33323-0000
EE	M	07/10/1961	GENA	HMO 1	POMPANO BEACH	FL	33069-0000
EE	M	10/19/1973	PASA	HMO 1	MIRAMAR	FL	33027-0000
CH	M	04/08/1996	PASA	HMO 1	MIRAMAR	FL	33027-0000
CH	F	04/01/1999	PASA	HMO 1	MIRAMAR	FL	33027-0000
EE	M	03/11/1962	GENA	HMO 2	LAUDERDALE LAKES	FL	33319-0000
SP	F	11/02/1968	GENA	HMO 2	LAUDERDALE LAKES	FL	33319-0000
CH	F	01/30/1999	GENA	HMO 2	LAUDERDALE LAKES	FL	33319-0000
CH	M	02/23/1994	GENA	HMO 2	LAUDERDALE LAKES	FL	33319-0000
CH	M	04/23/1996	GENA	HMO 2	LAUDERDALE LAKES	FL	33319-0000
EE	F	01/02/1965	GENA	HMO 1	LAKE WORTH	FL	33463-0000
EE	F	06/24/1988	GENA	HMO 1	SUNRISE	FL	33351-0000
EE	M	03/11/1968	FIRA	HMO 1	LAKE WORTH	FL	33467-0000
EE	F	05/29/1962	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
SP	M	10/05/1959	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	06/22/1994	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	F	09/20/1969	MGTA	HDHP	SUNRISE	FL	33323-0000
EE	F	12/31/1979	GENA	HMO 1	MIRAMAR	FL	33023-0000
CH	M	02/24/1996	CONA	HDHP	TAMARAC	FL	33321-0000
CH	F	10/26/1998	CONA	HDHP	TAMARAC	FL	33321-0000
EE	M	02/21/1970	GENA	HMO 1	LAUDERHILL	FL	33313-0000
SP	F	03/29/1963	GENA	HMO 1	LAUDERHILL	FL	33313-0000
CH	M	01/10/1993	GENA	HMO 1	LAUDERHILL	FL	33313-0000
EE	M	04/09/1963	GENA	HDHP	LAUDERDALE LAKES	FL	33309-0000
SP	F	01/10/1965	GENA	HDHP	LAUDERDALE LAKES	FL	33309-0000
CH	F	08/13/1997	GENA	HDHP	LAUDERDALE LAKES	FL	33309-0000
CH	M	08/24/2000	GENA	HDHP	LAUDERDALE LAKES	FL	33309-0000
EE	M	11/01/1978	GENA	HDHP	N LAUDERDALE	FL	33068-0000
EE	M	06/18/1982	FIRA	HDHP	WESTON	FL	33327-0000
EE	M	11/16/1990	SPEC	HMO 1	MIRAMAR	FL	33025-0000
EE	F	03/02/1955	PASU65	HMO 1	CHIPLEY	FL	32428-0000
EE	F	03/07/1975	FIRA	HDHP	COOPER CITY	FL	33026-0000
SP	M	01/21/1980	FIRA	HDHP	COOPER CITY	FL	33026-0000
CH	F	04/20/2009	FIRA	HDHP	COOPER CITY	FL	33026-0000
EE	F	10/25/1979	GENA	HDHP	POMPANO BEACH	FL	33069-0000
SP	M	09/20/1965	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000

EE	F	12/06/1951	PASA	HDHP	TAMARAC	FL	33321-0000
SP	M	03/16/1965	PASA	HMO 1	FORT LAUDERDALE	FL	33309-0000
EE	M	11/04/1979	GENA	HDHP	CORAL SPRINGS	FL	33065-0000
EE	F	02/13/1973	GENA	HMO 1	LAKE WORTH	FL	33463-0000
EE	M	06/21/1961	FIRA	HDHP	ROYAL PALM BEACH	FL	33411-0000
CH	F	11/01/1995	FIRA	HDHP	ROYAL PALM BEACH	FL	33411-0000
CH	F	07/10/1997	FIRA	HDHP	ROYAL PALM BEACH	FL	33411-0000
EE	M	09/15/1975	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	M	10/06/1996	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	09/16/2004	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	F	08/04/1973	PASA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	M	05/23/1972	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	10/23/1986	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	06/27/1994	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	06/27/1994	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	10/21/1997	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	11/25/1998	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	04/07/2002	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	08/24/1974	GENA	HDHP	BOCA RATON	FL	33486-0000
CH	F	06/12/2015	GENA	HDHP	BOCA RATON	FL	33486-0000
EE	M	05/21/1959	PASA	HMO 1	HIALEAH	FL	33012-0000
SP	F	11/13/1960	PASA	HMO 1	HIALEAH	FL	33012-0000
EE	M	08/16/1968	FIRA	HDHP	JUPITER	FL	33478-0000
SP	F	09/07/1965	FIRA	HDHP	JUPITER	FL	33478-0000
CH	M	02/28/2004	FIRA	HDHP	JUPITER	FL	33478-0000
CH	M	03/02/2005	FIRA	HDHP	JUPITER	FL	33478-0000
CH	M	03/14/2007	FIRA	HDHP	JUPITER	FL	33478-0000
CH	M	10/21/2008	FIRA	HDHP	JUPITER	FL	33478-0000
EE	M	12/29/1967	FIRA	HDHP	DEERFIELD BEACH	FL	33442-0000
SP	F	11/09/1967	FIRA	HDHP	DEERFIELD BEACH	FL	33442-0000
CH	M	10/21/2006	FIRA	HDHP	DEERFIELD BEACH	FL	33442-0000
CH	F	02/08/2009	FIRA	HDHP	DEERFIELD BEACH	FL	33442-0000
EE	M	11/30/1964	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
SP	F	02/02/1968	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
EE	M	06/22/1963	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	F	07/17/1992	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
SP	M	03/06/1982	PASA	HMO 2	PEMBROKE PINES	FL	33024-0000
CH	M	02/27/2008	CONA	HDHP	CORAL SPRINGS	FL	33067-0000
CH	M	03/11/2009	CONA	HDHP	CORAL SPRINGS	FL	33067-0000
EE	M	03/26/1978	GENA	HDHP	CORAL SPRINGS	FL	33076-0000
EE	M	02/17/1969	FIRA	HMO 1	PALM CITY	FL	34990-0000
SP	F	06/08/1967	FIRA	HMO 1	PALM CITY	FL	34990-0000
CH	F	10/19/2010	FIRA	HMO 1	PALM CITY	FL	34990-0000

CH	M	11/19/1996	FIRA	HMO 1	PALM CITY	FL	34990-0000
EE	M	09/30/1959	FIRU65	HMO 1	HIGH SPRINGS	FL	32643-0000
EE	F	01/03/1980	PASA	HDHP	LAUDERDALE LAKES	FL	33309-0000
EE	F	07/25/1981	PASA	HDHP	HOLLYWOOD	FL	33019-0000
EE	M	08/31/1957	GENA	HMO 1	NORTH MIAMI	FL	33162-0000
SP	F	05/11/1967	GENA	HMO 1	NORTH MIAMI	FL	33162-0000
CH	F	03/21/1993	GENA	HMO 1	NORTH MIAMI	FL	33162-0000
CH	M	04/30/1994	GENA	HMO 1	NORTH MIAMI	FL	33162-0000
CH	F	04/30/1994	GENA	HMO 1	NORTH MIAMI	FL	33162-0000
CH	M	01/12/1996	GENA	HMO 1	NORTH MIAMI	FL	33162-0000
EE	F	12/08/1970	MGTA	HDHP	FORT LAUDERDALE	FL	33315-0000
SP	M	12/07/1967	MGTA	HDHP	FORT LAUDERDALE	FL	33315-0000
CH	F	02/28/1996	MGTA	HDHP	FORT LAUDERDALE	FL	33315-0000
CH	F	06/21/1998	MGTA	HDHP	FORT LAUDERDALE	FL	33315-0000
EE	M	10/06/1970	GENA	HMO 1	MIAMI	FL	33179-0000
CH	M	02/06/1999	GENA	HMO 1	MIAMI	FL	33179-0000
EE	M	04/18/1961	FIRA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	07/16/1968	PASA	HMO 1	MIRAMAR	FL	33027-0000
SP	F	12/07/1961	PASA	HMO 1	MIRAMAR	FL	33027-0000
CH	F	07/19/2005	PASA	HMO 1	MIRAMAR	FL	33027-0000
CH	M	07/19/2005	PASA	HMO 1	MIRAMAR	FL	33027-0000
EE	M	06/24/1981	GENA	HMO 1	MIAMI GARDENS	FL	33054-0000
CH	F	10/10/2005	GENA	HMO 1	MIAMI GARDENS	FL	33054-0000
CH	M	07/23/2003	GENA	HMO 1	NAPLES	FL	34120-0000
EE	M	10/07/1970	FIRA	HMO 1	PARKLAND	FL	33067-0000
SP	F	02/02/1978	FIRA	HMO 1	PARKLAND	FL	33067-0000
CH	F	04/07/2006	FIRA	HMO 1	PARKLAND	FL	33067-0000
CH	M	04/18/2008	FIRA	HMO 1	PARKLAND	FL	33067-0000
SP	M	09/02/1961	MGTA	HMO 2	PLANTATION	FL	33317-0000
EE	M	11/17/1967	GENA	HMO 2	FORT LAUDERDALE	FL	33308-0000
CH	M	09/09/2007	GENA	HMO 2	FORT LAUDERDALE	FL	33308-0000
EE	M	09/17/1957	FIRU65	HMO 1	LIGHTHOUSE POINT	FL	33064-0000
EE	M	03/21/1973	GENA	HMO 1	HIALEAH	FL	33010-0000
EE	M	10/31/1956	GENA	HMO 1	DAVIE	FL	33314-0000
EE	M	09/06/1984	GENA	HMO 1	TAMARAC	FL	33309-0000
EE	M	05/02/1970	PASA	HMO 2	POMPANO BEACH	FL	33062-0000
SP	F	12/04/1973	PASA	HMO 2	POMPANO BEACH	FL	33062-0000
CH	F	03/23/2002	PASA	HMO 2	POMPANO BEACH	FL	33062-0000
CH	F	10/15/2003	PASA	HMO 2	POMPANO BEACH	FL	33062-0000
EE	M	12/14/1967	GENA	HMO 1	WILTON MANORS	FL	33334-0000
EE	F	09/17/1969	MGTA	HMO 2	DAVIE	FL	33314-0000
EE	F	10/07/1967	GENA	HMO 1	CORAL SPRINGS	FL	33065-0000
EE	M	08/02/1972	GENA	HMO 1	CORAL SPRINGS	FL	33065-0000

CH	M	02/25/2003	GENA	HMO 1	CORAL SPRINGS	FL	33065-0000
EE	F	08/02/1964	GENA	HMO 1	DAVIE	FL	33324-0000
SP	M	09/20/1958	GENA	HMO 1	DAVIE	FL	33324-0000
CH	F	07/11/1997	GENA	HMO 1	DAVIE	FL	33324-0000
CH	F	05/13/1993	GENA	HMO 1	DAVIE	FL	33324-0000
EE	F	01/28/1961	MGTA	HMO 2	NORTH LAUDERDALE	FL	33068-0000
SP	M	06/19/1956	MGTA	HMO 2	NORTH LAUDERDALE	FL	33068-0000
CH	M	07/13/1990	MGTA	HMO 2	NORTH LAUDERDALE	FL	33068-0000
EE	M	11/10/1963	MGTA	HDHP	MIAMI LAKES	FL	33015-0000
SP	M	04/14/1965	MGTA	HMO 2	CORAL SPRINGS	FL	33065-0000
CH	M	09/12/1994	MGTA	HMO 2	CORAL SPRINGS	FL	33065-0000
CH	F	02/08/1999	MGTA	HMO 2	CORAL SPRINGS	FL	33065-0000
EE	F	08/09/1985	GENA	HMO 1	MIAMI	FL	33190-0000
CH	M	04/09/1995	GENA	HMO 1	POMPANO BEACH	FL	33073-0000
EE	M	09/15/1963	GENA	HDHP	SUNRISE	FL	33322-0000
EE	F	07/11/1969	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	F	03/05/1977	MGTA	HMO 1	TAMARAC	FL	33321-0000
CH	F	03/27/1990	GENA	HMO 2	LAUDERDALE LAKES	FL	33311-0000
EE	M	08/08/1971	FIRA	HDHP	HOLLYWOOD	FL	33019-0000
SP	F	01/09/1975	FIRA	HDHP	HOLLYWOOD	FL	33019-0000
CH	M	12/28/2010	FIRA	HDHP	HOLLYWOOD	FL	33019-0000
EE	F	07/23/1980	GENA	HMO 2	DEERFIELD BEACH	FL	33443-0000
CH	F	07/17/2012	GENA	HMO 2	DEERFIELD BEACH	FL	33443-0000
CH	M	08/22/1996	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
SP	F	11/04/1974	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
SP	F	12/22/1969	GENA	HDHP	OAKLAND PARK	FL	33311-0000
CH	F	12/29/2004	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	09/11/2007	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	10/10/1956	GENA	HMO 1	LAUDERHILL	FL	33319-0000
EE	F	09/04/1979	MGTA	HMO 1	POMPANO BEACH	FL	33062-0000
SP	M	05/18/1980	MGTA	HMO 1	POMPANO BEACH	FL	33062-0000
CH	M	10/15/2013	MGTA	HMO 1	POMPANO BEACH	FL	33062-0000
EE	F	09/22/1971	GENA	HMO 1	CORAL SPRINGS	FL	33065-0000
EE	F	08/06/1948	PAS65O	HMO 2	CLERMONT	FL	34711-0000
EE	M	04/10/1972	PASA	HMO 1	DEERFIELD BEACH	FL	33441-0000
SP	F	07/20/1976	PASA	HMO 1	DEERFIELD BEACH	FL	33441-0000
CH	M	12/12/2008	PASA	HMO 1	DEERFIELD BEACH	FL	33441-0000
CH	F	12/12/2008	PASA	HMO 1	DEERFIELD BEACH	FL	33441-0000
CH	F	02/20/1999	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	M	05/08/1999	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	07/01/1968	PASA	HDHP	DAVIE	FL	33325-0000
SP	F	09/25/1975	PASA	HDHP	DAVIE	FL	33325-0000
CH	M	03/22/1996	PASA	HDHP	DAVIE	FL	33325-0000

CH	M	01/16/2001	PASA	HDHP	DAVIE	FL	33325-0000
EE	F	09/02/1952	PASA	HMO 1	FORT LAUDERDALE	FL	33308-0000
SP	M	08/13/1951	PASA	HMO 1	FORT LAUDERDALE	FL	33308-0000
EE	F	05/11/1987	GENA	HMO 2	FORT LAUDERDALE	FL	33304-0000
EE	M	09/05/1968	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
SP	F	07/09/1968	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
CH	F	01/08/1999	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
EE	M	11/01/1978	GENA	HMO 1	LAUDERHILL	FL	33313-0000
CH	F	11/10/1998	GENA	HMO 1	LAUDERHILL	FL	33313-0000
CH	F	01/04/2002	GENA	HDHP	LAUDERHILL	FL	33313-0000
EE	F	01/25/1956	MGTA	HDHP	HOLLYWOOD	FL	33021-0000
EE	M	01/21/1971	GENA	HMO 1	NORTH MIAMI BEACH	FL	33162-0000
SP	F	03/27/1973	GENA	HMO 1	NORTH MIAMI BEACH	FL	33162-0000
CH	M	07/24/2013	GENA	HMO 1	NORTH MIAMI BEACH	FL	33162-0000
EE	M	02/05/1968	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
SP	F	12/31/1973	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	10/13/1998	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	07/23/2000	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	09/14/2006	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	M	01/24/2013	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	09/10/2014	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	12/08/1977	PASA	HMO 1	MIAMI	FL	33186-0000
EE	M	07/04/1983	GENA	HDHP	MARGATE	FL	33063-0000
EE	M	07/11/1973	FIRA	HDHP	CORAL SPRINGS	FL	33065-0000
SP	F	11/21/1976	FIRA	HDHP	CORAL SPRINGS	FL	33065-0000
EE	F	03/18/1968	GENA	HMO 1	COCONUT CREEK	FL	33066-0000
CH	F	06/20/1996	GENA	HMO 1	COCONUT CREEK	FL	33066-0000
EE	M	05/09/1973	FIRA	HDHP	DAVIE	FL	33328-0000
CH	M	08/05/2006	FIRA	HDHP	DAVIE	FL	33328-0000
CH	F	11/04/2010	FIRA	HDHP	DAVIE	FL	33328-0000
EE	F	09/25/1968	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	05/22/1963	MGTA	HDHP	POMPANO BEACH	FL	33060-0000
SP	F	06/13/1957	MGTA	HDHP	POMPANO BEACH	FL	33060-0000
CH	M	07/30/1994	MGTA	HDHP	POMPANO BEACH	FL	33060-0000
EE	F	03/25/1963	FIRA	HDHP	FORT LAUDERDALE	FL	33304-0000
EE	F	03/31/1972	PASA	HMO 1	COOPER CITY	FL	33328-0000
CH	F	04/24/2015	PASA	HMO 1	COOPER CITY	FL	33328-0000
CH	M	05/22/2015	PASA	HMO 1	COOPER CITY	FL	33328-0000
EE	M	06/30/1962	FIRA	HDHP	COCONUT CREEK	FL	33066-0000
SP	F	03/09/1958	FIRA	HDHP	COCONUT CREEK	FL	33066-0000
CH	M	11/24/1995	FIRA	HDHP	COCONUT CREEK	FL	33066-0000
EE	M	07/09/1964	GENA	HMO 1	NORTH MIAMI BEACH	FL	33162-0000
SP	F	05/23/1952	GENA	HMO 1	NORTH MIAMI BEACH	FL	33162-0000

EE	M	06/30/1965	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
SP	F	02/13/1955	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
CH	M	03/08/1994	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
CH	M	02/01/1996	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
EE	M	06/22/1964	GENA	HMO 1	COCONUT CREEK	FL	33063-0000
SP	F	07/21/1968	GENA	HMO 1	COCONUT CREEK	FL	33063-0000
CH	M	05/16/1995	GENA	HMO 1	HIGH SPRINGS	FL	32643-0000
CH	F	08/23/2015	GENA	HMO 1	COCONUT CREEK	FL	33063-0000
EE	M	06/16/1963	PASA	HDHP	COOPER CITY	FL	33328-0000
SP	F	03/01/1962	PASA	HDHP	COOPER CITY	FL	33328-0000
CH	F	05/11/1990	PASA	HDHP	COOPER CITY	FL	33328-0000
CH	F	01/17/1994	PASA	HDHP	COOPER CITY	FL	33328-0000
SP	F	12/15/1989	GENA	HMO 1	OAKLAND PARK	FL	33309-0000
SP	M	10/20/1966	PASA	HMO 1	FORT LAUDERDALE	FL	33305-0000
EE	F	11/25/1963	PASA	HMO 1	PARKLAND	FL	33067-0000
SP	M	04/13/1970	PASA	HMO 1	PARKLAND	FL	33067-0000
CH	M	05/10/1994	PASA	HMO 1	PARKLAND	FL	33067-0000
EE	M	03/24/1959	GENA	HMO 1	PLANTATION	FL	33322-0000
SP	F	09/25/1961	GENA	HMO 1	PLANTATION	FL	33322-0000
EE	M	01/25/1985	GENA	HDHP	SUNRISE	FL	33351-0000
EE	M	11/13/1961	GENA	HMO 1	PEMBROKE PINES	FL	33023-0000
EE	F	09/06/1953	MGTU65	HMO 1	PENSACOLA	FL	32514-0000
SP	F	11/01/1975	PASA	HDHP	WILTON MANORS	FL	33334-0000
SP	F	01/06/1957	GENA	HDHP	SUNRISE	FL	33351-0000
EE	M	07/22/1957	GENA	HMO 1	FORT LAUDERDALE	FL	33334-0000
EE	M	05/15/1966	MGTA	HMO 1	FORT LAUDERDALE	FL	33309-0000
SP	F	04/09/1964	MGTA	HMO 1	FORT LAUDERDALE	FL	33309-0000
EE	F	12/21/1965	PASA	HMO 1	SUNRISE	FL	33326-0000
EE	M	03/23/1971	FIRA	HDHP	COCONUT CREEK	FL	33073-0000
SP	F	12/24/1956	FIRA	HDHP	COCONUT CREEK	FL	33073-0000
EE	M	12/22/1984	GENA	HMO 1	WEST PALM BEACH	FL	33411-0000
CH	M	03/07/2011	GENA	HMO 1	WEST PALM BEACH	FL	33411-0000
EE	M	12/02/1972	GENA	HMO 1	LAUDERDALE LAKES	FL	33301-0000
CH	M	12/05/1998	GENA	HMO 1	LAUDERDALE LAKES	FL	33301-0000
CH	F	03/21/2002	GENA	HMO 1	LAUDERDALE LAKES	FL	33301-0000
EE	M	09/19/1963	PASA	HMO 1	POMPANO BEACH	FL	33062-0000
EE	M	03/25/1963	PASA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	09/10/1963	GENA	HDHP	COCONUT CREEK	FL	33066-0000
CH	M	05/26/1993	GENA	HDHP	COCONUT CREEK	FL	33066-0000
CH	M	10/29/1998	GENA	HDHP	COCONUT CREEK	FL	33066-0000
EE	F	07/19/1972	MGTA	HMO 1	MIRAMAR	FL	33025-0000
EE	M	07/26/1964	GENA	HMO 2	HOLLYWOOD	FL	33021-0000
EE	M	10/06/1979	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000

SP	F	02/09/1982	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	01/29/1976	GENA	HMO 1	TAMARAC	FL	33321-0000
SP	F	01/31/1977	GENA	HMO 1	TAMARAC	FL	33321-0000
EE	M	06/03/1951	GENA	HMO 2	BOCA RATON	FL	33498-0000
SP	F	10/17/1954	GENA	HMO 2	BOCA RATON	FL	33498-0000
EE	F	07/21/1961	GENA	HDHP	FORT LAUDERDALE	FL	33304-0000
SP	F	10/26/1962	GENA	HMO 2	FORT LAUDERDALE	FL	33308-0000
EE	M	09/04/1975	GENA	HDHP	MARGATE	FL	33063-0000
EE	M	01/09/1966	PASA	HDHP	SUNNY ISLES BEACH	FL	33160-0000
EE	M	05/01/1960	GENA	HMO 1	FORT LAUDERDALE	FL	33304-0000
EE	M	03/25/1992	FIRA	HDHP	PEMBROKE PINES	FL	33023-0000
EE	M	08/31/1991	MGTA	HDHP	MIAMI	FL	33144-0000
EE	F	10/20/1972	GENA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	M	12/09/1983	FIRA	HMO 2	PEMBROKE PINES	FL	33029-0000
EE	F	01/18/1950	CONA	HMO 2	FORT LAUDERDALE	FL	33312-0000
EE	M	02/18/1961	FIRA	HDHP	MARGATE	FL	33063-0000
SP	F	12/15/1960	FIRA	HDHP	MARGATE	FL	33063-0000
EE	M	05/14/1953	MGTA	HMO 1	FORT LAUDERDALE	FL	33301-0000
SP	F	08/13/1954	MGTA	HMO 1	FORT LAUDERDALE	FL	33301-0000
EE	M	12/11/1975	PASA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	07/31/1988	FIRA	HMO 2	MARGATE	FL	33063-0000
EE	M	08/18/1965	GENA	HDHP	DAVIE	FL	33325-0000
CH	M	01/09/1996	GENA	HDHP	DAVIE	FL	33325-0000
CH	M	10/03/1993	GENA	HDHP	DAVIE	FL	33325-0000
EE	M	02/16/1973	GENA	HMO 1	OPA LOCKA	FL	33055-0000
EE	M	05/13/1977	GENA	HMO 2	HOLLYWOOD	FL	33023-0000
EE	M	03/26/1959	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
EE	F	07/26/1956	GENA	HMO 1	CORAL SPRINGS	FL	33067-0000
EE	F	09/14/1977	MGTA	HMO 1	MIAMI BEACH	FL	33139-0000
EE	F	07/23/1983	GENA	HDHP	SUNRISE	FL	33322-0000
EE	F	09/01/1964	GENA	HMO 1	PLANTATION	FL	33317-0000
SP	M	04/15/1958	GENA	HMO 1	PLANTATION	FL	33317-0000
CH	M	12/10/1991	GENA	HMO 1	PLANTATION	FL	33317-0000
EE	F	05/27/1968	MGTA	HDHP	PLANTATION	FL	33322-0000
EE	M	04/08/1960	GENA	HDHP	HOLLYWOOD	FL	33024-0000
SP	F	06/24/1958	GENA	HDHP	HOLLYWOOD	FL	33024-0000
CH	F	09/25/1990	GENA	HDHP	HOLLYWOOD	FL	33024-0000
EE	F	12/20/1988	MGTA	HMO 1	LIGHTHOUSE POINT	FL	33064-0000
EE	M	01/28/1954	GENA	HMO 2	OAKLAND PARK	FL	33309-0000
SP	F	02/25/1955	GENA	HMO 2	OAKLAND PARK	FL	33309-0000
EE	F	11/15/1977	FIRA	HMO 2	POMPANO BEACH	FL	33060-0000
EE	M	12/09/1951	GENA	HMO 1	PEMBROKE PINES	FL	33029-0000
EE	M	05/31/1967	GENA	HMO 1	RIVIERA BEACH	FL	33404-0000

EE	M	03/14/1975	FIRA	HMO 1	JUPITER	FL	33478-0000
SP	F	04/03/1978	FIRA	HMO 1	JUPITER	FL	33478-0000
CH	M	08/17/2006	FIRA	HMO 1	JUPITER	FL	33478-0000
CH	F	02/19/2010	FIRA	HMO 1	JUPITER	FL	33478-0000
EE	M	02/26/1974	FIRA	HMO 1	PARKLAND	FL	33076-0000
EE	M	04/19/1943	GENA	HMO 1	MARGATE	FL	33068-0000
SP	F	12/16/1951	GENA	HMO 1	MARGATE	FL	33068-0000
EE	M	11/07/1964	GENA	HMO 1	PEMBROKE PINES	FL	33028-0000
EE	M	04/21/1958	PASA	HMO 1	CORAL SPRINGS	FL	33071-0000
SP	F	10/22/1956	PASA	HMO 1	CORAL SPRINGS	FL	33071-0000
EE	M	10/26/1961	PASA	HMO 1	WEST PALM BEACH	FL	33405-0000
SP	F	02/01/1957	PASA	HMO 1	WEST PALM BEACH	FL	33405-0000
EE	M	11/23/1964	PASA	HDHP	DEERFIELD	FL	33442-0000
SP	F	07/16/1975	PASA	HDHP	DEERFIELD	FL	33442-0000
CH	F	11/10/2015	PASA	HDHP	DEERFIELD	FL	33442-0000
EE	M	06/07/1972	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	06/30/1996	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	06/30/1996	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	F	10/14/1951	CONU65	HMO 1	OAKLAND PARK	FL	33334-0000
EE	M	11/28/1967	MGTA	HDHP	COCONUT CREEK	FL	33073-0000
SP	F	01/22/1971	MGTA	HDHP	COCONUT CREEK	FL	33073-0000
CH	M	02/19/1998	MGTA	HDHP	COCONUT CREEK	FL	33073-0000
CH	F	10/31/1999	MGTA	HDHP	COCONUT CREEK	FL	33073-0000
EE	M	05/30/1985	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	06/23/2004	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	03/22/2010	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	03/13/1952	GENA	HDHP	WESTON	FL	33326-0000
CH	M	12/19/1991	GENA	HDHP	WESTON	FL	33326-0000
CH	F	11/13/1997	GENA	HDHP	WESTON	FL	33326-0000
EE	F	09/01/1957	GENU65	HMO 1	MARGATE	FL	33063-0000
SP	M	02/03/1955	GENU65	HMO 1	MARGATE	FL	33063-0000
EE	M	06/30/1966	FIRA	HMO 1	MARGATE	FL	33063-0000
SP	F	08/23/1968	FIRA	HMO 1	MARGATE	FL	33063-0000
CH	M	07/12/1994	FIRA	HMO 1	MARGATE	FL	33063-0000
CH	F	09/10/1996	FIRA	HMO 1	BOSTON	MA	02115-0000
EE	M	12/09/1974	FIRA	HDHP	WELLINGTON	FL	33414-0000
SP	F	02/17/1980	FIRA	HDHP	WELLINGTON	FL	33414-0000
CH	M	04/22/2004	FIRA	HDHP	WELLINGTON	FL	33414-0000
CH	F	05/02/2000	FIRA	HDHP	WELLINGTON	FL	33414-0000
EE	M	03/02/1978	FIRA	HMO 1	SUNRISE	FL	33351-0000
CH	M	04/28/2012	FIRA	HMO 1	SUNRISE	FL	33351-0000
EE	M	03/18/1973	FIRA	HDHP	LOXAHATCHEE	FL	33470-0000
SP	F	02/23/1973	FIRA	HDHP	LOXAHATCHEE	FL	33470-0000

CH	M	06/27/1995	FIRA	HDHP	LOXAHATCHEE	FL	33470-0000
CH	F	09/02/2005	FIRA	HDHP	LOXAHATCHEE	FL	33470-0000
CH	F	09/02/2005	FIRA	HDHP	LOXAHATCHEE	FL	33470-0000
EE	M	01/31/1965	GENA	HDHP	HOLLYWOOD	FL	33021-0000
EE	M	06/16/1968	MGTA	HDHP	FORT LAUDERDALE	FL	33315-0000
SP	F	01/22/1966	MGTA	HDHP	FORT LAUDERDALE	FL	33315-0000
CH	F	02/11/1995	MGTA	HDHP	FORT LAUDERDALE	FL	33315-0000
CH	F	07/12/1996	MGTA	HDHP	FORT LAUDERDALE	FL	33315-0000
EE	M	12/03/1982	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	F	12/19/1979	GENA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	11/07/1955	GENA	HMO 2	PEMBROKE PINES	FL	33025-0000
CH	M	12/21/1992	GENA	HMO 1	LAUDERHILL	FL	33311-0000
EE	M	12/29/1969	GENA	HMO 1	HALLANDALE BEACH	FL	33009-0000
EE	F	10/23/1978	MGTA	HMO 1	POMPANO BEACH	FL	33069-0000
EE	M	07/25/1954	GENA	HMO 1	SUNRISE	FL	33323-0000
SP	F	05/30/1956	GENA	HMO 1	SUNRISE	FL	33323-0000
EE	M	03/14/1981	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
EE	F	12/07/1982	GENA	HMO 1	LAUDERHILL	FL	33313-0000
EE	M	09/29/1966	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
CH	F	03/15/2000	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
CH	M	08/31/1995	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
CH	M	03/30/1994	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
CH	M	02/12/1997	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	M	09/16/1963	GENA	HDHP	DEERFIELD BEACH	FL	33442-0000
EE	M	01/26/1961	GENA	HDHP	SUNRISE	FL	33351-0000
SP	F	02/23/1963	GENA	HDHP	SUNRISE	FL	33351-0000
CH	M	08/27/1992	GENA	HDHP	SUNRISE	FL	33351-0000
EE	M	01/20/1964	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
SP	M	01/28/1989	PASA	HMO 1	OAKLAND PARK	FL	33334-0000
EE	M	04/14/1974	GENA	HDHP	OAKLAND PARK	FL	33309-0000
EE	M	01/10/1977	FIRA	HDHP	BOCA RATON	FL	33486-0000
SP	F	08/11/1977	FIRA	HDHP	BOCA RATON	FL	33486-0000
CH	F	07/14/2007	FIRA	HDHP	BOCA RATON	FL	33486-0000
CH	F	11/10/2010	FIRA	HDHP	BOCA RATON	FL	33486-0000
CH	M	08/23/2012	FIRA	HDHP	BOCA RATON	FL	33486-0000
EE	F	07/08/1970	GENA	HDHP	DEERFIELD BEACH	FL	33441-0000
CH	M	07/03/1997	GENA	HDHP	DEERFIELD BEACH	FL	33441-0000
CH	M	11/16/2001	GENA	HDHP	DEERFIELD BEACH	FL	33441-0000
CH	F	07/27/2004	GENA	HDHP	DEERFIELD BEACH	FL	33441-0000
EE	F	05/27/1954	MGTA	HDHP	MARGATE	FL	33063-0000
EE	M	07/05/1946	GENA	HMO 1	FORT LAUDERDALE	FL	33317-0000
SP	F	02/09/1955	GENA	HMO 1	FORT LAUDERDALE	FL	33317-0000
EE	M	07/26/1975	MGTA	HDHP	FORT LAUDERDALE	FL	33315-0000

SP	F	07/20/1977	MGTA	HDHP	FORT LAUDERDALE	FL	33315-0000
CH	M	07/09/2006	MGTA	HDHP	FORT LAUDERDALE	FL	33315-0000
EE	M	07/23/1991	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	03/06/1955	GENA	HMO 1	MARGATE	FL	33063-0000
EE	M	06/22/1969	FIRA	HDHP	FORT LAUDERDALE	FL	33334-0000
SP	F	06/28/1969	FIRA	HDHP	FORT LAUDERDALE	FL	33334-0000
CH	F	02/16/1996	FIRA	HDHP	FORT LAUDERDALE	FL	33334-0000
EE	F	06/12/1975	GENA	HMO 1	PEMBROKE PINES	FL	33026-0000
EE	F	02/13/1964	FIRA	HDHP	DAVIE	FL	33324-0000
EE	M	04/02/1958	GENA	HMO 1	LAUDERHILL	FL	33351-0000
EE	M	06/04/1960	GENA	HMO 2	FORT LAUDERDALE	FL	33335-0000
EE	F	02/21/1987	MGTA	HDHP	DEERFIELD BEACH	FL	33442-0000
EE	M	01/06/1964	GENA	HMO 1	TAMARAC	FL	33309-0000
SP	F	05/07/1982	GENA	HMO 1	TAMARAC	FL	33309-0000
CH	F	09/20/2007	GENA	HMO 1	TAMARAC	FL	33309-0000
CH	M	03/31/1994	GENA	HMO 1	TAMARAC	FL	33309-0000
CH	M	06/01/1992	GENA	HMO 1	TAMARAC	FL	33309-0000
EE	M	12/18/1972	FIRA	HDHP	BOCA RATON	FL	33432-0000
SP	F	09/04/1971	FIRA	HDHP	BOCA RATON	FL	33432-0000
CH	F	08/30/2006	FIRA	HDHP	BOCA RATON	FL	33432-0000
CH	F	08/25/2010	FIRA	HDHP	BOCA RATON	FL	33432-0000
EE	M	11/02/1965	FIRA	HDHP	PALM CITY	FL	34990-0000
SP	F	06/16/1959	FIRA	HDHP	PALM CITY	FL	34990-0000
CH	F	04/06/1996	FIRA	HDHP	PALM CITY	FL	34990-0000
CH	F	01/25/2001	FIRA	HDHP	PALM CITY	FL	34990-0000
EE	M	09/23/1970	FIRA	HDHP	DAVIE	FL	33325-0000
SP	F	03/12/1971	FIRA	HDHP	DAVIE	FL	33325-0000
CH	M	11/15/2006	FIRA	HDHP	DAVIE	FL	33325-0000
CH	M	03/12/2002	FIRA	HDHP	DAVIE	FL	33325-0000
EE	M	03/22/1988	FIRA	HDHP	POMPANO BEACH	FL	33060-0000
EE	M	12/05/1982	MGTA	HDHP	FORT LAUDERDALE	FL	33304-0000
EE	M	03/30/1955	GENA	HDHP	FORT LAUDERDALE	FL	33315-0000
SP	F	01/23/1947	GENA	HDHP	FORT LAUDERDALE	FL	33315-0000
EE	M	01/16/1958	MGTU65	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	F	01/09/1964	GENA	HMO 1	SUNRISE	FL	33322-0000
CH	F	05/10/1994	MGTA	HMO 1	DAVIE	FL	33328-0000
CH	F	11/09/1990	MGTA	HMO 1	DAVIE	FL	33328-0000
EE	F	10/02/1955	MGTA	HMO 1	DAVIE	FL	33328-0000
SP	F	05/20/1973	GENA	HMO 1	OPA LOCKA	FL	33055-0000
EE	M	11/02/1953	FIRA	HMO 1	FORT LAUDERDALE	FL	33308-0000
EE	M	12/27/1979	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
SP	F	07/16/1978	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
CH	F	04/13/2003	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000

CH	M	05/22/2006	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
CH	M	09/28/2007	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
CH	F	02/04/2002	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
EE	M	07/18/1975	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	M	11/14/2000	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	05/13/1965	FIRA	HDHP	WEST PALM BEACH	FL	33412-0000
SP	F	12/12/1960	FIRA	HDHP	WEST PALM BEACH	FL	33412-0000
CH	M	09/20/1995	FIRA	HDHP	WEST PALM BEACH	FL	33412-0000
CH	F	08/22/1997	FIRA	HDHP	WEST PALM BEACH	FL	33412-0000
EE	M	06/28/1951	PASA	HMO 1	FORT LAUDERDALE	FL	33315-0000
SP	F	05/11/2015	PASA	HMO 1	FORT LAUDERDALE	FL	33315-0000
CH	F	05/11/2015	PASA	HMO 1	FORT LAUDERDALE	FL	33315-0000
EE	M	04/27/1964	GENA	HMO 1	FORT LAUDERDALE	FL	33309-0000
CH	F	02/18/1998	GENA	HMO 1	FORT LAUDERDALE	FL	33309-0000
EE	M	04/28/1961	PASA	HMO 1	COCONUT CREEK	FL	33066-0000
CH	M	05/31/2000	PASA	HMO 1	COCONUT CREEK	FL	33066-0000
EE	M	03/12/1962	GENA	HMO 2	DEERFIELD BEACH	FL	33441-0000
SP	F	01/16/1966	GENA	HMO 2	DEERFIELD BEACH	FL	33441-0000
CH	M	09/29/2003	GENA	HMO 2	DEERFIELD BEACH	FL	33441-0000
CH	F	06/20/1995	GENA	HMO 2	DEERFIELD BEACH	FL	33441-0000
CH	F	01/29/1999	GENA	HMO 2	DEERFIELD BEACH	FL	33441-0000
EE	M	02/08/1965	FIRA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	M	05/27/1978	PASA	HDHP	DAVIE	FL	33325-0000
SP	F	03/24/1989	PASA	HDHP	DAVIE	FL	33325-0000
CH	F	05/21/2011	PASA	HDHP	DAVIE	FL	33325-0000
EE	M	03/10/1970	GENA	HDHP	COCONUT CREEK	FL	33063-0000
EE	M	07/12/1963	GENA	HMO 1	OAKLAND PARK	FL	33334-0000
EE	M	04/22/1970	FIRA	HDHP	PEMBROKE PINES	FL	33028-0000
EE	M	06/17/1977	PASA	HMO 1	WILTON MANORS	FL	33305-0000
EE	F	02/08/1965	CONA	HDHP	TAMARAC	FL	33321-0000
EE	F	11/25/1963	GENA	HDHP	LAUDERHILL	FL	33319-0000
CH	F	12/01/1992	GENA	HDHP	LAUDERHILL	FL	33319-0000
CH	F	05/14/1997	GENA	HDHP	LAUDERHILL	FL	33319-0000
EE	F	07/18/1989	CONA	HMO 2	LAUDERHILL	FL	33313-0000
SP	M	12/17/1961	CONA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	M	12/14/1987	GENA	HDHP	HOLLYWOOD	FL	33020-0000
EE	M	03/06/1977	MGTA	HDHP	BOYNTON BEACH	FL	33472-0000
SP	F	11/05/1982	MGTA	HDHP	BOYNTON BEACH	FL	33472-0000
CH	M	04/21/2013	MGTA	HDHP	BOYNTON BEACH	FL	33472-0000
EE	M	05/10/1956	GENA	HMO 1	LIGHTHOUSE POINT	FL	33064-0000
SP	F	05/29/1954	GENA	HMO 1	LIGHTHOUSE POINT	FL	33064-0000
EE	M	05/12/1981	FIRA	HDHP	DEERFIELD BCH	FL	33442-0000
EE	M	05/12/1944	GENA	HMO 1	FORT LAUDERDALE	FL	33308-0000

SP	F	06/07/1954	GENA	HMO 1	FORT LAUDERDALE	FL	33308-0000
CH	M	04/16/1997	GENA	HMO 1	FORT LAUDERDALE	FL	33308-0000
EE	F	12/11/1981	PASA	HMO 1	LAUDERHILL	FL	33351-0000
SP	M	08/21/1980	PASA	HMO 1	LAUDERHILL	FL	33351-0000
CH	F	08/28/2006	PASA	HMO 1	LAUDERHILL	FL	33351-0000
CH	F	09/04/2010	PASA	HMO 1	LAUDERHILL	FL	33351-0000
CH	F	01/24/2012	PASA	HMO 1	LAUDERHILL	FL	33351-0000
CH	M	04/19/2004	MGTA	HMO 1	CORAL SPRINGS	FL	33071-0000
EE	M	12/16/1936	GENA	HMO 1	LAUDERHILL	FL	33319-0000
EE	F	04/22/1961	MGTA	HMO 2	HOLLYWOOD	FL	33020-0000
EE	M	10/01/1963	GENA	HDHP	BOCA RATON	FL	33432-0000
SP	F	02/09/1971	GENA	HDHP	BOCA RATON	FL	33432-0000
CH	F	08/16/2011	GENA	HDHP	BOCA RATON	FL	33432-0000
CH	F	03/24/1998	GENA	HDHP	BOCA RATON	FL	33432-0000
CH	M	04/08/1996	GENA	HDHP	BOCA RATON	FL	33432-0000
EE	M	01/18/1972	FIRA	HDHP	FORT LAUDERDALE	FL	33308-0000
SP	F	10/04/1975	FIRA	HDHP	FORT LAUDERDALE	FL	33308-0000
CH	F	12/21/2005	FIRA	HDHP	FORT LAUDERDALE	FL	33308-0000
CH	M	08/06/2004	FIRA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	M	12/02/1952	FIRU65	HMO 1	PLANTATION	FL	33317-0000
SP	F	09/21/1954	FIRU65	HMO 1	PLANTATION	FL	33317-0000
EE	M	11/16/1980	FIRA	HDHP	MIAMI GARDENS	FL	33169-0000
CH	M	05/18/2003	FIRA	HDHP	MIAMI GARDENS	FL	33169-0000
CH	F	08/07/2008	FIRA	HDHP	MIAMI GARDENS	FL	33169-0000
EE	F	04/03/1962	FIRA	HDHP	DAVIE	FL	33325-0000
EE	F	12/02/1968	PASA	HMO 1	PEMBROKE PINES	FL	33028-0000
EE	M	12/17/1974	FIRA	HMO 1	STUART	FL	34997-0000
EE	F	08/22/1957	PASA	HMO 1	OAKLAND PARK	FL	33334-0000
EE	M	04/14/1982	PASA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	05/13/1980	PASA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	10/02/2007	PASA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	01/21/2010	PASA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	06/24/2011	PASA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	08/02/2013	PASA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	10/17/2015	PASA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	12/24/1982	GENA	HMO 1	POMPANO BEACH	FL	33060-0000
SP	F	09/05/1988	GENA	HMO 1	POMPANO BEACH	FL	33060-0000
SP	F	03/28/1954	PASA	HDHP	POMPANO BEACH	FL	33060-0000
EE	M	05/17/1984	GENA	HMO 1	MIRAMAR	FL	33025-0000
SP	M	03/25/1977	MGTA	HMO 1	LAUDERHILL	FL	33319-0000
SP	F	11/11/1980	GENA	HMO 1	MIRAMAR	FL	33025-0000
EE	F	12/10/1953	CONA	HDHP	HOLLYWOOD	FL	33021-0000
EE	M	12/24/1974	FIRA	HMO 1	CORAL SPRINGS	FL	33076-0000

EE	M	02/06/1954	GENA	HDHP	CORAL SPRINGS	FL	33071-0000
SP	F	12/31/1954	GENA	HDHP	CORAL SPRINGS	FL	33071-0000
SP	M	11/30/1958	GENA	HDHP	COCONUT CREEK	FL	33073-0000
EE	M	05/24/1950	MGTA	HDHP	FORT LAUDERDALE	FL	33315-0000
SP	F	01/31/1952	MGTA	HDHP	FORT LAUDERDALE	FL	33315-0000
EE	M	04/15/1977	FIRA	HDHP	PALM CITY	FL	34990-0000
SP	F	07/31/1975	FIRA	HDHP	PALM CITY	FL	34990-0000
CH	F	10/04/2004	FIRA	HDHP	PALM CITY	FL	34990-0000
CH	F	12/23/2007	FIRA	HDHP	PALM CITY	FL	34990-0000
EE	M	08/08/1976	FIRA	HMO 2	MARGATE	FL	33063-0000
SP	F	06/09/1977	FIRA	HMO 2	MARGATE	FL	33063-0000
CH	F	10/06/2000	FIRA	HMO 2	MARGATE	FL	33063-0000
CH	F	07/26/2003	FIRA	HMO 2	MARGATE	FL	33063-0000
EE	F	07/13/1979	GENA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	M	11/10/1978	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
SP	F	10/31/1981	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	02/11/2006	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	04/28/1987	FIRA	HDHP	SUNRISE	FL	33323-0000
EE	F	10/17/1962	MGTA	HMO 1	WESTON	FL	33311-0000
CH	F	08/14/1994	GENA	HMO 1	DAVIE	FL	33325-0000
SP	F	02/05/1964	GENA	HMO 1	DAVIE	FL	33325-0000
SP	F	05/13/1966	PASA	HMO 1	CORAL SPRINGS	FL	33076-0000
EE	M	09/01/1985	GENA	HDHP	POMPANO BEACH	FL	33069-0000
SP	F	01/26/1986	GENA	HDHP	POMPANO BEACH	FL	33069-0000
EE	F	12/28/1973	MGTA	HMO 2	BOCA RATON	FL	33432-0000
EE	M	01/26/1953	PASU65	HMO 1	WILTON MANORS	FL	33305-0000
EE	M	04/24/1990	GENA	HDHP	OAKLAND PARK	FL	33334-0000
EE	M	01/21/1963	PASA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	M	11/10/1984	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
SP	F	05/26/1992	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
CH	M	10/28/2014	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
EE	M	08/10/1952	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	12/06/1996	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	11/11/1960	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
SP	M	11/11/1960	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
EE	M	05/22/1963	FIRU65	HMO 1	CUTLER BAY	FL	33189-0000
SP	F	10/27/1971	FIRU65	HMO 1	CUTLER BAY	FL	33189-0000
CH	F	01/21/1997	FIRU65	HMO 1	CUTLER BAY	FL	33189-0000
CH	M	06/08/2005	FIRU65	HMO 1	CUTLER BAY	FL	33189-0000
CH	M	11/02/1998	FIRU65	HMO 1	CUTLER BAY	FL	33189-0000
EE	M	09/04/1968	GENA	HMO 1	LAUDERHILL	FL	33314-0000
SP	F	08/04/1966	GENA	HMO 1	LAUDERHILL	FL	33314-0000
EE	M	09/23/1966	PASA	HDHP	WILTON MANORS	FL	33334-0000

CH	F	10/24/1991	PASA	HDHP	WILTON MANORS	FL	33334-0000
CH	M	02/25/2014	PASA	HDHP	WILTON MANORS	FL	33334-0000
EE	M	02/11/1980	GENA	HDHP	POMPANO BEACH	FL	33064-0000
SP	F	01/29/1980	GENA	HDHP	POMPANO BEACH	FL	33064-0000
CH	F	08/07/2004	GENA	HDHP	POMPANO BEACH	FL	33064-0000
EE	F	10/22/1959	GENA	HDHP	OAKLAND PARK	FL	33309-0000
SP	F	05/10/1951	MGTA	HMO 1	HOLLYWOOD	FL	33021-0000
EE	M	10/30/1981	GENA	HMO 1	MARGATE	FL	33063-0000
CH	F	03/29/2012	GENA	HMO 1	MARGATE	FL	33063-0000
EE	F	11/01/1975	GENA	HMO 2	CORAL SPRINGS	FL	33067-0000
EE	M	08/29/1968	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	07/25/2005	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	07/25/2008	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	08/13/2000	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	10/08/1971	FIRA	HDHP	NORTH LAUDERDALE	FL	33068-0000
EE	M	09/05/1971	FIRA	HDHP	PLANTATION	FL	33323-0000
SP	F	11/22/1985	FIRA	HDHP	PLANTATION	FL	33323-0000
SP	F	12/30/1990	GENA	HDHP	CORAL SPRINGS	FL	33067-0000
EE	F	03/17/1975	MGTA	HMO 1	LAUDERDALE LAKES	FL	33309-0000
EE	M	09/27/1980	FIRA	HDHP	MIAMI GARDENS	FL	33056-0000
CH	F	01/08/2011	FIRA	HDHP	MIAMI GARDENS	FL	33056-0000
CH	F	10/12/2007	FIRA	HDHP	MIAMI GARDENS	FL	33056-0000
CH	F	06/18/2009	FIRA	HDHP	MIAMI GARDENS	FL	33056-0000
CH	F	11/05/2012	FIRA	HDHP	MIAMI GARDENS	FL	33056-0000
CH	F	10/28/2014	FIRA	HDHP	MIAMI GARDENS	FL	33056-0000
EE	M	12/17/1971	GENA	HDHP	HOLLYWOOD	FL	33021-0000
SP	F	04/07/1968	GENA	HDHP	HOLLYWOOD	FL	33021-0000
CH	F	06/03/2006	GENA	HDHP	HOLLYWOOD	FL	33021-0000
CH	F	11/19/2007	GENA	HDHP	HOLLYWOOD	FL	33021-0000
EE	M	06/16/1988	MGTA	HMO 1	DEERFIELD BEACH	FL	33441-0000
SP	F	12/17/1986	MGTA	HMO 1	DEERFIELD BEACH	FL	33441-0000
CH	F	12/17/2011	MGTA	HMO 1	DEERFIELD BEACH	FL	33441-0000
CH	F	11/21/2014	MGTA	HMO 1	DEERFIELD BEACH	FL	33441-0000
EE	M	07/23/1975	FIRA	HDHP	JUPITER	FL	33478-0000
SP	F	09/22/1978	FIRA	HDHP	JUPITER	FL	33478-0000
CH	M	07/24/2004	FIRA	HDHP	JUPITER	FL	33478-0000
CH	M	02/29/2012	FIRA	HDHP	JUPITER	FL	33478-0000
EE	F	10/16/1973	MGTA	HDHP	JUPITER	FL	33478-0000
EE	M	07/23/1965	FIRA	HMO 1	PORT ST LUCIE	FL	34952-0000
CH	F	05/21/1992	FIRA	HMO 1	PORT ST LUCIE	FL	34952-0000
CH	M	08/30/1994	FIRA	HMO 1	PORT ST LUCIE	FL	34952-0000
EE	M	12/10/1986	PASA	HDHP	FORT LAUDERDALE	FL	33315-0000
EE	M	06/07/1988	PASA	HMO 1	CORAL SPRINGS	FL	33071-0000

EE	M	02/26/1951	GENA	HMO 1	POMPANO BEACH	FL	33069-0000
CH	M	06/04/2007	FIRA	HMO 2	MIAMI	FL	33178-0000
EE	M	05/31/1982	MGTA	HMO 1	HOLLYWOOD	FL	33021-0000
SP	F	05/13/1979	MGTA	HMO 1	HOLLYWOOD	FL	33021-0000
CH	M	12/16/2011	MGTA	HMO 1	HOLLYWOOD	FL	33021-0000
CH	F	11/18/2013	MGTA	HMO 1	HOLLYWOOD	FL	33021-0000
EE	F	12/28/1957	MGTA	HDHP	WEST PALM BEACH	FL	33409-0000
EE	M	03/16/1958	GENA	HDHP	MIAMI	FL	33169-0000
EE	M	05/10/1959	GENA	HDHP	FORT LAUDERDALE	FL	33306-0000
EE	F	07/14/1980	CONA	HDHP	CORAL SPRINGS	FL	33067-0000
EE	M	03/04/1968	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
SP	F	02/22/1975	GENA	HMO 1	FORT LAUDERDALE	FL	33315-0000
EE	M	04/06/1988	FIRA	HDHP	MIRAMAR	FL	33029-0000
EE	F	12/01/1979	FIRA	HMO 1	GREENACRES	FL	33413-0000
CH	M	08/18/1997	FIRA	HMO 1	GREENACRES	FL	33413-0000
CH	F	05/11/2001	FIRA	HMO 1	GREENACRES	FL	33413-0000
CH	F	06/24/2009	FIRA	HMO 1	GREENACRES	FL	33413-0000
EE	M	09/27/1977	FIRA	HDHP	PEMBROKE PINES	FL	33028-0000
EE	M	10/07/1967	PASA	HMO 1	FORT LAUDERDALE	FL	33305-0000
EE	M	06/22/1964	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	F	03/13/1997	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	02/27/1970	FIRA	HDHP	LAKE WORTH	FL	33467-0000
SP	F	01/11/1962	FIRA	HDHP	LAKE WORTH	FL	33467-0000
CH	F	07/04/1997	FIRA	HDHP	LAKE WORTH	FL	33467-0000
CH	F	03/17/1999	FIRA	HDHP	LAKE WORTH	FL	33467-0000
EE	M	05/21/1970	FIRA	HDHP	FORT LAUDERDALE	FL	33309-0000
SP	F	07/27/1979	FIRA	HDHP	FORT LAUDERDALE	FL	33309-0000
CH	M	12/11/2011	FIRA	HDHP	FORT LAUDERDALE	FL	33309-0000
EE	F	09/06/1971	MGTA	HMO 1	CORAL SPRINGS	FL	33067-0000
EE	M	01/30/1976	MGTA	HMO 1	TAMARAC	FL	33321-0000
SP	F	07/14/1979	MGTA	HMO 1	TAMARAC	FL	33321-0000
CH	M	08/07/2011	MGTA	HMO 1	TAMARAC	FL	33321-0000
CH	F	11/08/2006	MGTA	HMO 1	TAMARAC	FL	33321-0000
EE	M	09/15/1978	GENA	HDHP	TAMARAC	FL	33321-0000
SP	F	11/10/1979	GENA	HDHP	TAMARAC	FL	33321-0000
CH	M	12/22/1997	GENA	HDHP	TAMARAC	FL	33321-0000
CH	M	10/23/2002	GENA	HDHP	TAMARAC	FL	33321-0000
CH	F	04/06/2004	GENA	HDHP	TAMARAC	FL	33321-0000
CH	M	07/02/2010	GENA	HDHP	TAMARAC	FL	33321-0000
EE	M	09/21/1961	GENA	HDHP	FORT LAUDERDALE	FL	33302-0000
CH	F	04/07/2000	GENA	HDHP	FORT LAUDERDALE	FL	33302-0000
CH	F	08/02/2002	GENA	HDHP	FORT LAUDERDALE	FL	33302-0000
EE	M	10/20/1958	GENA	HDHP	LAUD BY THE SEA	FL	33062-0000

EE	M	01/03/1952	GENA	HMO 1	LAUDERHILL	FL	33319-0000
CH	M	01/13/2013	GENA	HMO 1	LAUDERHILL	FL	33319-0000
EE	F	08/08/1986	GENA	HMO 2	OAKLAND PARK	FL	33309-0000
EE	F	08/28/1986	GENA	HDHP	SUNRISE	FL	33313-0000
SP	M	09/08/1983	GENA	HDHP	SUNRISE	FL	33313-0000
CH	M	01/05/2011	GENA	HDHP	SUNRISE	FL	33313-0000
EE	M	06/18/1958	GENA	HMO 1	FORT LAUDERDALE	FL	33335-0000
EE	M	12/04/1962	MGTA	HMO 1	TAMARAC	FL	33319-0000
SP	F	02/19/1964	MGTA	HMO 1	TAMARAC	FL	33319-0000
CH	F	09/06/1998	MGTA	HMO 1	TAMARAC	FL	33319-0000
EE	M	01/09/1970	PASA	HDHP	FORT LAUDERDALE	FL	33304-0000
EE	M	04/09/1983	MGTA	HMO 1	FORT LAUDERDALE	FL	33308-0000
EE	M	03/11/1970	MGTA	HDHP	LAKE WORTH	FL	33467-0000
SP	F	09/15/1971	MGTA	HDHP	LAKE WORTH	FL	33467-0000
CH	F	09/27/1994	MGTA	HDHP	LAKE WORTH	FL	33467-0000
CH	M	01/20/2005	MGTA	HDHP	LAKE WORTH	FL	33467-0000
CH	M	05/27/2007	MGTA	HDHP	LAKE WORTH	FL	33467-0000
EE	M	12/13/1960	GENA	HDHP	TAMARAC	FL	33321-0000
SP	F	02/18/1958	GENA	HDHP	TAMARAC	FL	33321-0000
EE	M	01/29/1959	PASA	HMO 1	FORT LAUDERDALE	FL	33328-0000
CH	F	02/08/1991	PASA	HMO 1	FORT LAUDERDALE	FL	33328-0000
CH	M	04/04/1996	PASA	HMO 1	FORT LAUDERDALE	FL	33328-0000
EE	F	12/27/1960	GENA	HMO 1	SUNRISE	FL	33313-0000
EE	M	04/29/1956	GENA	HMO 1	MIRAMAR	FL	33023-0000
EE	M	08/27/1956	FIRU65	HMO 1	CORAL SPRINGS	FL	33067-0000
SP	F	03/20/1962	GENA	HMO 1	DEERFIELD BEACH	FL	33441-0000
EE	F	12/29/1951	GENU65	HMO 1	FT LAUDERDALE	FL	33315-0000
EE	M	09/24/1979	FIRA	HMO 1	PALMETTO BAY	FL	33158-0000
CH	M	02/17/2013	FIRA	HMO 1	PALMETTO BAY	FL	33158-0000
EE	F	09/12/1961	CONA	HDHP	FORT LAUDERDALE	FL	33338-0000
EE	M	01/02/1967	GENA	HDHP	DAVID	FL	33314-0000
SP	F	04/24/1966	GENA	HDHP	DAVID	FL	33314-0000
CH	M	07/10/2006	GENA	HDHP	DAVID	FL	33314-0000
CH	F	10/12/2009	GENA	HDHP	DAVID	FL	33314-0000
SP	M	08/02/1969	MGTA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	03/30/1952	MGTU65	HMO 1	SUMMERFIELD	FL	34491-0000
EE	M	08/07/1940	MGT65O	HMO 1	FORT LAUDERDALE	FL	33316-0000
SP	M	01/05/1977	MGTA	HDHP	PEMBROKE PINES	FL	33029-0000
CH	M	12/23/2005	MGTA	HDHP	PEMBROKE PINES	FL	33029-0000
CH	F	10/28/2008	MGTA	HDHP	PEMBROKE PINES	FL	33029-0000
EE	F	11/02/1976	PASA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	M	12/18/2008	PASA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	01/30/1972	PASA	HMO 1	BOCA RATON	FL	33428-0000

CH	M	07/31/2004	PASA	HMO 1	BOCA RATON	FL	33428-0000
SP	F	05/27/1966	GENA	HMO 2	OAKLAND PARK	FL	33334-0000
EE	F	02/11/1961	GENA	HMO 1	TAMARAC	FL	33321-0000
CH	M	06/07/1991	GENA	HMO 1	TAMARAC	FL	33321-0000
EE	M	01/03/1971	GENA	HMO 1	POMPANO BEACH	FL	33060-0000
EE	F	10/27/1964	GENA	HDHP	FORT LAUDERDALE	FL	33307-0000
EE	M	11/13/1989	GENA	HMO 2	LAUDERHILL	FL	33313-0000
EE	M	10/19/1969	FIRA	HMO 1	BOCA RATON	FL	33486-0000
CH	F	11/22/2008	FIRA	HMO 1	BOCA RATON	FL	33486-0000
EE	F	03/13/1964	PASA	HDHP	OAKLAND PARK	FL	33334-0000
SP	M	09/17/1965	PASA	HDHP	OAKLAND PARK	FL	33334-0000
CH	M	12/20/2007	PASA	HDHP	OAKLAND PARK	FL	33334-0000
CH	M	03/26/2002	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	02/19/1953	MGTU65	HMO 1	MARCO ISLAND	FL	34145-0000
SP	F	11/19/1958	MGTU65	HMO 1	MARCO ISLAND	FL	34145-0000
EE	F	11/21/1955	MGTU65	HMO 1	WILTON MANORS	FL	33305-0000
EE	M	06/20/1959	GENA	HDHP	PLANTATION	FL	33324-0000
EE	M	07/27/1986	GENA	HDHP	TAMARAC	FL	33321-0000
EE	M	02/17/1973	FIRA	HMO 1	PLANTATION	FL	33322-0000
EE	M	06/25/1967	GENA	HMO 1	SUNRISE	FL	33351-0000
SP	F	04/14/1965	GENA	HMO 1	SUNRISE	FL	33351-0000
CH	M	08/20/1994	GENA	HMO 1	SUNRISE	FL	33351-0000
CH	M	10/19/1999	GENA	HMO 1	SUNRISE	FL	33351-0000
EE	M	10/16/1967	GENA	HMO 1	MIRAMAR	FL	33023-0000
SP	F	04/15/1977	GENA	HMO 1	MIRAMAR	FL	33023-0000
CH	M	01/04/2003	GENA	HMO 1	MIRAMAR	FL	33023-0000
CH	M	09/20/2007	GENA	HMO 1	MIRAMAR	FL	33023-0000
EE	F	12/28/1953	GENA	HDHP	MARGATE	FL	33063-0000
EE	F	11/29/1958	PASA	HMO 1	FORT LAUDERDALE	FL	33306-0000
SP	M	04/29/1966	GENA	HDHP	COCONUT CREEK	FL	33073-0000
CH	F	05/18/2010	GENA	HDHP	COCONUT CREEK	FL	33073-0000
EE	M	01/29/1960	FIRA	HMO 2	PARKLAND	FL	33076-0000
EE	M	06/20/1969	GENA	HDHP	SUNRISE	FL	33351-0000
SP	F	12/16/1971	GENA	HDHP	SUNRISE	FL	33351-0000
CH	F	11/21/1998	GENA	HDHP	SUNRISE	FL	33351-0000
CH	M	12/27/2006	GENA	HDHP	SUNRISE	FL	33351-0000
CH	F	12/07/2002	GENA	HDHP	SUNRISE	FL	33351-0000
CH	F	09/29/1993	GENA	HDHP	CORAL SPRINGS	FL	33065-0000
EE	M	08/07/1952	GENA	HMO 1	DEERFIELD BEACH	FL	33442-0000
CH	F	12/21/1995	CONA	HMO 1	SUNRISE	FL	33351-0000
EE	F	11/22/1959	GENA	HMO 1	SUNRISE	FL	33351-0000
EE	M	01/08/1967	GENA	HDHP	COCONUT CREEK	FL	33073-0000
EE	M	04/03/1958	GENA	HDHP	SUNRISE	FL	33322-0000

EE	M	10/05/1953	MGTA	HDHP	FORT LAUDERDALE	FL	33309-0000
SP	F	03/12/1955	MGTA	HDHP	FORT LAUDERDALE	FL	33309-0000
EE	M	05/16/1985	GENA	HMO 1	PLANTATION	FL	33317-0000
EE	M	03/02/1973	FIRA	HDHP	HOLLYWOOD	FL	33020-0000
SP	M	09/07/1953	GENA	HMO 1	FORT LAUDERDALE	FL	33316-0000
EE	F	07/20/1974	GENA	HDHP	HOLLYWOOD	FL	33021-0000
EE	F	07/04/1966	PASA	HMO 1	PLANTATION	FL	33324-0000
CH	F	07/04/2001	PASA	HMO 1	PLANTATION	FL	33324-0000
EE	M	06/08/1960	GENA	HDHP	LAUDERHILL	FL	33319-0000
SP	F	03/27/1984	FIRA	HDHP	BOCA RATON	FL	33486-0000
EE	M	02/06/1964	MGTA	HDHP	COCONUT CREEK	FL	33073-0000
SP	F	04/28/1965	MGTA	HDHP	COCONUT CREEK	FL	33073-0000
CH	F	02/28/1998	MGTA	HDHP	COCONUT CREEK	FL	33073-0000
EE	F	10/01/1952	GENA	HMO 1	PLANTATION	FL	33322-0000
EE	M	10/19/1953	MGTU65	HMO 1	OAKLAND PARK	FL	33334-0000
EE	M	03/01/1966	PASA	HMO 1	CORAL SPRINGS	FL	33076-0000
CH	M	02/14/2005	PASA	HMO 1	CORAL SPRINGS	FL	33076-0000
EE	M	11/11/1970	FIRA	HMO 1	BOCA RATON	FL	33428-0000
CH	M	10/20/2002	FIRA	HMO 1	BOCA RATON	FL	33428-0000
CH	F	04/23/2005	FIRA	HMO 1	BOCA RATON	FL	33428-0000
CH	M	12/20/1995	FIRA	HMO 1	BOCA RATON	FL	33428-0000
EE	M	05/12/1960	FIRA	HDHP	PALM BCH GARDENS	FL	33418-0000
SP	F	06/15/1960	FIRA	HDHP	PALM BCH GARDENS	FL	33418-0000
CH	M	07/04/1992	FIRA	HDHP	PALM BCH GARDENS	FL	33418-0000
CH	M	05/24/1994	FIRA	HDHP	PALM BCH GARDENS	FL	33418-0000
EE	M	02/19/1983	FIRA	HDHP	SOUTHWEST RANCHES	FL	33331-0000
SP	F	11/09/1982	FIRA	HDHP	SOUTHWEST RANCHES	FL	33331-0000
CH	M	12/11/2009	FIRA	HDHP	SOUTHWEST RANCHES	FL	33331-0000
CH	M	06/28/2012	FIRA	HDHP	SOUTHWEST RANCHES	FL	33331-0000
EE	F	01/10/1989	GENA	HMO 2	FORT LAUDERDALE	FL	33312-0000
EE	F	05/31/1961	CONA	HMO 2	WILTON MANORS	FL	33311-0000
EE	M	10/20/1959	GENA	HDHP	MIAMI	FL	33169-0000
CH	F	02/18/1991	GENA	HDHP	MIAMI	FL	33169-0000
CH	M	11/07/1995	GENA	HDHP	MIAMI	FL	33169-0000
CH	F	11/03/2010	GENA	HDHP	MIAMI	FL	33169-0000
EE	M	07/18/1988	GENA	HDHP	MIAMI GARDENS	FL	33169-0000
EE	F	12/15/1966	PASA	HMO 1	FORT LAUDERDALE	FL	33309-0000
EE	F	04/06/1952	GENU65	HMO 1	KINGSTREE	SC	29556-0000
EE	M	10/20/1966	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
SP	F	04/29/1967	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	F	02/08/1995	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	10/05/1996	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	F	05/15/2014	GENA	HDHP	LAUDERHILL	FL	33311-0000

EE	F	11/20/1965	GENA	HDHP	LAUDERHILL	FL	33313-0000
SP	M	04/10/1962	GENA	HDHP	LAUDERHILL	FL	33313-0000
SP	F	07/02/1982	GENA	HDHP	LAUDERHILL	FL	33313-0000
EE	M	10/25/1969	PASA	HMO 1	PLANTATION	FL	33324-0000
EE	M	03/13/1984	PASA	HMO 1	FORT LAUDERDALE	FL	33301-0000
EE	F	03/15/1970	PASA	HDHP	TAMARAC	FL	33319-0000
SP	M	01/20/1953	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	12/12/1987	GENA	HDHP	LAUDERDALE LAKES	FL	33319-0000
EE	F	09/15/1967	GENA	HDHP	FORT LAUDERDALE	FL	33318-0000
SP	M	03/13/1963	GENA	HDHP	FORT LAUDERDALE	FL	33318-0000
CH	F	09/16/1994	GENA	HDHP	FORT LAUDERDALE	FL	33318-0000
CH	F	02/23/1991	GENA	HDHP	FORT LAUDERDALE	FL	33318-0000
EE	M	08/21/1941	GENA	HMO 1	DAVIE	FL	33325-0000
SP	F	10/12/1944	GENA	HMO 1	DAVIE	FL	33325-0000
EE	F	05/11/1964	GENA	HMO 2	PEMBROKE PINES	FL	33024-0000
SP	M	09/23/1964	GENA	HMO 2	PEMBROKE PINES	FL	33024-0000
EE	M	02/23/1980	GENA	HDHP	CORAL SPRINGS	FL	33067-0000
CH	F	05/27/2015	GENA	HDHP	CORAL SPRINGS	FL	33067-0000
CH	F	05/23/2000	MGTA	HMO 1	LAUDERHILL	FL	33319-0000
CH	F	12/19/1993	GENA	HDHP	SUNRISE	FL	33313-0000
EE	M	02/11/1961	MGTA	HDHP	PARKLAND	FL	33067-0000
CH	M	06/24/1996	MGTA	HDHP	PARKLAND	FL	33067-0000
CH	M	06/24/1993	MGTA	HDHP	PARKLAND	FL	33067-0000
CH	M	07/30/1994	MGTA	HDHP	PARKLAND	FL	33067-0000
CH	F	01/03/2001	MGTA	HDHP	PARKLAND	FL	33067-0000
EE	F	05/04/1967	MGTA	HMO 1	MARGATE	FL	33063-0000
SP	M	10/30/1961	MGTA	HMO 1	MARGATE	FL	33063-0000
CH	F	11/18/1990	MGTA	HMO 1	MARGATE	FL	33063-0000
CH	M	07/29/1995	MGTA	HMO 1	MARGATE	FL	33063-0000
EE	M	06/02/1972	FIRA	HMO 1	N LAUDERDALE	FL	33068-0000
EE	M	12/24/1983	GENA	HDHP	MIAMI GARDENS	FL	33169-0000
CH	M	07/22/2012	GENA	HDHP	MIAMI GARDENS	FL	33169-0000
CH	F	06/02/2004	GENA	HDHP	MIAMI GARDENS	FL	33169-0000
CH	F	01/28/2009	GENA	HDHP	MIAMI GARDENS	FL	33169-0000
EE	F	11/17/1987	MGTA	HMO 1	FORT LAUDERDALE	FL	33308-0000
CH	M	04/27/2015	MGTA	HMO 1	FORT LAUDERDALE	FL	33308-0000
SP	M	08/08/1987	PASA	HMO 1	FORT LAUDERDALE	FL	33305-0000
SP	F	08/27/1961	GENA	HMO 2	SUNRISE	FL	33313-0000
EE	F	03/18/1976	PASA	HMO 1	TAMARAC	FL	33321-0000
CH	M	04/19/2012	PASA	HMO 1	TAMARAC	FL	33321-0000
CH	F	09/10/1990	FIRA	HDHP	JENSEN BEACH	FL	34957-0000
EE	M	03/01/1967	GENA	HDHP	FORT LAUDERDALE	FL	33315-0000
SP	F	09/18/1972	GENA	HDHP	FORT LAUDERDALE	FL	33315-0000

CH	F	09/25/2006	GENA	HDHP	FORT LAUDERDALE	FL	33315-0000
CH	F	12/04/2014	GENA	HDHP	FORT LAUDERDALE	FL	33315-0000
EE	M	03/30/1986	FIRA	HDHP	DAVIE	FL	33314-0000
EE	M	10/23/1954	GENA	HMO 1	FORT LAUDERDALE	FL	33319-0000
EE	M	01/12/1983	GENA	HDHP	MARGATE	FL	33063-0000
EE	F	11/12/1960	PASA	HMO 1	COCONUT CREEK	FL	33073-0000
SP	M	06/25/1960	PASA	HMO 1	COCONUT CREEK	FL	33073-0000
EE	F	03/13/1968	GENA	HMO 1	SOUTHWEST RANCHES	FL	33331-0000
SP	M	01/16/1969	GENA	HMO 1	SOUTHWEST RANCHES	FL	33331-0000
CH	F	07/20/1995	GENA	HMO 1	SOUTHWEST RANCHES	FL	33331-0000
EE	M	04/10/1980	FIRA	HMO 2	CORAL SPRINGS	FL	33076-0000
SP	F	05/14/1983	FIRA	HMO 2	CORAL SPRINGS	FL	33076-0000
CH	F	08/03/2009	FIRA	HMO 2	CORAL SPRINGS	FL	33076-0000
CH	M	01/13/2012	FIRA	HMO 2	CORAL SPRINGS	FL	33076-0000
CH	M	12/11/2015	PASA	HMO 1	POMPANO BEACH	FL	33064-0000
EE	M	06/22/1979	FIRA	HDHP	MIRAMAR	FL	33027-0000
EE	M	09/30/1975	PASA	HMO 1	POMPANO BEACH	FL	33064-0000
EE	M	12/26/1960	GENA	HDHP	POMPANO BEACH	FL	33060-0000
SP	F	01/08/1965	GENA	HDHP	POMPANO BEACH	FL	33060-0000
EE	F	08/25/1984	PASA	HMO 2	PEMBROKE PINES	FL	33024-0000
SP	F	04/10/1972	PASA	HMO 1	PLANTATION	FL	33324-0000
EE	M	10/14/1953	MGTA	HMO 1	FORT LAUDERDALE	FL	33304-0000
EE	M	09/30/1964	GENA	HMO 1	PLANTATION	FL	33324-0000
CH	F	08/03/2000	GENA	HMO 1	PLANTATION	FL	33324-0000
EE	M	06/30/1951	GENA	HMO 1	HOLLYWOOD	FL	33024-0000
EE	M	04/23/1970	FIRA	HMO 1	DAVIE	FL	33314-0000
SP	F	01/28/1971	FIRA	HMO 1	DAVIE	FL	33314-0000
CH	M	02/20/2001	FIRA	HMO 1	DAVIE	FL	33314-0000
CH	M	05/05/2003	FIRA	HMO 1	DAVIE	FL	33314-0000
EE	M	10/28/1981	GENA	HMO 2	POMPANO BEACH	FL	33060-0000
EE	M	02/13/1960	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	M	10/05/1980	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	10/24/1977	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	01/21/2011	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	04/19/2002	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	09/11/2004	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	10/06/2000	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	08/15/1965	FIRA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	M	12/11/1992	FIRA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	F	08/16/1999	FIRA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	F	10/28/1975	PASA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	07/21/1958	GENA	HMO 2	LAUDERDALE LAKES	FL	33319-0000
SP	F	08/12/1959	GENA	HMO 2	LAUDERDALE LAKES	FL	33319-0000

CH	M	05/30/2007	GENA	HMO 2	LAUDERDALE LAKES	FL	33319-0000
EE	M	02/21/1974	GENA	HDHP	OAKLAND PARK	FL	33334-0000
EE	F	03/27/1961	MGTA	HMO 2	PLANTATION	FL	33317-0000
CH	F	01/28/1999	GENA	HMO 1	HOLLYWOOD	FL	33023-0000
EE	M	07/11/1971	FIRA	HMO 1	JUPITER	FL	33458-0000
CH	M	01/23/1997	FIRA	HMO 1	JUPITER	FL	33458-0000
CH	M	06/03/1999	FIRA	HMO 1	JUPITER	FL	33458-0000
EE	M	02/19/1953	MGTU65	HMO 1	FT LAUDERDALE	FL	33312-0000
EE	F	03/13/1952	MGTA	HMO 1	COCONUT CREEK	FL	33066-0000
EE	M	06/26/1958	GENA	HMO 1	MIRAMAR	FL	33023-0000
SP	F	02/22/1958	GENA	HMO 1	MIRAMAR	FL	33023-0000
CH	M	12/29/1991	GENA	HMO 1	MIRAMAR	FL	33023-0000
EE	F	12/16/1974	GENA	HMO 1	TAMARAC	FL	33321-0000
SP	M	12/23/1973	PASA	HMO 2	HOLLYWOOD	FL	33020-0000
EE	F	05/29/1964	GENA	HDHP	OAKLAND PARK	FL	33334-0000
EE	M	10/29/1983	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
SP	F	02/20/1960	GENA	HMO 1	PORT ST LUCIE	FL	34953-0000
CH	F	07/22/1994	GENA	HMO 1	PORT ST LUCIE	FL	34953-0000
CH	M	04/28/1997	GENA	HMO 1	PORT ST LUCIE	FL	34953-0000
EE	F	10/24/1982	PASA	HDHP	PLANTATION	FL	33322-0000
SP	M	01/08/1980	PASA	HDHP	PLANTATION	FL	33322-0000
CH	M	01/23/2015	PASA	HDHP	PLANTATION	FL	33322-0000
EE	M	07/23/1965	MGTA	HDHP	OAKLAND PARK	FL	33334-0000
EE	M	05/09/1954	GENA	HDHP	POMPANO BEACH	FL	33069-0000
EE	M	06/08/1965	GENA	HMO 1	PORT ST LUCIE	FL	34953-0000
SP	F	02/27/1977	GENA	HMO 1	POMPANO BEACH	FL	33062-0000
EE	F	02/09/1951	PASA	HMO 1	PEMBROKE PINES	FL	33026-0000
EE	M	06/29/1961	GENA	HMO 1	SUNRISE	FL	33322-0000
CH	F	05/30/1990	GENA	HMO 1	SUNRISE	FL	33322-0000
EE	F	10/29/1961	GENA	HDHP	MARGATE	FL	33063-0000
EE	M	11/04/1978	GENA	HMO 1	TAMARAC	FL	33319-0000
CH	F	10/28/2015	GENA	HMO 1	TAMARAC	FL	33319-0000
CH	M	11/29/2011	GENA	HMO 1	TAMARAC	FL	33319-0000
CH	M	09/09/2005	GENA	HMO 1	TAMARAC	FL	33319-0000
EE	M	08/26/1979	GENA	HMO 1	GREENACRES	FL	33463-0000
SP	F	05/15/1981	GENA	HMO 1	GREENACRES	FL	33463-0000
CH	F	11/30/2010	GENA	HMO 1	GREENACRES	FL	33463-0000
EE	F	01/26/1960	FIRA	HMO 1	WEST PALM BCH	FL	33412-0000
EE	M	12/02/2010	MGTC	HMO 1	LAUDERHILL	FL	33319-0000
EE	F	10/10/1990	GENA	HMO 2	PEMBROKE PINES	FL	33025-0000
CH	M	02/29/1996	MGTA	HDHP	WESTON	FL	33331-0000
CH	M	06/03/1999	MGTA	HDHP	WESTON	FL	33331-0000
SP	F	08/13/1970	MGTA	HDHP	WESTON	FL	33331-0000

EE	M	08/10/1958	GENA	HDHP	FORT LAUDERDALE	FL	33314-0000
EE	M	09/12/1946	GEN65O	HMO 1	JUPITER	FL	33478-0000
EE	F	02/05/1974	PASA	HDHP	FORT LAUDERDALE	FL	33305-0000
EE	M	02/10/1979	GENA	HDHP	PEMBROKE PINES	FL	33024-0000
EE	F	08/29/1990	MGTA	HDHP	NORTH LAUDERDALE	FL	33068-0000
EE	M	10/31/1953	GENA	HDHP	FORT LAUDERDALE	FL	33334-0000
SP	F	06/27/1956	GENA	HDHP	FORT LAUDERDALE	FL	33334-0000
CH	M	03/01/1996	GENA	HDHP	FORT LAUDERDALE	FL	33334-0000
CH	M	12/23/1991	GENA	HDHP	FORT LAUDERDALE	FL	33334-0000
EE	M	01/24/1972	PASA	HMO 1	CORAL SPRINGS	FL	33065-0000
EE	M	02/08/1961	PASA	HMO 1	OAKLAND PARK	FL	33334-0000
SP	F	01/16/1955	PASA	HMO 1	OAKLAND PARK	FL	33334-0000
EE	M	08/24/1970	FIRA	HDHP	JUPITER	FL	33478-0000
SP	F	02/21/1976	FIRA	HDHP	JUPITER	FL	33478-0000
CH	M	12/14/2006	FIRA	HDHP	JUPITER	FL	33478-0000
CH	F	05/27/2008	FIRA	HDHP	JUPITER	FL	33478-0000
EE	F	12/27/1967	MGTA	HDHP	WILTON MANORS	FL	33334-0000
SP	M	10/28/1960	MGTA	HDHP	WILTON MANORS	FL	33334-0000
CH	F	11/07/2007	MGTA	HDHP	WILTON MANORS	FL	33334-0000
CH	M	05/06/2003	MGTA	HDHP	WILTON MANORS	FL	33334-0000
EE	M	12/27/1952	GENA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	F	04/07/1979	GENA	HMO 1	DEERFIELD BEACH	FL	33441-0000
SP	M	08/05/1976	GENA	HMO 1	DEERFIELD BEACH	FL	33441-0000
CH	F	02/02/2015	GENA	HMO 1	DEERFIELD BEACH	FL	33441-0000
EE	F	10/07/1972	GENA	HDHP	POMPANO BEACH	FL	33060-0000
CH	M	08/20/1994	GENA	HDHP	POMPANO BEACH	FL	33060-0000
SP	M	05/20/1965	PASA	HDHP	PLANTATION	FL	33322-0000
EE	M	04/24/1966	PASA	HMO 1	LAUDERDALE LAKES	FL	33309-0000
SP	F	06/18/1969	PASA	HMO 1	LAUDERDALE LAKES	FL	33309-0000
CH	M	11/07/2002	PASA	HMO 1	LAUDERDALE LAKES	FL	33309-0000
CH	M	06/24/2000	PASA	HMO 1	LAUDERDALE LAKES	FL	33309-0000
EE	M	09/23/1969	PASA	HDHP	PLANTATION	FL	33317-0000
SP	F	09/18/1971	PASA	HDHP	PLANTATION	FL	33317-0000
CH	M	07/23/2001	PASA	HDHP	PLANTATION	FL	33317-0000
CH	M	03/26/2004	PASA	HDHP	PLANTATION	FL	33317-0000
EE	M	03/15/1979	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
SP	F	03/06/1983	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	F	02/05/2008	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	F	02/12/2001	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	02/24/1966	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	06/11/1984	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
SP	F	05/01/1984	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	10/06/1971	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000

CH	M	03/09/2010	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	F	09/01/1994	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	F	09/05/2000	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	M	11/18/1970	GENA	HMO 1	LAUDERHILL	FL	33313-0000
EE	M	10/23/1976	GENA	HDHP	POMPANO BEACH	FL	33069-0000
CH	F	06/28/1994	GENA	HDHP	POMPANO BEACH	FL	33069-0000
EE	F	03/20/1954	CONA	HMO 1	DAVIE	FL	33324-0000
EE	F	04/24/1951	GENA	HMO 1	COCONUT CREEK	FL	33063-0000
SP	F	06/15/1965	GENA	HMO 2	CORAL SPRINGS	FL	33065-0000
SP	M	09/12/1963	MGTA	HDHP	PEMBROKE PINES	FL	33029-0000
CH	M	09/20/2003	MGTA	HDHP	PEMBROKE PINES	FL	33029-0000
CH	M	09/28/2006	MGTA	HDHP	PEMBROKE PINES	FL	33029-0000
EE	F	10/25/1966	GENA	HDHP	PLANTATION	FL	33317-0000
CH	F	12/08/2005	CONA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	F	02/11/1970	CONA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	F	05/20/1965	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	12/13/1976	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	04/04/2000	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	M	04/11/1996	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	M	02/26/1954	GENA	HDHP	HOLLYWOOD	FL	33020-0000
SP	F	01/22/1965	GENA	HDHP	HOLLYWOOD	FL	33020-0000
CH	M	12/07/1995	GENA	HDHP	HOLLYWOOD	FL	33020-0000
CH	M	05/19/1999	GENA	HDHP	HOLLYWOOD	FL	33020-0000
CH	F	11/24/2002	GENA	HDHP	HOLLYWOOD	FL	33020-0000
EE	M	05/19/1978	GENA	HDHP	LAUDERHILL	FL	33313-0000
CH	F	09/06/1999	GENA	HDHP	LAUDERHILL	FL	33313-0000
CH	M	11/08/2001	GENA	HDHP	LAUDERHILL	FL	33313-0000
EE	M	03/07/1973	GENA	HDHP	LAUDERHILL	FL	33313-0000
SP	F	07/02/1977	GENA	HDHP	LAUDERHILL	FL	33313-0000
CH	M	07/13/2013	GENA	HDHP	LAUDERHILL	FL	33313-0000
EE	M	09/16/1977	FIRA	HMO 1	PARKLAND	FL	33067-0000
CH	M	01/21/2010	FIRA	HMO 1	PARKLAND	FL	33067-0000
CH	M	04/12/2015	FIRA	HMO 1	PARKLAND	FL	33067-0000
SP	F	11/10/1967	GENA	HDHP	LAUDERDALE LAKES	FL	33309-0000
EE	M	05/27/1988	GENA	HMO 1	OAKLAND PARK	FL	33309-0000
EE	F	05/06/1980	GENA	HDHP	SUNRISE	FL	33351-0000
SP	M	11/24/1981	GENA	HDHP	SUNRISE	FL	33351-0000
EE	M	07/20/1972	FIRA	HDHP	WELLINGTON	FL	33414-0000
CH	F	11/11/1998	FIRA	HDHP	WELLINGTON	FL	33414-0000
CH	M	05/10/2002	FIRA	HDHP	WELLINGTON	FL	33414-0000
EE	M	02/11/1955	GENA	HMO 1	SUNRISE	FL	33351-0000
EE	M	09/02/1956	GENU65	HMO 1	ST PETERSBURG	FL	33716-0000
EE	M	05/14/1957	MGTU65	HDHP retiree	PORT ORANGE	FL	32128-0000

SP	F	04/11/1961	MGTU65	HDHP retiree	PORT ORANGE	FL	32128-0000
CH	F	06/01/1998	MGTU65	HDHP retiree	PORT ORANGE	FL	32128-0000
CH	M	11/16/2001	MGTU65	HDHP retiree	PORT ORANGE	FL	32128-0000
CH	M	05/17/2005	PASA	HDHP	OAKLAND PARK	FL	33309-0000
EE	M	09/29/1986	FIRA	HDHP	PALMETTO BAY	FL	33157-0000
SP	F	07/16/1986	FIRA	HDHP	PALMETTO BAY	FL	33157-0000
EE	M	11/16/1961	MGTA	HMO 1	PLANTATION	FL	33324-0000
SP	F	05/02/1962	MGTA	HMO 1	PLANTATION	FL	33324-0000
CH	F	01/20/1997	MGTA	HMO 1	PLANTATION	FL	33324-0000
CH	F	07/31/2005	GENA	HDHP	PLANTATION	FL	33317-0000
EE	M	01/07/1969	FIRA	HDHP	FORT LAUDERDALE	FL	33315-0000
SP	F	09/23/1970	FIRA	HDHP	FORT LAUDERDALE	FL	33315-0000
CH	F	07/28/2004	FIRA	HDHP	FORT LAUDERDALE	FL	33315-0000
CH	F	10/23/1999	FIRA	HDHP	FORT LAUDERDALE	FL	33315-0000
EE	M	12/23/1973	FIRA	HDHP	DELRAY BEACH	FL	33446-0000
EE	M	08/22/1972	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
SP	F	01/15/1968	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
CH	F	01/14/1992	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
CH	F	05/02/1993	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
CH	F	04/22/1998	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
EE	F	11/15/1969	FIRA	HDHP	DAVIE	FL	33325-0000
EE	M	12/10/1954	GENA	HMO 1	PLANTATION	FL	33317-0000
SP	F	09/11/1955	GENA	HMO 1	PLANTATION	FL	33317-0000
EE	M	11/22/1979	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	12/20/1981	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	05/28/1967	GENA	HDHP	SUNRISE	FL	33323-0000
EE	M	05/06/1952	PASA	HMO 2	FORT LAUDERDALE	FL	33306-0000
SP	F	05/06/1956	PASA	HMO 2	FORT LAUDERDALE	FL	33306-0000
EE	M	05/25/1989	ADCH	HMO 2	FORT LAUDERDALE	FL	33306-0000
EE	M	03/21/1973	FIRA	HMO 1	DAVIE	FL	33325-0000
SP	F	07/05/1973	FIRA	HMO 1	DAVIE	FL	33325-0000
CH	M	08/12/2008	FIRA	HMO 1	DAVIE	FL	33325-0000
EE	M	07/08/1983	FIRA	HDHP	CORAL SPRINGS	FL	33071-0000
EE	F	10/08/1962	GENA	HDHP	POMPANO BEACH	FL	33062-0000
EE	M	03/29/1977	MGTA	HMO 2	FORT LAUDERDALE	FL	33303-0000
CH	F	08/20/2007	MGTA	HMO 2	LAS VEGAS	NV	89135-0000
EE	M	06/07/1983	GENA	HMO 1	MARGATE	FL	33063-0000
SP	F	07/06/1978	GENA	HMO 1	MARGATE	FL	33063-0000
CH	F	09/08/2011	GENA	HMO 1	MARGATE	FL	33063-0000
EE	M	05/27/1977	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	03/08/1999	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	09/15/1958	PASA	HMO 1	LAUDERHILL	FL	33319-0000
EE	M	01/20/1986	GENA	HDHP	MARGATE	FL	33063-0000

SP	F	07/09/1987	FIRA	HDHP	DEERFIELD BCH	FL	33442-0000
SP	M	03/29/1966	GENA	HDHP	MIAMI GARDENS	FL	33055-0000
CH	F	06/18/1999	GENA	HDHP	MIAMI GARDENS	FL	33055-0000
EE	M	08/22/1960	GENA	HMO 1	LAUDERHILL	FL	33311-0000
SP	M	09/08/1969	GENA	HMO 1	DEERFIELD BCH	FL	33441-0000
EE	M	02/28/1968	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
SP	F	10/07/1968	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	12/11/2007	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
CH	F	02/05/2002	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	F	07/23/1977	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
SP	M	04/30/1968	GENA	HDHP	NORTH LAUDERDALE	FL	33068-0000
EE	M	09/19/1966	GENA	HMO 1	NORTH LAUDERDALE	FL	33311-0000
CH	F	12/31/1996	GENA	HMO 1	NORTH LAUDERDALE	FL	33311-0000
CH	F	08/16/2001	GENA	HMO 1	NORTH LAUDERDALE	FL	33311-0000
EE	F	04/12/1970	PASA	HMO 2	MIRAMAR	FL	33023-0000
EE	M	06/06/1960	GENA	HMO 1	FORT LAUDERDALE	FL	33310-0000
CH	F	02/23/1990	GENA	HMO 1	FORT LAUDERDALE	FL	33310-0000
CH	F	01/19/1993	GENA	HMO 1	FORT LAUDERDALE	FL	33310-0000
EE	M	04/07/1970	GENA	HDHP	BOCA RATON	FL	33498-0000
CH	M	01/11/2003	GENA	HDHP	BOCA RATON	FL	33498-0000
EE	M	09/15/1982	MGTA	HMO 1	MIAMI GARDENS	FL	33169-0000
CH	M	02/22/2011	MGTA	HMO 1	MIAMI GARDENS	FL	33169-0000
EE	M	12/25/1985	GENA	HDHP	COCONUT CREEK	FL	33066-0000
EE	M	07/12/1980	FIRA	HDHP	BOCA RATON	FL	33433-0000
SP	F	01/17/1982	FIRA	HDHP	BOCA RATON	FL	33433-0000
CH	M	12/09/2010	FIRA	HDHP	BOCA RATON	FL	33433-0000
CH	F	12/22/2014	FIRA	HDHP	BOCA RATON	FL	33433-0000
EE	M	07/29/1965	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	F	03/08/1990	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	M	06/11/1976	GENA	HMO 1	LAUDERHILL	FL	33313-0000
CH	F	11/19/2009	GENA	HMO 1	LAUDERHILL	FL	33313-0000
EE	F	06/09/1984	CONA	HDHP	MIRAMAR	FL	33023-0000
SP	M	09/29/1975	CONA	HDHP	MIRAMAR	FL	33023-0000
CH	M	09/03/2004	CONA	HDHP	MIRAMAR	FL	33023-0000
CH	M	08/18/2009	CONA	HDHP	MIRAMAR	FL	33023-0000
CH	F	01/27/1998	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	M	02/27/1994	GENA	HDHP	POMPANO BEACH	FL	33069-0000
EE	M	01/26/1969	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
CH	M	06/20/1992	PASA	HMO 1	FORT LAUDERDALE	FL	33312-0000
EE	M	03/30/1965	GENA	HDHP	LAUDERHILL	FL	33313-0000
CH	F	01/27/2002	GENA	HDHP	LAUDERHILL	FL	33313-0000
EE	M	08/25/1961	FIRA	HMO 1	DAVIE	FL	33330-0000
SP	F	02/02/1969	FIRA	HMO 1	DAVIE	FL	33330-0000

EE	M	05/18/1967	GENA	HMO 1	PEMBROKE PINES	FL	33024-0000
CH	F	05/22/2001	GENA	HMO 1	PEMBROKE PINES	FL	33024-0000
EE	M	10/14/1985	GENA	HMO 1	LAUDERHILL	FL	33313-0000
CH	M	07/09/2014	GENA	HMO 1	NORTH LAUDERDALE	FL	33068-0000
EE	M	07/23/1985	FIRA	HDHP	DAVIE	FL	33328-0000
SP	F	08/16/1980	FIRA	HDHP	DAVIE	FL	33328-0000
CH	M	09/30/2015	FIRA	HDHP	DAVIE	FL	33328-0000
CH	F	08/08/2013	FIRA	HDHP	DAVIE	FL	33328-0000
EE	F	09/12/1969	PASA	HMO 1	CORAL SPRINGS	FL	33067-0000
EE	M	05/12/1972	MGTA	HDHP	PEMBROKE PINES	FL	33028-0000
CH	F	06/22/2013	MGTA	HDHP	PEMBROKE PINES	FL	33028-0000
SP	F	03/28/1982	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	F	11/13/1992	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	M	02/03/1953	PASA	HMO 2	FORT LAUDERDALE	FL	33312-0000
SP	F	02/24/1954	PASA	HMO 2	FORT LAUDERDALE	FL	33312-0000
CH	M	02/24/1999	PASA	HMO 2	FORT LAUDERDALE	FL	33312-0000
CH	M	03/01/1997	PASA	HMO 2	FORT LAUDERDALE	FL	33312-0000
EE	F	05/16/1952	GENU65	HMO 1	LAUD BY THE SEA	FL	33308-0000
EE	M	08/12/1950	PASA	HMO 1	FORT LAUDERDALE	FL	33334-0000
EE	F	08/07/1953	GENA	HDHP	HOLLYWOOD	FL	33019-0000
EE	M	10/30/1977	GENA	HDHP	FORT LAUDERDALE	FL	33311-0000
EE	F	07/27/1975	MGTA	HDHP	FORT LAUDERDALE	FL	33308-0000
CH	M	12/27/2005	MGTA	HDHP	FORT LAUDERDALE	FL	33308-0000
EE	M	11/24/1982	GENA	HMO 2	FORT LAUDERDALE	FL	33309-0000
SP	F	11/02/1988	GENA	HMO 2	FORT LAUDERDALE	FL	33309-0000
CH	F	06/20/2014	GENA	HMO 2	FORT LAUDERDALE	FL	33309-0000
CH	F	08/22/2015	GENA	HMO 2	FORT LAUDERDALE	FL	33309-0000
EE	M	10/21/1976	GENA	HDHP	OAKLAND PARK	FL	33309-0000
EE	F	12/01/1967	PASA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	M	08/26/1967	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	M	12/07/1996	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
CH	F	08/08/1998	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	M	08/22/1978	FIRA	HDHP	DAVIE	FL	33324-0000
CH	F	06/17/2008	FIRA	HDHP	DAVIE	FL	33324-0000
CH	F	02/01/2010	FIRA	HDHP	DAVIE	FL	33324-0000
CH	M	12/16/2011	FIRA	HDHP	DAVIE	FL	33324-0000
CH	M	06/29/1993	GENA	HDHP	FORT LAUDERDALE	FL	33308-0000
CH	M	06/30/1997	GENA	HDHP	FORT LAUDERDALE	FL	33309-0000
CH	F	01/15/2000	FIRA	HMO 1	KEY LARGO	FL	33037-0000
SP	F	10/18/1973	GENA	HMO 2	FORT LAUDERDALE	FL	33311-0000
EE	F	06/29/1954	GENA	HMO 1	NO MIAMI BEACH	FL	33162-0000
EE	M	10/24/1967	MGTA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	10/08/2002	GENA	HMO 1	LAUDERHILL	FL	33319-0000

EE	M	03/08/1969	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
SP	F	12/18/1962	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	F	04/01/1994	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
CH	M	02/11/2004	GENA	HDHP	FORT LAUDERDALE	FL	33312-0000
EE	M	07/17/1967	FIRA	HDHP	CORAL SPRINGS	FL	33076-0000
EE	M	08/03/1951	GENA	HMO 1	SUNRISE	FL	33322-0000
SP	F	11/30/1956	GENA	HMO 1	SUNRISE	FL	33322-0000
EE	F	10/05/1975	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
CH	M	08/03/1996	GENA	HMO 1	FORT LAUDERDALE	FL	33311-0000
EE	F	01/20/1967	GENA	HMO 1	SUNRIES	FL	33325-0000
SP	M	11/16/1961	GENA	HMO 1	SUNRIES	FL	33325-0000
CH	M	08/23/1993	GENA	HMO 1	SUNRIES	FL	33325-0000
CH	M	06/30/2004	GENA	HDHP	MARGATE	FL	33063-0000
EE	M	09/25/1955	GENA	HMO 1	LAUDERHILL	FL	33319-0000
CH	F	11/30/2003	GENA	HMO 1	LAUDERHILL	FL	33319-0000
CH	M	11/22/2008	GENA	HMO 1	LAUDERHILL	FL	33319-0000
EE	M	10/24/1966	PASA	HMO 1	LAUDERHILL	FL	33313-0000
EE	M	03/31/1977	FIRA	HDHP	FORT LAUDERDALE	FL	33309-0000
SP	F	06/21/1977	FIRA	HDHP	FORT LAUDERDALE	FL	33309-0000
CH	M	03/21/2012	FIRA	HDHP	FORT LAUDERDALE	FL	33309-0000
CH	F	09/17/2013	FIRA	HDHP	FORT LAUDERDALE	FL	33309-0000
SP	F	10/05/1984	FIRA	HDHP	BOYNTON BEACH	FL	33437-0000
EE	M	02/19/1977	MGTA	HMO 1	PLANTATION	FL	33324-0000
EE	M	02/01/1963	MGTA	HDHP	WESTON	FL	33331-0000
EE	M	08/06/1973	FIRA	HDHP	POMPANO BEACH	FL	33069-0000
SP	F	08/29/1977	FIRA	HDHP	POMPANO BEACH	FL	33069-0000
CH	M	11/20/2001	FIRA	HDHP	POMPANO BEACH	FL	33069-0000
CH	F	01/14/2004	FIRA	HDHP	POMPANO BEACH	FL	33069-0000
CH	F	01/14/2004	FIRA	HDHP	POMPANO BEACH	FL	33069-0000

Question and Answers for Bid #565-11734 - Actuarial Services for Self-Funded Medical & Pharmacy Plans

Overall Bid Questions

Question 1

1. Our firm is not currently licensed and registered to do business in Florida. Is it acceptable for our firm to register as a legal entity in the State of Florida upon notification of award?
2. Who is the incumbent actuarial firm?
3. How long has the incumbent actuarial firm held this contract?
4. What is the current hourly fee structure?
5. What was the total number of hours charged by the current actuarial firm in 2015?
6. What was the total amount of fees charged by the current actuarial firm in 2015?
7. What was the total amount of fees charged by the current actuarial firm for the three year period of 2013 through 2015?
8. What were the total number of hours and actuarial fees charged for Ad Hoc services in 2015?
9. How many meetings did the incumbent actuarial firm attend in 2015?
10. How many meetings did the incumbent actuarial firm attend during the three year period of 2013 through 2015? **(Submitted: Apr 12, 2016 3:18:58 PM EDT)**

Answer

- 1. Yes, you may register upon notification of award.
2. Wakely Consulting Group
3. 2 years (Current contract commenced 11/2014). Wakely has been the Cityâ€™s Actuary since the inception of the self-funded health plan in 2000.
4. $350 per hour.
5. 69 hours
6. $23,880
7. $42,975
8. 0 hours / $0
9. All meeting/discussions were via teleconference.
10. Same as Question #9. **(Answered: Apr 13, 2016 3:26:02 PM EDT)**

Question 2

Please provide a Current Census. **(Submitted: Apr 14, 2016 12:08:35 PM EDT)**

Answer

- A census has been included for review purposes only. **(Answered: Apr 14, 2016 3:56:15 PM EDT)**

Question 3

Section 3.2.6 requires the cost impact of plan design changes be calculated by the actuary. Is the number and/or the mix of types of plans expected to change during the term of this contract? If so, is the actuary selected expected to participate in developing future offering mix and plan design strategies, or price options only? **(Submitted: Apr 18, 2016 10:24:29 AM EDT)**

Answer

- While it is not certain at this time what the changes to the Plan structure/design will be during the term of the contract, the City anticipates that changes to the Plan mix and design will be considered during the term of the contract. The Actuarial firm selected would be included for developing future offering mix and plan design strategies. They would be responsible for determining the cost effects of any potential changes to Plan design/mix. See Scope of Services Section 3.2. **(Answered: Apr 19, 2016 12:12:15 PM EDT)**

Question 4

Please provide the details of how the claim data is provided, specifically the type of files (summary or claim dump), the frequency with which claim and enrollment data is provided (monthly, quarterly, annually), the number of sources of data (TPA, PBM, City, etc.), and if summary data will be provided in order to reconcile totals. **(Submitted: Apr 18, 2016 10:29:08 AM EDT)**

Answer

- The claim files for the TPA will be provided as a data dump and summary format as requested and necessary. **(Answered: Apr 19, 2016 12:12:15 PM EDT)**

Question 5

Please provide details on the data that will be provided by the Health Center, including how the claims are administered for this entity. **(Submitted: Apr 18, 2016 10:30:21 AM EDT)**

Answer

- The Health Center costs are paid directly by the City and include the management fee, pharmacy costs and all other costs related to the operation. The detail of this information is tracked by the City on a monthly basis and is made available in an excel format. **(Answered: Apr 19, 2016 12:12:15 PM EDT)**

Question 6

Are any of the following benefits expected to go out to bid during the initial term of the contract: Medical, PBM, Dental, Stop Loss, or other? If so, please provide the timeline for RFP release date, due date, and selection date. **(Submitted: Apr 18, 2016 10:32:22 AM EDT)**

Answer

- Estimated timelines are as follows:

Plan Release Date Due Date Selection Date
Medical TPA /PBM/EAP 4/2016 5/2016 8/2016
Stop Loss 6/2016 7/2016 8/2016
Dental 4/2017 5/2017 8/2017
Health and Wellness Ctr 11/2016 12/2016 1/2017 **(Answered: Apr 19, 2016 12:12:15 PM EDT)**

Question 7

Please elaborate on the role of the actuary in the RFP process. In addition to providing input on financial questions and reviewing responses to financial questions, will the actuary be expected to have an additional role? **(Submitted: Apr 18, 2016 10:35:21 AM EDT)**

Answer

- Please refer to Section 3.2 of the Scope of Services **(Answered: Apr 19, 2016 12:18:16 PM EDT)**

Question 8

Regarding Section 3.3.1 and the completion of the Actuarial Certification and State exhibits, is a bidder required to have actually completed the form in the past or is having extensive experience in calculating all of the information required to be disclosed in Statute 112.08 sufficient? **(Submitted: Apr 18, 2016 10:40:26 AM EDT)**

Answer

- Yes. The actuarial firm's personnel assigned to this project must have first-hand experience in preparing and completing the Actuarial Certification and State exhibits required by Florida Statute 112.08 (rate sufficiency certification) and the evaluation and assessment of the reserving practices of governmental entities of similar size and complexities. Resumes of personnel who will be assigned to this project must be included. **(Answered: Apr 19, 2016 12:12:15 PM EDT)**

Question 9

When do you anticipate making a contract award? Based on that timing, is it your expectation that the current or new actuarial firm will be responsible for the plan evaluation and recommendations of benefits for the plan year beginning 1/1/16? **(Submitted: Apr 18, 2016 10:45:58 AM EDT)**

Answer

- Contract award is scheduled and estimated to be made in June, 2016. The selected firm will be responsible for all services and recommendations of benefits (based on contract award date) for plan year beginning 1/1/2017. **(Answered: Apr 19, 2016 12:12:15 PM EDT)**