Town of Fort Myers Beach
Agenda Item Summary Blue Sheet Number: **2011-120**

1. Requested Motion: **Meeting Date: October 17, 2011**

Motion to reject all proposals in response to RFP 11-01- FIN, Employee Benefits Coverage for the Town of Fort Myers Beach, and authorize staff to execute a three-year contract renewal with the Florida Municipal Insurance Trust (FMIT).

Why the action is necessary:

Council must approve all contract extensions.

What the action accomplishes:

The action provides for the continuation of the Employee Health Care Benefits Coverage.

2. Agenda:
_ Consent
√ Administrative

3. Requirement/Purpose:
_ Resolution
_ Ordinance
√ Other – Contract

4. Submitter of Information:
_ Council
√ Town Staff - Public Works
_ Town Attorney

5. Background:

On July 22, 2011 the Town of Fort Myers Beach issued RFP 11-01-FIN for Employee Benefits Coverage. At the same time, the Town received a proposal for renewal from the Florida Municipal Insurance Trust (FMIT). Five (5) responses were received on the due date. The Town's Consultant, Ben Few & Co., reviewed the responses as wells as the FMIT renewal proposal and recommended award to Public Risk Insurance Agency (PRIA) for employee health, dental, and vision coverage. Subsequent to this recommendation, Staff negotiated a more favorable renewal from FMIT which will result in a cost savings of $ 64,246.80 over the current year and $27, 328.80 over the PRIA proposal.

Attached are:

1. Request for Proposals RFP 11-01- FIN Employee Benefits Coverage for the Town of Fort Myers Beach
2. Consultants analysis for the proposals
3. Renewal quotation from FMIT
4. Cost savings associated with adoption of renewal.

6. Alternative Action:

Do not approve the renewal and contract with the lowest responsive responsible proposer (PRIA).

7. Management Recommendations:

Approve the contract renewal with FMIT.

8. Recommended Approval:

Town Manager	Town Attorney	Finance Director	Public Works Director	Community Development Director	Cultural Resources Director	Town Clerk

9. Council Action:

_ Approved _ Denied _Deferred _Other

THE TOWN OF FORT MYERS BEACH

REQUEST FOR PROPOSALS
TO PROVIDE

EMPLOYEE BENEFITS COVERAGE

FOR THE TOWN OF FORT MYERS BEACH

RFP-11-01-FIN

Prepared by:

Town of Fort Myers Beach
2523 Estero Blvd.
Fort Myers Beach, FL 33931

TOWN OF FORT MYERS BEACH
ADVERTISEMENT - REQUEST FOR PROPOSALS #RFP-11-01-FIN

The Town of Fort Myers Beach invites proposal submissions from Employee Benefit Insurers for the Town of Fort Myers Beach #RFP-11-01-FIN. The Town Hall is located at 2523 Estero Boulevard, Fort Myers Beach, Florida 33931. Sealed proposals must be received in Town Hall, attention Contracts Manager, no later than **August 26, 2011, at 11:00 AM** local time. Any proposal received by the Town later than the above time will be returned unopened.

Interested parties must obtain the package of project documents for **EMPLOYEE BENEFITS COVERAGE RFP #11-01-FIN**. The package may be obtained from Town Hall, located at: TOWN OF FORT MYERS BEACH, 2523 Estero Blvd, Fort Myers Beach, Florida 33931, (239) 765-0202, Extension 116. There shall be an additional charge to cover expenses if packaging and mailing is required.

Respondents are solely responsible for checking the Town web site for the issuance of any addenda prior to submitting a proposal, and for providing the Town with a current email address and facsimile number for this purpose. If the package is not obtained directly from the Town of Fort Myers Beach, or is modified in any manner, the Proposal will not be accepted for consideration by the Town.

No later than **August 26, 2011, at 11:00 AM** local time, Respondents shall submit one (1) original proposal and four (4) identical copies of the accompanying information with an electronic copy of the same as a PDF on CD/DVD in a sealed envelope which is clearly and visibly marked on the outside, "EMPLOYEE BENEFITS COVERAGE RFP #11-01-FIN". Respondent's complete name and address shall also appear on the exterior of the proposal package.

The Town of Fort Myers Beach reserves the right, in its sole judgment in the best interest of the Town, to waive any informalities in any proposals; to make award(s) including multiple awards; to waive any non-substantive, in Town's sole judgment, irregularity or technicality in proposals received, and/or to reject any or all proposals.

The Town's selection committee meeting dates will be posted at Town Hall and/or listed on the Town website or please contact the Town at (239) 765-0202 for such information.

TOWN OF FORT MYERS BEACH

Legal Ad:

Michelle Mayher, Town Clerk

RUN DATE: _____, 20_____

Please return affidavit of Publication to the Town Clerk.

Received at the News Press by _____

DATE: _____ TIME: _____

EMPLOYEE BENEFITS COVERAGE RFP# 11-01-FIN

Notice is hereby given that the Town of Fort Myers Beach, hereinafter known as the Town, invites proposal submissions from qualified proposers for employee benefits coverage for the Town of Fort Myers Beach. The Town Hall is located at 2523 Estero Boulevard, Fort Myers Beach, Florida 33931. Sealed proposals must be received in Town Hall, attention Contracts Manager, no later than **August 26, 2011, at 11:00 AM** local time. Any proposal received by the Town later than the above time will be returned unopened.

Interested parties must obtain the specifications package of project documents for EMPLOYEE BENEFITS COVERAGE RFP #11-01-FIN. The package may be obtained from Town Hall, located at: TOWN OF FORT MYERS BEACH, 2523 Estero Blvd, Fort Myers Beach, Florida 33931, (239) 765-0202, Extension 116. There shall be an additional charge to cover expenses if packaging and mailing is required.

Respondents are solely responsible for checking the Town web site for the issuance of any addenda prior to submitting a proposal, and for providing the Town with a current email address and facsimile number for this purpose. If the package is not obtained directly from the Town of Fort Myers Beach, or is modified in any manner, the Proposal will not be accepted for consideration by the Town.

A. PROPOSAL SUBMITTAL:

Submit one (1) original and four (4) identical copies of the complete proposal, and an electronic copy of the same as a PDF on CD/DVD. Proposals must be submitted by mail or in person to Town of Fort Myers Beach, Town Hall, on the second floor, 2523 Estero Boulevard, Fort Myers Beach, FL 33931, not later than **11:00 AM on August 26, 2011.**

All Proposals shall be in a sealed envelope clearly marked – **"EMPLOYEE BENEFITS COVERAGE RFP #11-01-FIN"**. For proper identification, the Respondent's complete name and address shall also appear on the exterior of the proposal package.

Proposals submitted after the specified time and date will not be considered and will be returned unopened to Respondent. Proposals received by telephone, telegraph, facsimile and/or e-mail will not be accepted.

Proposals will be opened at 11:00 am on August 26, 2011 at Town Hall. If necessary, the Town's short-list and final selection meeting dates will be posted at Town Hall and/or listed on the Town website at www.fortmyersbeachfl.gov or contact the Town (239) 765-0202 ext. 116.

It is the Respondent's responsibility to insure the proposal is mailed or delivered by the due date. The Town will not be held responsible for proposals delayed by the U.S. Mail or any other courier. The Town shall not be held liable for any expenses incurred by the Respondent in preparing and submitting the proposal and/or attendance at any interviews, contract negotiations or applicable site visits.

B. RECEIPT OF PROPOSALS:

In the event a team of firms is entering into a joint venture to respond to the RFP, one firm shall be named the prime contractor and the proposal shall be submitted in the name of the prime contractor. All correspondence concerning the RFP will be between the Town and prime contractor.

C. SUBCONTRACTING:

Should the Respondent intend to subcontract all or any part of the work specified, name(s) and address(es) of subcontractor(s) must be provided in proposal response. The Respondent shall be responsible for subcontractor(s) full compliance with the requirements of the RFP specifications. If awarded the contract, payments will only be made to prime Respondents submitting the proposal. The Town will not be responsible for payments to subcontractors.

D. QUESTIONS ABOUT THE RFP:
Any questions or communications concerning conditions and specifications shall be submitted in writing to the Town representative no later than August 5, 2011, by fax or e-mail. Communications shall be addressed to Contracts Manager, Phone (239)765-0202 ext. 116; Fax (239) 765-0909; e-mail peter@fortmyersbeachfl.gov . Replies will be issued to all Respondents of record via email as addenda that will become part of the contract documents.

E. ADDENDA:
The Respondent shall include acknowledgment of receipt of addenda (if any) in their sealed proposal. The Respondent should include an initialed copy of each addendum in the proposal package

F. PUBLIC INFORMATION:
All information and materials submitted will become the property of the Town and shall be subject to the provisions of the public records laws in effect at this time. If awarded the contract, the proposal submission, in its entirety, will be included as part of the contract documents and filed, as public record, with the Clerk of the Town.

G. CONTRACT:
Each proposal is received with the understanding that an acceptance in writing by the Town of the offer to furnish any or all of the services and materials described shall constitute a contract between the Respondent and the Town. This contract shall bind the Respondent to furnish and deliver the services and materials quoted, at the prices stated and in accordance with the condition of said accepted proposal. It is agreed that the Respondent will not assign, transfer, convey or otherwise dispose of the contract or its right, title or interest in or to the same, or any part thereof, without previous consent of the Town and any sureties.

H. AWARDS:
As the best interest of the Town may require, the right is reserved to accept or reject any and all proposals or to waive any irregularity in proposals received; and to accept or reject any item or group of items unless qualified by Respondent.

I. QUALIFICATION PROCEDURES:
All applicants must be qualified to do business in the State of Florida and must have an address (not a post office box) in the State of Florida.

J. INDEMNITY:
The successful Respondent agrees, by entering into this contract, to defend, indemnify and hold the Town harmless from any and all causes of action or claims of damages arising out or under this contract, including but not limited to attorney fees and costs incurred by the Town as a result of Respondent's response.

K. EQUAL OPPORTUNITY STATEMENT:
The Town of Fort Myers Beach, in accordance with the provisions of Title VI of the Civil Rights Act of 1964, et seq. hereby notifies all firms and individuals that it will require affirmative efforts be made to ensure equal participation in all contracts. No firm or individual shall be discriminated against on the grounds of race, color, gender, national origin, religious affiliation, sexual orientation, age or disability in consideration for qualification or selection.

L. TAXES:
All Town business license, personal property, real estate and other applicable tax requirements shall be met by Proposer.

M. DRUG-FREE WORKPLACE:
The policy of the Town requires all Proposers maintain a drug free workplace policy. Consequently, any vendor providing goods or services to the Town must comply with all applicable Federal and State Drug Free Workplace Acts.

N. FEDERAL, STATE, LOCAL LAWS:
All Proposers will comply with all Federal, State and Local laws, ordinances, rules and regulations relative to conducting business in The Town and performing the prescribed service. Ignorance on the part of the Proposer

shall not, in any way, relieve the Proposer from responsibility for compliance with said laws and regulations or any of the provisions of these documents.

O. INSURANCE:
All Proposers shall submit proof of insurance as set forth below. Certificates of insurance written by a company or companies acceptable to the Town shall be submitted to the Town no later than ten (10) days after award of the contract. Failure to do so will disqualify the Proposer automatically. The award of a contract is conditioned upon such submittal to the Town's satisfaction. Certificates of insurance shall list the Town as the certificate holder and as an additional insured. Insurance shall be maintained during the entire term of the contract, shall include Contractual Liability and Products and Completed Operations Coverage, and shall be of the following forms and limits:

Workers Compensation Coverage for all employees to comply with Statutory Limits in compliance with the applicable State and Federal laws;

Commercial General Liability Insurance with minimum limits of $1,000,000 each occurrence combined single limit or $1,000,000 each occurrence/$1,000,000 general aggregate;

Business Automobile Liability Insurance with minimum limits of $1,000,000 each occurrence Combined Single Limit or $1,000,000 each occurrence/$1,000,000 general aggregate; and

Professional Liability with limits of $1,000,000.

The establishment of minimum limits of insurance by Town does not reduce or limit the liability or responsibilities of Proposer.

Renewal shall be sent to the Town at least 30 days prior to any expiration date. Proposer shall ensure that its insurer provides a 30 day notification to the Town in the event of cancellation, renewal, or modification of any required insurance coverage requirements that the Proposer is required to meet. The Proposer shall provide the Town with certificates of insurance meeting the required insurance provisions.

P. TIME OF CONTRACT:
The Town anticipates awarding a Professional Service Agreement for a term of one (1) year with an option for two (2) additional terms of one (1) year each, for a possible total of four (3) years. Hourly rates and all other negotiated expenses will remain in effect throughout the duration of the contract term, including the renewal, unless mutually agreed upon by both parties. The resulting Agreement may be terminated by the Town without cause and/or at its convenience, or due to the fault of the Proposer, by the Town giving thirty (30) days' written notice to the Proposer.

Q. TIME FOR CONSIDERATION:
Due to the evaluation process, proposals must remain in effect for at least 60 days after date of opening.

PROPOSAL SPECIFICATIONS

1. **INTRODUCTION AND BACKGROUND:** The Town of Fort Myers Beach is located in Southwest Florida on the Gulf of Mexico and was incorporated in 1995 Currently the Town enjoys a population of approximately 9,000 residents, with a City Staff of 34.

   It is the intent of this RFP to solicit proposals for employee benefits coverage, per the following specifications for the staff of the Town of Fort Myers Beach, to be effective October 1, 2011.

   The Town currently maintains an employee benefits package, primarily written through the Florida Municipal Trust (FMIT), utilizing the CIGNA Open Access Plus plan for its medical benefits. You will find the current plan, in its entirety in the exhibit section. In addition to medical benefits, The Town also provides Dental, Vision, Short Term Disability, Long Term Disability and Life Insurance. All of these plans are represented in the exhibit section. Please refer to the actual plan documents within the exhibition section for plan design.

   There are currently 34 employees on the plan: 25 employee only; 1 employee and children; 4 employee and spouse; 3 employee and family dental and 1 employee and family dental and vision

   FMIT has written the medical benefits for several years and the Town is pleased with the service and benefit structure currently in place. Thus, we are requesting the same benefit schedule and format as the current plan found in the exhibit section. Any deviations from this plan must be shown and explained.

   The Town of Fort Myers Beach retains the rights to negotiate benefits with the selected bidder, should the financial situation dictate.

   Indicate on your proposal if you will be providing "COBRA" service within your quote, or if it is available at additional cost. COBRA is currently handled by FMIT. There is no one on COBRA at this time.

   Due care and diligence have been exercised in preparing these specifications, and all information is believed to be substantially correct. However, the responsibility for determining the full extent of the exposures to risk and verification of all information rest solely with the proposer. Neither the Town of Fort Myers Beach, Ben Few & Company, Inc. nor any of either entity's representatives shall be responsible for any error or omission in these specifications, nor for the failure on the part of the proposer to understand the full extent of the exposure.

2. **CURRENT PREMIUM:** Current monthly premiums are as follows:

Medical	
Medicare Supplement	$346.87
Employee only	$768.5
Employee and spouse	$1637.75
Employee and child (ren)	$1436.28
Employee and family	$2208.58
Dental	
Employee only	$33.86
Employee and family	$49.77

Life and AD&D	
Employee only	$.33/1000
Employee and family	$1.5/1000
Vision	
Employee only	$5.74
Employee and family	$8.43

*SHORT TERM AND LONG TERM DISABILITY RATES NOT AVAILABLE

The Town of Fort Myers Beach pays 100% of all benefit premiums for all employees and pays 50% for dependent coverage. There is no Section 125 in effect.

Claims history and summary of claims over $25,000 are shown in the exhibit section.

3. **TERM**: The 2011-2012 Plan Year's effective date is October 1, 2011.

4. **MINIMUM QUALIFICATIONS**: Proposers must be duly licensed by, and in good standing with, the State of Florida. Proposers must have experience in providing services for governmental organizations. Proposers must describe and demonstrate their expertise and experience in placing and servicing insurance for each of the types of coverage currently maintained by the Town.

5. **PROPOSAL FORMAT:** To facilitate comparison of proposals, proposers must submit proposals in exact accordance with the current medical benefits. Should this not be possible, proposers must identify in deviation from the current benefits.

   Proposers must provide rates for employee only; employee and children; employee and spouse; and employee and family.

   Proposers must provide at least three references of current clients that utilize products and services similar to that requested in this proposal. Please provide the entity name; individual contact; phone number and e-mail address for that contact.

6. **CLAIMS HISTORY:** Claims history is shown at the end of the exhibit section.

   Three employees that were responsible for claims over $25,000 are no longer part of this group census. Those claims were:
   1) male awaiting transplant
   2) female with medical and mental claims
   3) female with a difficult pregnancy

7. ADDITIONAL INSTRUCTIONS

7.1 Conditions of Work

Each Proposer shall inform itself fully of the conditions relating to the project and the employment of labor therein. Failure to do so will not relieve a Proposer of the obligation to furnish all materials and labor necessary to carry out the provisions of their agreement.

7.2 Subcontractors

The use of subcontractors and the work they are to perform must receive prior written approval of the Town. Proposer shall be solely responsible for all work performed and materials provided by subcontractors. Proposer shall be responsible for the liability of subcontractors for the types and limits required of the Proposer.

7.3 Criminal Background Investigations

The Proposer shall provide the Town with criminal background check information for each employee and any and all subcontractors hired by the Proposer to provide services for the management and operations of the technical support services program.

7.4 Public Information

Respondents are advised that all information submitted in the proposal shall be considered public information upon award of one or more contracts under this RFP.

7.5 Public Entities Crime Form

Respondents shall complete and submit with their proposal the sworn statement required by Section 287.133, Florida Statutes, Public Entity Crimes, attached as Exhibit H of the Professional Services Agreement.

7.6 Affidavit Certification Immigration Laws

Respondents shall complete and submit with their proposal the Affidavit Certification Immigration Laws, attached as Exhibit I of the Professional Services Agreement.

7.7. Commercial Warranty

The Respondent agrees that the products and services furnished under any award resulting from this solicitation shall be covered by the most favorable commercial warranties the Respondent gives any customer for such.

7.8. Alternatives/Exceptions

In offering its best proposal, Respondent may note exceptions to any of the provisions in this RFP. Respondent is to specify the RFP page number and section number and to detail the exception. Respondent should not incorporate by reference its entire, standard contract document.

Respondent may present alternative methods to meet the Town's objectives for this contract. However, Respondent is encouraged to first respond to the objectives detailed in the Services Required herein.

7.9. Presentation

The Town may elect, but is not obligated, to offer to one or more Respondents the opportunity to present their proposal to the Town. Presentations, if any, will be in a form and manner prescribed by the Town.

7.10. Negotiations

Negotiations shall then be conducted with one or more of the Respondents so selected. After negotiations have been conducted with such Respondent(s) so selected, the Town shall select the Respondent(s) which, in its sole judgment and opinion, made the best proposal, and shall award one or more contract(s) to the selected Respondent(s).

7.11. Town Discretion in Award; Costs of Proposal Preparation; Section Headings

The Town shall have the ability to decide not to award any contract under this Request for Proposal, or to award only a portion of the work provided under this Request for Proposal, in its sole discretion. All Respondents shall have sole responsibility for any cost(s) they incur related to this Request for Proposal and the Town shall bear no responsibility therefore. The Section headings are meant for the convenience of the Town only.

PROPOSAL SUBMITTAL CHECKLIST

THIS CHECKLIST IS MERELY A GUIDE TO ASSIST THE RESPONDENT IN PREPARING A COMPLETE PROPOSAL SUBMITTAL

I M P O R T A N T: Please read carefully and follow each item.

Please check off each of the following items as the necessary action is completed:

☐ 1. The Proposal has been signed.

☐ 2. Include a signed copy of each addendum, if any.

☐ 3. Public Entities Crime Form properly completed, signed and notarized.

☐ 4. Affidavit Certification Immigration Laws properly completed, signed, and notarized.

☐ 5. List of subcontractors, including the name and address of each subcontractor.

☐ 6. List any technical support service contracts to which the Respondent was a party that have been terminated, and the reason for termination.

☐ 7. The mailing envelope has been addressed to:

Town of Fort Myers Beach
Town Hall
2523 Estero Boulevard
Fort Myers Beach, Florida 33931
ATTN: Contracts Manager

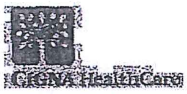
☐ 8. The mailing envelope must be sealed and marked **"EMPLOYEE BENEFITS COVERAGE RFP #11-01-FIN"** with the due date and time noted. All courier delivered proposals must have the RFP title and number on the outside of the courier packet.

☐ 9. For proper identification, the Respondent's complete name and address must also appear on the exterior of the proposal package.

☐ 10. Submit one (1) original and four (4) identical copies of the complete proposal, and an electronic copy of the same as PDF on CD/DVD.

☐ 11. Proposals must be submitted by mail or in person to the address herein no later than **August 26, 2011 at 11:00 AM.**

EXHIBIT A – MEDICAL BENEFITS



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 Copayment, Deductible or Coinsurance.

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 In-Network and Out-of-Network charges that are not paid by the benefit plan because of any Coinsurance.

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:

- Mental Health and Substance Abuse treatment.
- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% except for:

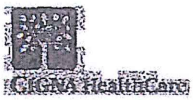
- Mental Health and Substance Abuse treatment.
- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums will accumulate in one direction (e.g. 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.

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.



OPEN ACCESS PLUS MEDICAL BENEFITS

The Schedule

Assistant Surgeon and Co-Surgeon Charges

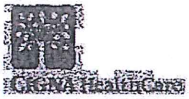
Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

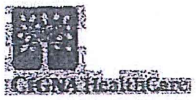
Co-Surgeon

The maximum amount payable will be limited to charges made by co-surgeons that do not exceed 20 percent of the surgeon's allowable charge plus 20 percent. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to coinsurance or deductible amounts.)

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	$5,000,000	
Coinsurance Levels	90%	70% of the Maximum Reimbursable Charge
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 percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected. **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, copayments and coinsurance.	Not Applicable	80th Percentile



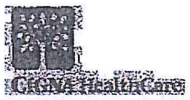
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
Individual	Not Applicable	$300 per person
Family Maximum	Not Applicable	$900 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual deductible and then their claims will be covered 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.		
Out-of-Pocket Maximum		
Individual	$2,500 per person	$5,000 per person
Family Maximum	$5,000 per family	$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%.		



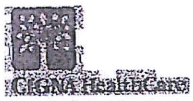
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office visit	No charge after $20 per office visit copay	70% after plan deductible
Specialty Care Physician's Office Visits Consultant and Referral Physician's Services **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with CG.	No charge after $40 Specialist per office visit copay	70% after plan deductible
Surgery Performed In the Physician's Office	No charge after the $20 PCP or $40 Specialist per office visit copay	70% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	No charge after the $20 PCP or $40 Specialist per office visit copay	70% after plan deductible
Allergy Treatment/Injections	No charge after either the $20 PCP or $40 Specialist per office visit copay or the actual charge, whichever is less	70% after plan deductible
Allergy Serum (dispensed by the Physician in the office)	No charge	70% after plan deductible
Preventive Care Routine Preventive Care Calendar Year Maximum through age 15 (including immunizations): Unlimited Calendar Year Maximum for ages 16 and above (including immunizations): $750 **Note:** Well-woman OB/GYN visits will be considered either a PCP or Specialist depending on how the provider contracts with CG. **Note:** Charges for lab and radiology services, when billed by the physician's office, will be subject to the plan's Preventive Care dollar maximum. Charges for lab and radiology services, when billed by an independent diagnostic facility or outpatient hospital do not apply to the plan's Preventive Care dollar maximum.		
Physician's Office Visit (routine Preventive Care for children through age 15)	No charge after the $20 PCP or $40 Specialist per office visit copay	70%, no plan deductible
Immunizations	No charge	70%, no plan deductible
Physician's Office Visit (routine Preventive Care for ages 16 and over)	No charge after the $20 PCP or $40 Specialist per office visit copay	In-Network coverage only
Immunizations	No charge	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mammograms, PSA, Pap Smear **Notes:** • Mammogram charges do not accumulate to the plan's Preventive Care dollar maximum, regardless of place of service. • PSA and Pap Smear charges, when billed by the physician's office, will be subject to the plan's Preventive Care dollar maximum. • PSA and Pap Smear charges, when billed by an independent diagnostic facility or outpatient hospital, do not accumulate to the plan's Preventive Care dollar maximum.	90% if billed by an independent diagnostic facility or outpatient hospital **Note:** The associated wellness exam will be covered at no charge after the $20 PCP or $40 Specialist per visit copay.	70% after plan deductible
Inpatient Hospital - Facility Services	90%	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%	70% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	90%	70% after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	90%	70% after plan deductible
Outpatient Professional Services		
Surgeon Anesthesiologist	90%	70% after plan deductible
Radiologist Pathologist	No charge	70% after plan deductible

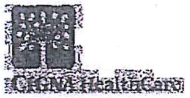
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency and Urgent Care Services		
Physician's Office Visit	No charge after the $20 PCP or $40 Specialist per office visit copay	No charge after the $20 PCP or $40 Specialist per office visit copay (except if not a true emergency, then 70% after plan deductible)
Hospital Emergency Room	No charge after $100 per visit copay*	No charge after $100 per visit copay* (except if not a true emergency, then 70% after plan deductible)
	*waived if admitted	*waived if admitted
Outpatient Professional services (radiology, pathology and ER Physician)	No charge	No charge (except if not a true emergency, then 70% after plan deductible)
Urgent Care Facility or Outpatient Facility	No charge after $50 per visit copay*	No charge after $50 per visit copay* (except if not a true emergency, then 70% after plan deductible)
	*waived if admitted	*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	No charge (except if not a true emergency, then 70% after plan deductible)
Independent x-ray and/or Lab Facility in conjunction with an ER visit	No charge	No charge (except if not a true emergency, then 70% after plan deductible)
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) The scan copay/deductible applies per type of scan per day	No charge after $250 scan copay	No charge after $250 scan copay (except if not a true emergency, then 70% after $500 scan deductible and plan deductible)
Ambulance	90%	90% (except if not a true emergency, then 70% after plan deductible)
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 60 days combined	90%	70% after plan deductible



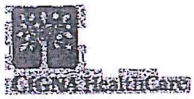
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Laboratory and Radiology Services (includes pre-admission testing)		
Physician's Office Visit	No charge after the $20 PCP or $40 Specialist per office visit copay	70% after plan deductible
Outpatient Hospital Facility	No charge	70% after plan deductible
Independent X-ray and/or Lab Facility	No charge	70% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
The scan copay/deductible applies per type of scan per day		
Physician's Office Visit	No charge after $250 scan copay	$500 scan deductible, then 70% after plan deductible
Inpatient Facility	100%	70% after plan deductible
Outpatient Facility	$250 scan copay, then 90%	$500 scan deductible, then 70% after plan deductible
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: 20 days for all therapies combined Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	No charge after the $20 PCP or $40 Specialist per office visit copay **Note:** Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.	70% after plan deductible
Outpatient Cardiac Rehabilitation Calendar Year Maximum: 36 days	No charge after the $20 PCP or $40 Specialist per office visit copay	70% after plan deductible
Chiropractic Care Calendar Year Maximum: 20 days Physician's Office Visit	No charge after the $20 PCP or $40 Specialist per office visit copay	70% after plan deductible
Home Health Care Calendar Year Maximum: 60 days (includes outpatient private nursing when approved as medically necessary)	90%	70% after plan deductible



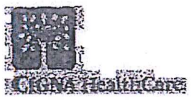
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Hospice		
Inpatient Services	90%	70% after plan deductible
Outpatient Services	90%	70% after plan deductible
(same coinsurance level as Home Health Care)		
Bereavement Counseling		
Services provided as part of Hospice Care		
Inpatient	90%	70% after plan deductible
Outpatient	90%	70% after plan deductible
Services provided by Mental Health Professional	Covered under Mental Health Benefit	Covered under Mental Health Benefit
Maternity Care Services		
Initial Visit to Confirm Pregnancy	No charge after the $20 PCP or $40 Specialist per office visit copay	70% after plan deductible
Note: OB/GYN providers will be considered either a PCP or Specialist depending on how the provider contracts with CG.		
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	90%	70% 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 $20 PCP or $40 Specialist per office visit copay	70% after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	90%	70% after plan deductible
Abortion		
Includes only non-elective procedures		
Physician's Office Visit	No charge after the $20 PCP or $40 Specialist per office visit copay	70% after plan deductible
Inpatient Facility	90%	70% after plan deductible
Outpatient Facility	90%	70% after plan deductible
Physician's Services	90%	70% after plan deductible



BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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	No charge after the $20 PCP or $40 Specialist per office visit copay	In-Network coverage only
Inpatient Facility	100% at Lifesource center, otherwise 90%	In-Network coverage only
Physician's Services	100% at Lifesource center, otherwise 90%	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 Calendar Year Maximum: $2,500	90%	70% after plan deductible
External Prosthetic Appliances Calendar Year Maximum: $2,500	90%	70% after plan deductible



BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Nutritional Evaluation Calendar Year Maximum: 3 visits per person		
Physician's Office Visit	No charge after the $20 PCP or $40 Specialist per office visit copay	70% after plan deductible
Inpatient Facility	90%	70% after plan deductible
Outpatient Facility	90%	70% after plan deductible
Physician's Services	90%	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	No charge after the $20 PCP or $40 Specialist per office visit copay	70% after plan deductible
Inpatient Facility	90%	70% after plan deductible
Outpatient Facility	90%	70% after plan deductible
Physician's Services	90%	70% after plan deductible
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.
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 and will not count toward any plan limits that are shown in the Schedule for mental health and substance abuse services including in-hospital services. 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.		



BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mental Health and Substance Abuse		
Inpatient Calendar Year Maximum: 30 days Mental Health: Acute: based on a ratio of 1:1 Partial: based on a ratio of 2:1 Residential: based on a ratio of 2:1 Substance Abuse: Acute detox: requires 24 hour nursing; based on a ratio of 1:1 Acute Inpatient Rehab: requires 24 hour nursing; based on a ratio of 1:1 Partial: based on a ratio of 2:1 Residential: based on a ratio of 2:1	$50 per day copay, then 90%	$50 per day deductible, then 70% after plan deductible
Outpatient Calendar Year Maximum: 44 visits	No charge after $40 per office visit copay	70% after plan deductible
Mental Health Outpatient Group Therapy (One group therapy session equals one individual therapy session)	No charge after $20 per visit copay	70% after plan deductible
Intensive Outpatient Calendar Year Maximum: Up to 3 programs Based on a ratio of 1:1	50% after $50 per program copay	50% after $50 per program deductible

EXHIBIT B – DENTAL PLAN

Dental Plan 1000

Florida Municipal Insurance Trust

Summary of Benefits	Per Covered Participant
Calendar year Deductible	$ 50
Calendar Year Maximum	$1,000

Type A: Preventive Dental Services

Oral examinations, dental x-rays, prophylaxis, and fluoride and sealant applications (for dependents under age 15)

- 100% of covered expenses, no deductible

Type B: Basic Dental Services

Emergency treatment for pain, space maintainers, dental x-rays, biopsies of oral tissue, pulp vitality tests, fillings, extractions, oral surgery, endodontics, periodontics

- 80% of covered expenses, after deductible

Type C: Dental Restorations and Specialty Services

Inlays, onlays, crowns, bridges, dentures

- 50% of covered expenses, after deductible

Type D: Orthodontia Services

Diagnostic procedures, comprehensive treatment, appliances

- 50% of covered expenses, after deductible
- $50 lifetime deductible per person
- $1,000 lifetime maximum per person
- Eligible dependents under age 19 only

[This is intended as a Summary of Benefits and does not include all of the benefits, limitations, and exclusions of the plan. Complete terms of the plan are contained in the Dental Master Plan of Benefits.]

EXHIBIT C– VISION PLAN

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CompBenefits

Florida Municipal Insurance Trust

Open your eyes to high-quality vision care! The average family spends close to **$600 each year** on routine eye health care. Using CompBenefits' VisionCare Plan, you will receive your routine eye health care with just a small copayment.

CompBenefits' **VisionCare** Plan provides benefits for covered:

- **Eye health examinations**
- **Frames**
- **Eyeglass Lenses**
- **Contact Lenses**

Plus you will receive:

- **LASIK surgery discount**
- **Preferred member pricing for other frame and lens options***

When ordering from one of our network eye doctors, you will also receive in the year of your eye exam:

- A **20% discount** on a second pair of eyeglasses
- A **15% discount** on your contact lens fitting fee

SERVICE FREQUENCY		COPAYMENTS	
Vision exam:	Once every **12** months	**Exam/Materials:**	**$10**
Lenses:	Once every **12** months		
Frame:	Once every **24** months		

SAVINGS! SEE THE DIFFERENCE

You can save money two ways with VisionCare. First, the cost of plan services and materials is discounted and prepaid. So **except for any co-payments**, you have **no out-of-pocket expenses** for covered services and supplies when you use one of our network doctors. Second, your coverage costs are deducted from your pay *before* any federal income or FICA taxes are taken out. This makes your taxable wage base lower, so you would pay less tax.

Here's an **example** of how the plan helps you save over the course of a year:

If You Get:	You Pay:	
	VisionCare Doctor	Typical Retail
Eye exam	.00	$ 85.00
Frame (designer style)	.00	120.00
Lenses: Bifocal	.00	100.00
Co-payments: $10 exam/materials	$10.00	.00
	$10.00	**$ 305.00**

YOUR TOTAL SAVINGS THROUGH VISIONCARE: 97% OFF RETAIL

In this example, you would have saved **$295.00** in vision care costs with VisionCare Plan. Keep in mind, however, that your actual savings will depend on your plan allowances, your actual premium, the doctors and materials you select, and your own tax situation.

* This is not a schedule of maximum benefits. For example, the plan covers frames based on the manufacturer's *wholesale* price guide. So while the retail price of a covered frame may vary among plan doctors, the *value* of your covered frame stays the same. Typically, the wholesale frame allowance is equivalent to a retail price of $80-150. You may be required to pay extra only if you choose a frame that exceeds the covered wholesale price.

Maximum Allowances	Participating Doctor (After copayments/ Up to plan limits)
Eye Exam	Paid in full
Lenses (per pair)	
Single	Paid in full
Bifocal	Paid in full
Trifocal	Paid in full
Lenticular	Paid in full
Contact Lenses	
Elective (exam & lenses)	$120*
Medically necessary**	Paid in full
Frame	$35 wholesale
Lasik* **	

Members receive benefits when services are received from a TLC Truvision network provider with the following preferred rates:

- Silver Package: $895/eye for Conventional LASIK
- Gold Package: $1,295/eye for CustomLASIK
- Platinum Package: $1,895/eye for CustomLASIK plus Bladeless LASIK (using IntraLase technology).

Members will also receive a 10% discount off UCR charges at other preferred LASIK provider locations, and pay no more than $1,800 per eye for the Conventional LASIK procedure and $2,300 per eye for CustomLASIK.

* This allowance is paid with the same frequency as lenses, in place of all other benefits.

** Medically necessary (prior authorization required) is defined as 1) following cataract surgery w/o intraocular lens; 2) correction of extreme visual acuity problems not correctable with glasses; 3) anisometropia greater than 5.00 diopters and asthenopia or diplopia; with spectacles; 4) Keratoconus; or 5) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life.

*** Plan members must first contact CompBenefits for a list of providers and to receive a Refractive Care ID card.

This schedule shows only a few of the covered procedures. Please see your Benefit Administrator for a complete schedule. This schedule is intended for comparison purposes only. The benefits of each plan will be determined by the contract. For a complete listing of benefits and exclusions and limitations, please reference your certificate of coverage.

Out-of-network benefits apply under the VisionCare Plan, but benefits are higher when a participating doctor is utilized.

Limitations and Exclusions apply.

HOW DOES VISIONCARE PLAN WORK?

You can choose a network provider at www.mycompbenefits.com. Depending on your plan, either you or your doctor will download a VisionPass Form from www.compbenefits.com. You must use the form in the time specified for services*. Visit your doctor, who will provide you with a comprehensive eye exam and order prescribed eyeglasses or contacts, if necessary.

Pay any copayments as well as any additional expenses for cosmetic items you have chosen. That's the end of your "paperwork". CompBenefits pays the doctor directly for his or her professional services. It's as easy as that!

* If you do not use your form in the time specified for services, you won't be able to download another until the next time you are eligible for benefits. However, you can request an extension from our Customer Care team at 800-865-3676.

CAN I GET CONTACTS INSTEAD OF LENSES?

Yes. If you prefer contact lenses, the plan provides an allowance of **$120.00** *in place of all other benefits.*

HOW DO I GET FURTHER QUESTIONS ANSWERED?

You may contact CompBenefits Customer Care Department with any questions or concerns at: 1-800-865-3676, Monday – Thursday 8am-8pm; and Friday 8am-6pm EST. or locate us on the web at www.mycompbenefits.com.

frequently asked questions

Q. *What are CompBenefits' VisionCare Plans?*

A. CompBenefits' VisionCare Plans are network-based vision plans that emphasize high quality routine eye health care from independent eye care professionals. Services and materials are provided on a pre-paid basis, and the plans pay network doctors directly. VisionCare Plan members can also use non-network doctors if they wish.

Q. *How does VisionCare Plan work?*

A. Members simply select any in-network optometrist or ophthalmologist and make their appointments. At the time of the appointment, members pay only their co-payments and for any extra cosmetic options selected. There are no forms to complete or claims to file.

Members can also choose an out-of-network provider. In this case, they pay their doctor at the time of the visit and submit receipts to CompBenefits for reimbursement. Benefits are paid according to a reimbursement schedule.

Q. *Are there any limitations to my vision benefit?*

A. Yes, there are a few. Oversized lenses, when prescribed, may be covered only when patient's face size indicates they are necessary. Blended and progressive lenses are not normally required for visual welfare and are generally excluded. Elective or cosmetic items such as photochromic lenses, fashion color-coated lenses and sun lenses are not normally covered.

Q. *Does VisionCare Plan exclude anything?*

A. Yes, some items and services are excluded.

- Orthoptics or vision training, subnormal vision aids or plano (non-prescription) lenses
- Replacement of lost or broken lenses, except at the regularly-scheduled plan intervals
- Medical or surgical treatment of the eyes
- Care provided through or required by any government agency or program, including Workers' Compensation or similar law

Q. *What do I need to access my benefits?*

A. You'll need a CompBenefits VisionPass which you can download from our Web site, www.mycompbenefits.com. You'll take it to your eye doctor, and he or she will file it for you.

Some groups, however, may have a plan in which the eye doctor downloads your VisionPass for you.

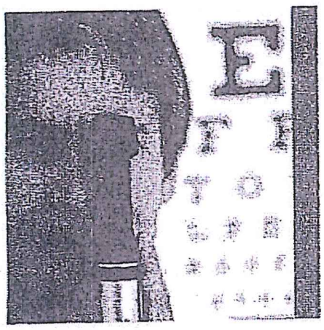
Check with your benefit administrator for more details on how you should obtain your VisionPass.

Q. *Can I go online to find out more about my plan or get assistance?*

A. Yes. You can visit www.mycompbenefits.com to learn about your plan, to check your benefits, to use our Provider Locator, to send us an e-mail and more.

LASIK & PRK

*Opening doors to better vision for thousands of people — with affordable LASIK & PRK procedures.**



Extensive publicity and positive patient experience have created the acceptance and growth of laser vision correction. Network doctors can help plan members understand these new procedures and provide access to our network of LASIK and PRK providers.

reduced fees

The LASIK and PRK procedures are available for plan members who are nearsighted or have astigmatism and wear glasses or contacts.** We have contracted with many of the finest facilities and eye doctors to offer these procedures at substantially reduced fees. Our network of centers features all TLC Laser Center (TLC Vision) facilities as well as many of the leading independent laser centers in the country. Members receive benefits when services are received from a TLC Vision network provider with the following preferred rates:

- Silver Package: $895/eye for Conventional LASIK
- Gold Package: $1,295/eye for CustomLASIK PRK is available on this package only. TLC Lifetime Commitment can be purchased, $200 (per eye).
- Platinum Package: $1,895/eye for CustomLASIK plus Bladeless LASIK (using IntraLase technology). Includes the TLC Lifetime Commitment.

Members must call TLC Vision Advantage Program at 888.358.3937 to initiate services. If a member chooses another participating LASIK location, the member will receive a 10% discount from the provider and pay no more than $1,800 per eye for the Conventional LASIK procedure and $2,300 per eye for Custom LASIK.

quality providers

Network providers have been selected for this program based upon their experience and quality results. All providers of these procedures are board certified ophthalmologists who work in the most advanced facilities.

easy access to service

During your comprehensive eye health examination, your doctor can determine if you are a candidate for LASIK or PRK. If you qualify, the doctor can also make arrangements for the procedure with one of the centers that participates in this program. Plan members can also go directly to one of the participating providers.

Your VisionPass Form or your VCP ID Card verifies your eligibility for LASIK and PRK discounts. In either case, you may obtain a VisionPass Form and list of providers from our website (www.mycompbenefits.com) or by calling our Customer Care Department at 800-865-3676.***

This discount cannot be combined with any other discount or promotional offer. The CompBenefits LASIK and PRK Program is not affiliated with any medical or health plan.

* Laser-assisted in-situ keratomileusis; photorefractive keratectomy.

** If qualified as a LASIK and PRK candidate by the network doctor

*** Program availability and professional fees may vary based on location and regulatory approval.

LSK 03/07

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CompBenefits

CompBenefits
1511 N. Westshore Blvd
Suite 1000
Tampa, FL 33607
(800) 749-5855
(813) 289-2020
www.compbenefits.com

EXHIBIT D – LIFE INSURANCE (SAME SCHEDULE FOR AD&D)

***

SCHEDULE OF BENEFITS

EMPLOYEE BASIC TERM LIFE INSURANCE

BASIC TERM LIFE INSURANCE BENEFIT:

Amount of coverage 1x Salary (rounded to the next highest $1,000)

Class	% Salary	Benefit Amount
I		
II		
III		
IV		
V		
VI		
VII		
VIII		

THE BASIC TERM LIFE INSURANCE BENEFIT IS REDUCED TO THE FOLLOWING FOR YOUR EMPLOYEES:

Reduced by 35% AT AGE 65 based on the amount of Basic Term Life Insurance in force at age 64
Reduced by 55% AT AGE 70 based on the amount of Basic Term Life Insurance in force at age 64
Reduced by 70% AT AGE 75 based on the amount of Basic Term Life Insurance in force at age 64
Reduced by 80% AT AGE 80 based on the amount of Basic Term Life Insurance in force at age 64
Reduced by 85% AT AGE 85 based on the amount of Basic Term Life Insurance in force at age 64

DEPENDENT CHILD TERM LIFE INSURANCE BENEFIT

DEPENDENT CHILD – BIRTH THROUGH 14 DAYS	$0
DEPENDENT CHILD – 15 DAYS UP TO 6 MONTHS	$500
DEPENDENT CHILD – FROM AGE 6 MONTHS TO ATTAINMENT OF LIMITING AGE	$2,500

DEPENDENT SPOUSE TERM LIFE INSURANCE BENEFIT

SPOUSE	LIFE BENEFIT
THROUGH AGE 64	$5,000

DEPENDENT SPOUSE LIFE INSURANCE BENEFITS TERMINIATE AT ATTAINMENTOF AGE 65.

EXHIBIT E – SHORT TERM DISABILITY

SCHEDULE OF BENEFITS

EMPLOYEE SHORT TERM DISABILITY BENEFIT

WEEKLY SHORT TERM DISABILITY BENEFIT IS AVAILABLE AS FOLLOWS:
NOT TO EXCEED 50% OF "BASIC SALARY"

Per Week 50% x Salary (rounded to the next highest $10)

Class	% Salary	Benefit Amount
I		
II		
III		
IV		
V		
VI		
VII		
VIII		

ELIMINATION PERIODS

BENEFITS ARE AVAILABLE FOR **TOTAL DISABILITY**:

- THE 1 DAY AFTER **BODILY INJURY**, OR
- 8 DAYS AFTER A **SICKNESS** COMMENCES.

MAXIMUM BENEFIT PERIOD 26 WEEK(S)

BENEFITS ARE AVAILABLE FOR **PARTIAL DISABILITY**:

- THE 1 DAY AFTER **TOTAL DISABILITY** DUE TO A **BODILY INJURY**, OR
- THE DAY FOLLOIWNG 8 CONSECUTIVE DAYS OF **TOTAL DISABILITY** AFTER A **SICKNESS**.

MAXIMUM BENEFIT PERIOD FOR PARTIAL DISABILITY IS 24 WEEKS, NOT TO EXCEED 26 WEEKS WHEN COMBINED WITH THE **TOTAL DISABILITY** BENEFIT.

EMPLOYEE SHORT TERM DISABILITY BENEFITS TERMINATE AT ATTAINMENT OF AGE 70, UNLESS THE **EMPLOYEE** IS EMPLOYED BY AN **EMPLOYER** WITH 20 OR MORE **EMPLOYEES.**

"BASIC SALARY" MEANS THE **EMPLOYEE'S** BASIC WAGE, SALARY OR EARNINGS FROM HIS OR HER **EMPLOYER** WHO SPONSORS THE GROUP INSURANCE PLAN. "BASIC SALARY" DOES NOT INCLUDE COMMISSIONS, BONUSES, OVERTIME OR ANY OTHER SPECIAL REMUNERATION.

GN-70051-07 EM ERSCBSTDP 7

EXHIBIT F – LONG TERM DISABILITY

SCHEDULE OF BENEFITS

MAXIMUM BENEFIT $6000 PER MONTH*

*Long term benefits are equal to the lesser of:
a. 60% of the insured individual's monthly earnings; or
b. the amount produced by first computing 70% of the insured individual's monthly earnings and then subtracting, from that computation, any other income benefits; or
c. the maximum benefit as elected by the participating employer but in no event greater than $6,000 per month.

ELIMINATION PERIOD 180 DAYS

MAXIMUM BENEFIT PERIOD:

Payment of Long Term Disability ceases as of the earliest of :
a. the date which the individual ceases to be totally disable or;
b. the end of the Benefit Period shown in the following schedule:

The age of the employee on the date total disability begins:	Benefit Period
Less than 60	to age 65
60	60 months
62	48 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

EXHIBIT G – CENSUS

Gender	Coverage	Birth Date	Salary
F	Single	4/26/79	41,516
M	EE + Family Dental	7/14/70	56,305
M	Single	5/12/83	24,960
M	EE + Children	7/14/63	43,000
M	Single	10/17/58	35,202
F	Single	9/28/81	44,000
M	Single	3/11/67	24,960
M	Single	8/16/64	26,737
F	Single	9/27/82	44,000
M	Single	2/17/50	33,421
M	Single	8/10/63	70,271
M	Single	2/11/58	32,423
M	Single	7/20/69	31,200
M	Single	6/5/71	38,570
F	Single	10/18/50	30,451
M	Single	3/21/74	50,000
M	Single	6/7/59	31,228
F	Single	9/18/57	65,066
F	Single	11/28/54	49,816
F	Single	7/12/80	32,760
M	Single	9/8/69	24,960
M	EE + Spouse	6/7/50	58,400
M	Single + Family Dental	2/25/77	31,200

M	EE + Spouse	6/1/79	32,760
F	Single	7/11/79	44,562
M	Single	12/13/76	24,960
F	EE + Spouse	10/19/44	41,472
M	Single	4/16/78	32,760
M	Single	1/16/78	24,960
F	EE + Spouse	4/28/70	66,693
M	Single	9/28/48	33,663
M	Employee/Family Dental & Vision Only	1/26/49	145,653
M	Single + Family Dental	1/19/45	35,064
F	Single	5/13/48	78,545

EXHIBIT H - PUBLIC ENTITY CRIME AFFIDAVIT

SWORN STATEMENT PURSUANT TO SECTION 287.133(3) (a),
FLORIDA STATUTES, ON PUBLIC ENTITY CRIMES

THIS FORM MUST BE SIGNED AND SWORN TO IN THE PRESENCE OF A NOTARY PUBLIC OR OTHER OFFICIAL AUTHORIZED TO ADMINISTER OATHS.

1. This sworn statement is submitted to _____
(print name of public entity)

by _____
(print individual's name and title)

for _____
(print name of entity submitting sworn statement)

whose business address is _____

_____

and (if applicable) its Federal Employer Identification Number (FEIN) is _____
(If the entity has no FEIN, include the Social Security Number of individual signing this sworn statement:_____
_____.)

2. I understand that a "public entity crime" as defined in Paragraph 287.233(1)(g), Florida Statutes, means a violation of any state or federal law by a person with respect to and directly related to the transaction of business with any public entity or with an agency or political subdivision of any other state or of the United States, including, but not limited to, any bid, proposal or contract for goods or services to be provided to any public entity or an agency or political subdivision of any other state or of the United States and involving antitrust, fraud, theft, bribery, collusion, racketeering, conspiracy, or material misrepresentation.

3. I understand that "convicted" or "conviction" as defined in Paragraph 287.233 (1) (b), Florida Statutes, means a finding of guilt or a conviction of a public entity crime, with or without an adjudication of guilt, in any federal or state trial court of record relating to charges brought by indictment or information after July 1, 1989, as a result of a jury verdict, non-jury trial, or entry of a plea of guilty or nolo contendere.

4. I understand that an "affiliate" as defined in Paragraph 287.133 (1) (a), Florida Statutes, means:

   1. A predecessor or successor of a person convicted of a public entity crime; or
   2. An entity under the control of any natural person who is active in the management of the entity and who has been convicted of a public entity crime. The term "affiliate" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in the management of an affiliate. The ownership by one person of shares constituting a controlling interest in another person, or a pooling of equipment or income among persons when not for fair market value under an arm's length agreement, shall be a prima facie case that one person controls another person. A person who knowingly enters into a joint venture with a person who has been convicted of a public entity crime in Florida during the preceding 36 months shall be considered an affiliate

5. I understand that a "person" as defined in Paragraph 287.133 (1) (e), Florida Statutes, means any natural person or entity organized under the laws of any state or of the United States with the legal power to enter into a binding contract and which bids or applies to bid on contracts for the provision of goods or services let by a public entity, or which otherwise transacts or applies to transact business with public entity. The term "person" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in management of an entity.

6. Based on information and belief, the statement, which I have marked below, is true in relation to the entity submitting this sworn statement. (Indicate which statement applies.)

_____Neither the entity submitting this sworn statement, nor any of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, nor any affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989.

_____The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989.

_____The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989. However, there has been a subsequent proceeding before a Hearing Officer of the State of Florida, Division of Administrative Hearings and the Final Order entered by the Hearing Officer determined that it was not in the public interest to place the entity submitting this sworn statement on the convicted vendor list. (Attach a copy of the final order)

I UNDERSTAND THAT THE SUBMISSION OF THIS FORM TO THE CONTRACTING OFFICER FOR THE PUBLIC ENTITY IDENTIFIED IN PARAGRAPH 1 (ONE) ABOVE IS FOR THAT PUBLIC ENTITY ONLY AND, THAT THIS FORM IS VALID THROUGH DECEMBER 31 OF THE CALENDAR YEAR IN WHICH IT IS FILED. I ALSO UNDERSTAND THAT I AM REQUIRED TO INFORM THE PUBLIC ENTITY PRIOR TO ENTERING INTO A CONTRACT IN EXCESS OF THE THRESHOLD AMOUNT PROVIDED IN SECTION 287.017, **FLORIDA STATUTES** FOR CATEGORY TWO OF ANY CHANGE IN THE INFORMATION CONTAINED IN THIS FORM.

_____
(Signature)

Sworn to and subscribed before me this _____ day of _____, 20_.

Personally known _____

OR Produced Identification _____ Notary Public – State of _____

_____ My Commission expires _____
(Type of Identification)

_____
(Printed typed or stamped

commissioned name of notary public)

(Rev. 3/20/07)

EXHIBIT I – AFFIDAVIT CERTIFICATION IMMIGRATION LAWS

Date: _____, 20__

TOWN OF FORT MYERS BEACH WILL NOT INTENTIONALLY AWARD TOWN CONTRACTS TO ANY CONTRACTOR WHO KNOWINGLY EMPLOYS UNAUTHORIZED ALIEN WORKERS, CONSTITUTING A VIOLATION OF THE EMPLOYMENT PROVISIONS CONTAINED IN 8 U.S.C. SECTION 1324 a(e) SECTION 274A(e) OF THE IMMIGRATION AND NATIONALITY ACT ("INA").

TOWN OF FORT MYERS BEACH SHALL CONSIDER THE EMPLOYMENT BY ANY CONTRACTOR OF UNAUTHORIZED ALIENS A VIOLATION OF SECTION 274A (e) OF THE INA. **SUCH VIOLATION BY THE RECIPIENT OF THE EMPLOYMENT PROVISIONS CONTAINED IN SECTION 274A (e) OF THE INA SHALL BE GROUNDS FOR UNILATERAL CANCELLATION OF THE CONTRACT BY LEE COUNTY.**

PROVIDER ATTESTS THAT THEY ARE FULLY COMPLIANT WITH ALL APPLICABLE IMMIGRATION LAWS (SPECIFICALLY TO THE 1986 IMMIGRATION ACT AND SUBSEQUENT AMENDMENTS).

Company Name: _____

_____ _____ _____
(Signature) (Title) (Date)

STATE OF _____

COUNTY OF _____

The foregoing instrument was signed and acknowledged before me this _____day of _____, 20___, by _____ who has produced
(Print or Type Name)

_____ as identification.
(Type of Identification and Number)

_____
Notary Public Signature

_____
Printed Name of Notary Public

_____
Notary Commission Number/Expiration

The signee of this Affidavit guarantee, as evidenced by the sworn affidavit required herein, the truth and accuracy of this affidavit to interrogatories hereinafter made. *TOWN OF FORT MYERS BEACH RESERVES THE RIGHT TO REQUEST SUPPORTING DOCUMENTATION, AS EVIDENCE OF SERVICES PROVIDED, AT ANY TIME.*

EXHIBIT J – CLAIMS HISTORY

From Date: 01/01/2006
Through Date: 05/31/2011
Group: 378

Cumulative Loss Ratio Breakdown

Created By: Steve

GROUP		CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
378	TOWN OF FORT MYERS BEACH				
	JAN - 06	RX	$1,498.40		
		TOTAL	$1,498.40	$0.00	0.00%
	FEB - 06	MEDICAL	$1,118.18	$0.00	0.00%
		DENTAL	$755.00	$0.00	0.00%
		RX	$1,922.94		
		TOTAL	$3,796.12	$0.00	0.00%
	MAR - 06	MEDICAL	$2,100.13	$0.00	0.00%
		DENTAL	$1,755.60	$0.00	0.00%
		RX	$1,188.27		
		TOTAL	$5,044.00	$0.00	0.00%
	APR - 06	MEDICAL	$425.31	$0.00	0.00%
		RX	$952.80		
		TOTAL	$1,378.11	$0.00	0.00%
	MAY - 06	MEDICAL	$6,601.37	$0.00	0.00%
		DENTAL	$245.60	$0.00	0.00%
		RX	$1,963.32		
		TOTAL	$8,810.29	$0.00	0.00%
	JUN - 06	MEDICAL	$3,331.83	$0.00	0.00%
		RX	$722.07		
		TOTAL	$4,053.90	$0.00	0.00%
	JUL - 06	MEDICAL	$3,327.09	$0.00	0.00%
		RX	$270.03		
		TOTAL	$3,597.12	$0.00	0.00%
	AUG - 06	MEDICAL	$2,064.47	$0.00	0.00%
		DENTAL	$68.80	$0.00	0.00%
		RX	$472.53		
		TOTAL	$2,605.80	$0.00	0.00%
	SEP - 06	MEDICAL	$688.47	$0.00	0.00%

Wednesday, June 22, 2011 Page 1 of 9

From Date: 01/01/2006
Through Date: 05/31/2011
Group: 378

Cumulative Loss Ratio Breakdown

Created By: Steve

GROUP	CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
	DENTAL	$104.00	$0.00	0.00%
	RX	$663.97		
	TOTAL	$1,456.44	$0.00	0.00%
OCT - 06	MEDICAL	$1,766.77	$0.00	0.00%
	DENTAL	$65.00	$0.00	0.00%
	RX	$1,145.09		
	TOTAL	$2,976.86	$0.00	0.00%
NOV - 06	MEDICAL	$735.58	$14,838.00	4.95%
	DENTAL	$256.95	$706.68	36.36%
	RX	$94.10		
	TOTAL	$1,086.63	$15,544.68	6.99%
DEC - 06	MEDICAL	$1,458.46	$13,497.62	10.80%
	DENTAL	$83.20	$643.78	12.92%
	RX	$859.38		
	TOTAL	$2,401.04	$14,141.40	16.97%
JAN - 07	MEDICAL	$5,101.87	$13,497.62	37.79%
	DENTAL	$142.11	$690.01	20.59%
	RX	$843.26		
	TOTAL	$6,087.24	$14,187.63	42.90%
FEB - 07	MEDICAL	$824.76	$15,508.19	5.31%
	DENTAL	$2,259.02	$784.36	288.00%
	RX	$153.79		
	TOTAL	$3,237.57	$16,292.55	19.87%
MAR - 07	MEDICAL	$5,614.18	$17,518.76	32.04%
	DENTAL	$194.18	$878.71	22.09%
	RX	$337.44		
	TOTAL	$6,145.80	$18,397.47	33.40%
APR - 07	MEDICAL	$1,196.16	$18,282.77	6.54%
	DENTAL	$183.30	$924.94	19.81%

From Date: 01/01/2006
Through Date: 05/31/2011
Group: 378

Cumulative Loss Ratio Breakdown

Created By: Steve

GROUP	CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
	RX	$990.92		
	TOTAL	$2,370.38	$19,207.71	12.34%
MAY - 07	MEDICAL	$1,180.41	$18,282.77	6.45%
	DENTAL	$758.05	$924.94	81.95%
	RX	$730.83		
	TOTAL	$2,669.29	$19,207.71	13.89%
JUN - 07	MEDICAL	$1,237.55	$18,952.96	6.52%
	DENTAL	$150.00	$956.39	15.68%
	RX	$348.55		
	TOTAL	$1,736.10	$19,909.35	8.72%
JUL - 07	MEDICAL	$862.79	$18,952.96	4.55%
	DENTAL	$76.00	$956.39	7.94%
	RX	$1,033.65		
	TOTAL	$1,972.44	$19,909.35	9.90%
AUG - 07	MEDICAL	$19,794.40	$18,952.96	104.43%
	DENTAL	$488.15	$956.39	51.04%
	RX	$1,972.12		
	TOTAL	$22,254.67	$19,909.35	111.77%
SEP - 07	MEDICAL	$2,529.01	$18,952.96	13.34%
	DENTAL	$848.38	$956.39	88.70%
	RX	$896.91		
	TOTAL	$4,274.30	$19,909.35	21.45%
OCT - 07	MEDICAL	$5,375.15	$19,722.46	27.25%
	DENTAL	$709.56	$1,014.45	69.94%
	RX	$2,976.13		
	TOTAL	$9,060.84	$20,736.91	43.69%
NOV - 07	MEDICAL	$41,105.74	$18,230.03	225.48%
	DENTAL	$103.30	$932.06	11.08%
	RX	$1,718.04		

From Date: 01/01/2006
Through Date: 05/31/2011
Group: 378

Cumulative Loss Ratio Breakdown

Created By: Steve

GROUP	CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
	TOTAL	$42,927.08	$19,162.09	224.02%
DEC - 07	MEDICAL	$4,621.01	$16,862.44	27.40%
	DENTAL	$158.00	$867.25	18.21%
	RX	$421.17		
	TOTAL	$5,200.18	$17,729.69	29.33%
JAN - 08	MEDICAL	$2,298.83	$19,624.83	11.71%
	DENTAL	$235.40	$998.78	23.56%
	RX	$2,343.15		
	TOTAL	$4,877.38	$20,623.61	23.64%
FEB - 08	MEDICAL	$39,785.68	$18,927.43	210.20%
	DENTAL	$461.00	$965.42	47.75%
	RX	$1,036.46		
	TOTAL	$41,283.14	$19,892.85	207.52%
MAR - 08	MEDICAL	$7,471.21	$18,927.43	39.47%
	DENTAL	$368.79	$965.42	38.19%
	RX	$1,095.15		
	TOTAL	$8,935.15	$19,892.85	44.91%
APR - 08	MEDICAL	$1,961.71	$19,624.83	9.99%
	DENTAL	$308.00	$998.78	30.83%
	RX	$1,403.90		
	TOTAL	$3,673.61	$20,623.61	17.81%
MAY - 08	MEDICAL	$5,468.30	$19,624.83	27.86%
	DENTAL	$126.00	$998.78	12.61%
	RX	$1,650.81		
	TOTAL	$7,245.11	$20,623.61	35.13%
JUN - 08	MEDICAL	$1,869.68	$20,322.23	9.20%
	DENTAL	$290.00	$1,081.17	26.82%
	RX	$3,687.50		
	TOTAL	$5,847.18	$21,403.40	27.31%

From Date: 01/01/2006
Through Date: 05/31/2011
Group: 378

Cumulative Loss Ratio Breakdown

Created By: Steve

GROUP	CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
JUL - 08	MEDICAL	$4,608.12	$20,322.23	22.67%
	DENTAL	$262.00	$1,081.17	24.23%
	RX	$490.54		
	TOTAL	$5,360.66	$21,403.40	25.04%
AUG - 08	MEDICAL	$4,261.45	$21,019.63	20.35%
	DENTAL	$314.20	$1,114.53	28.19%
	RX	$1,979.18		
	TOTAL	$6,574.84	$22,134.16	29.70%
SEP - 08	MEDICAL	$6,100.33	$20,322.23	30.01%
	DENTAL	$0.00	$1,081.17	0.00%
	RX	$1,712.00		
	TOTAL	$7,812.33	$21,403.40	36.50%
OCT - 08	MEDICAL	$5,292.97	$30,386.63	17.41%
	DENTAL	$316.00	$1,380.90	22.88%
	RX	$1,782.59		
	TOTAL	$7,391.56	$31,767.53	23.26%
NOV - 08	MEDICAL	$8,814.18	$27,499.40	32.05%
	DENTAL	$638.40	$1,231.79	51.82%
	RX	$1,502.91		
	TOTAL	$10,955.49	$28,731.19	38.13%
DEC - 08	MEDICAL	$15,233.99	$35,106.12	43.39%
	DENTAL	$304.80	$1,348.28	22.60%
	RX	$2,132.25		
	TOTAL	$17,671.04	$36,454.40	48.47%
JAN - 09	MEDICAL	$43,776.21	$31,521.67	138.87%
	DENTAL	$600.80	$1,398.05	42.97%
	RX	$799.42		
	TOTAL	$45,176.43	$32,919.72	137.23%
FEB - 09	MEDICAL	$38,133.40	$33,662.20	113.28%

From Date: 01/01/2006
Through Date: 05/31/2011
Group: 378

Cumulative Loss Ratio Breakdown

Created By: Steve

GROUP	CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
	DENTAL	$849.46	$1,348.28	63.00%
	RX	$1,414.86		
	TOTAL	$40,397.72	$35,010.48	115.38%
MAR - 09	MEDICAL	$18,084.64	$25,280.11	71.53%
	DENTAL	$1,491.50	$1,348.28	110.62%
	RX	$2,165.00		
	TOTAL	$21,741.14	$26,628.39	81.64%
APR - 09	MEDICAL	$65,828.46	$26,774.57	245.86%
	DENTAL	$1,622.74	$1,280.56	126.72%
	RX	$1,184.32		
	TOTAL	$68,635.52	$28,055.13	244.64%
MAY - 09	MEDICAL	$44,211.76	$24,356.85	181.51%
	DENTAL	$266.23	$1,314.42	20.25%
	RX	$2,202.50		
	TOTAL	$46,680.49	$25,671.27	181.83%
JUN - 09	MEDICAL	$84,517.72	$28,009.20	301.74%
	DENTAL	$347.00	$1,416.00	24.50%
	RX	$3,371.29		
	TOTAL	$88,236.01	$29,425.20	299.86%
JUL - 09	MEDICAL	$28,893.97	$25,539.88	113.13%
	DENTAL	$921.18	$1,280.56	71.93%
	RX	$1,911.96		
	TOTAL	$31,727.11	$26,820.44	118.29%
AUG - 09	MEDICAL	$26,009.46	$26,113.92	99.59%
	DENTAL	$115.00	$1,648.94	6.97%
	RX	$2,496.55		
	TOTAL	$28,621.01	$27,762.86	103.09%
SEP - 09	MEDICAL	$31,431.07	$26,774.54	117.39%
	DENTAL	$544.50	$1,431.91	38.02%

From Date: 01/01/2006
Through Date: 05/31/2011
Group: 378

Cumulative Loss Ratio Breakdown

Created By: Steve

GROUP	CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
	RX	$1,411.64		
	TOTAL	$33,387.21	$28,206.45	118.36%
OCT - 09	MEDICAL	$17,205.11	$30,911.48	55.65%
	DENTAL	$1,217.00	$1,617.12	75.25%
	RX	$1,752.32		
	TOTAL	$20,174.43	$32,528.60	62.02%
NOV - 09	MEDICAL	$19,874.54	$26,861.15	73.98%
	DENTAL	$192.60	$1,499.63	12.84%
	RX	$1,939.62		
	TOTAL	$22,006.76	$28,360.78	77.59%
DEC - 09	MEDICAL	$40,625.00	$24,045.45	168.95%
	DENTAL	$1,933.00	$1,264.65	152.84%
	RX	$3,255.99		
	TOTAL	$45,813.99	$25,310.10	181.01%
JAN - 10	MEDICAL	$8,996.38	$26,113.92	34.45%
	DENTAL	$2,393.88	$1,481.68	161.56%
	RX	$1,797.74		
	TOTAL	$13,188.00	$27,595.60	47.79%
FEB - 10	MEDICAL	-$2,581.00	$26,197.23	-9.85%
	DENTAL	$1,377.91	$1,449.86	95.03%
	RX	$3,738.63		
	TOTAL	$2,535.54	$27,647.09	9.17%
MAR - 10	MEDICAL	$12,305.00	$29,706.75	41.42%
	DENTAL	$271.28	$1,583.26	17.13%
	RX	$1,403.70		
	TOTAL	$13,979.98	$31,290.01	44.67%
APR - 10	MEDICAL	$8,028.00	$27,401.25	29.29%
	DENTAL	$2,104.22	$1,398.05	150.51%
	RX	$2,454.35		

From Date: 01/01/2006
Through Date: 05/31/2011
Group: 378

Cumulative Loss Ratio Breakdown

Created By: Steve

GROUP	CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
	TOTAL	$12,586.57	$28,799.30	43.70%
MAY - 10	MEDICAL	$2,492.00	$32,982.25	7.55%
	DENTAL	$1,127.60	$1,666.89	67.64%
	RX	$1,482.88		
	TOTAL	$5,102.48	$34,649.14	14.72%
JUN - 10	MEDICAL	$2,517.00	$34,418.50	7.31%
	DENTAL	$540.61	$1,718.70	31.45%
	RX	$2,267.62		
	TOTAL	$5,325.23	$36,137.20	14.73%
JUL - 10	MEDICAL	$4,133.00	$27,401.25	15.08%
	DENTAL	$1,209.80	$1,262.61	95.81%
	RX	$1,587.76		
	TOTAL	$6,930.56	$28,663.86	24.17%
AUG - 10	MEDICAL	$2,694.00	$26,897.50	10.01%
	DENTAL	$1,669.70	$1,384.18	120.62%
	RX	$1,763.34		
	TOTAL	$6,127.04	$28,281.68	21.66%
SEP - 10	MEDICAL	$8,162.00	$24,894.25	32.78%
	DENTAL	$738.05	$1,280.56	57.63%
	RX	$970.21		
	TOTAL	$9,870.26	$26,174.81	37.70%
OCT - 10	MEDICAL	$5,974.00	$27,199.75	21.96%
	DENTAL	$437.28	$1,382.14	31.63%
	RX	$1,305.05		
	TOTAL	$7,716.33	$28,581.89	26.99%
NOV - 10	MEDICAL	$2,745.00	$27,968.25	9.81%
	DENTAL	$0.00	$1,416.00	0.00%
	RX	$758.10		
	TOTAL	$3,503.10	$29,384.25	11.92%

From Date: 01/01/2006
Through Date: 05/31/2011
Group: 378

Cumulative Loss Ratio Breakdown

Created By: Steve

GROUP		CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
	DEC - 10	MEDICAL	$5,067.00	$27,867.53	18.18%
		DENTAL	$1,040.93	$1,431.91	72.69%
		RX	$1,954.82		
		TOTAL	$8,062.75	$29,299.44	27.51%
	JAN - 11	MEDICAL	$5,108.00	$26,330.53	23.19%
		DENTAL	$1,109.07	$1,364.19	81.29%
		RX	$1,840.96		
		TOTAL	$9,058.03	$27,694.72	32.70%
	FEB - 11	MEDICAL	$8,649.00	$27,867.53	31.03%
		DENTAL	$1,203.31	$1,515.54	79.39%
		RX	$4,010.10		
		TOTAL	$13,862.41	$29,383.07	47.17%
	MAR - 11	MEDICAL	$3,006.00	$31,143.03	9.65%
		DENTAL	$1,512.30	$1,682.80	89.86%
		RX	$2,752.95		
		TOTAL	$7,271.25	$32,825.83	22.15%
	APR - 11	MEDICAL	$3,387.00	$30,840.84	10.98%
		DENTAL	$285.30	$1,599.17	17.84%
		RX	$3,949.26		
		TOTAL	$7,621.56	$32,440.01	23.49%
	MAY - 11	MEDICAL	$6,163.00	$31,710.06	19.43%
		DENTAL	$842.00	$1,666.89	50.51%
		RX	$2,507.57		
		TOTAL	$9,512.57	$33,376.95	28.50%
GROUP TOTALS		MEDICAL	$762,683.87	$1,330,551.76	57.32%
		DENTAL	$40,993.04	$67,571.76	60.67%
		STD	$0.00	$0.00	0.00%
		RX	$105,442.66		
		TOTAL	$909,119.57	$1,398,123.52	65.02%

Wednesday, June 22, 2011 Page 9 of 9

TOWN of FORT MYERS BEACH

BID NO. **RFP-11-01-FIN**

ADDENDUM TO CONTRACT DOCUMENTS

Addendum No.: 1

CONTRACT/PROJECT NAME: Employee Benefits Coverage RFP-11-01-FIN

DATE OF ISSUE: August 8, 2011

The following information shall be included in the Contract documents and is hereby made part of the project bidding documents in the form of clarification, addition, deletion or revision to the contract specifications and/or drawings.

The following inquiries were received regarding the above referenced RFP:

Q. I'm looking forward to responding to the above referenced RFP. In order to do so, I will need the following:

- Zip codes for all employees on the census
- Job Titles for all employees on the census
  - This is needed in order to get disability quotes
- Completed questionnaire's for United Healthcare and BCBS
  - These are needed in order to get firm rates from the carriers as the City is considered a small group

A. Refer to the attached spreadsheet which includes zip codes and job titles and the completed BCBS and United Healthcare questionnaires.

Q. We are working on getting competitive proposals for you on this RFP and would like to request an updated census that includes occupations.

A. Refer to the attached spreadsheet which includes occupations.

Peter A. Boers, C.P.M., CPPB
Contracts Manager
Town of Fort Myers Beach
2523 Estero Blvd.
Fort Myers Beach, FL 33931
239-765-0202 ext 116

Town of Fort Myers Beach
Health Insurance Profile

Title	Department	Gender	Coverage	Zip
Finance Coordinator	Finance	F	Single	33993
Deputy Public Works Director	Public Works	M	EE + Family Dental	33990
Contracts Manager	Town Clerk	M	EE + Child	33907
Community Development Technician	Community Development	M	Single	33919
Zoning Coordinator	Community Development	F	Single	33908
Maintenance Crew	Maintenance	M	Single	33904
Maintenance Crew-BORC	BORC	M	Single	33931
Planning Coordinator	Community Development	F	Single	33931
Maintenance Crew Leader	Maintenance	M	Single	33905
Community Development Director	Community Development	M	Single	33931
Custodial Maintenance Crew Worker	Maintenance	M	Single	33914
Harbor & Facilities Maintenance	Mooring Field	M	Single	33931
Code Enforcement Officer	Code Enforcement	M	Single	33931
Administrative Assistant-PW	Public Works	F	Single	33909
Environmental Sciences Coordinator	Community Development	M	Single	33907
Maintenance Support	Maintenance	M	Single	34104
Public Works Director	Public Works	F	Single	33931
Town Clerk	Town Clerk	F	Single	33931
Recreation Program Coordinator	BORC	F	Single	33908
Maintenance Crew	Maintenance	M	EE + Child	33990
Building Safety Services Coordinator	Building	M	EE + Spouse	33931
Foreman	Maintenance	M	Single + Family Dental	33931
Community & Special Program Dev Coord.	BORC	M	EE + Spouse	33908
Recreation Manager	BORC	F	Single	33908
Maintenance Crew	Maintenance	M	Single	33904
Administrative Assistant/TM Assistant	Community Development	F	EE + Spouse	33908
Aquatics Supervisor	Pool	M	Single	33919
Maintenance Crew	Maintenance	M	Single	33913
Cultural Resources Director	Cultural Resources	F	EE + Spouse	33931
Front Desk Administrative Assistant	Town Clerk	M	Single	33917
Town Manager	Town Manager	M	Employee/Family Dental & Vision Only	33931
Code Enforcement Officer	Code Enforcement	M	Single + Family Dental	33914
Finance Director	Finance	F	Single	33905
VACANT-Maintenance Crew	Maintenance			33990
VACANT-Public Services Supervisor	Public Works			
VACANT-Special Projects Supervisor	Public Works			
VACANT-Director				

Health Addendum To Employer Application

For Rating Purposes

UnitedHealthcare
A UnitedHealth Group Company

Group Name: Town of Fort Myers Beach

Medical Profile (only for groups not requiring individual health statements)

Answer the following questions to the best of your knowledge for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses and dependent children). **Please provide details to "Yes" answers in the space provided.**
IMPORTANT: Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

☐ Yes ☒ No	1. Have any employees or dependents been diagnosed or treated during the past five years for: ☐ Cancer ☐ Multiple Sclerosis ☐ Lupus ☐ Tumor ☐ Immune Disorder ☐ Growth Hormones ☐ Heart/Circulatory ☐ Chronic Lung Disorder ☐ Transplants ☐ Stroke ☐ Kidney Disease/Failure ☐ Hemophilia/Blood Disorders ☐ Reproductive Disorder ☐ Liver Disorders (Hepatitis) ☐ Cerebral Palsy ☐ Intestinal Disorder ☐ Back Disorder ☐ Sickle cell anemia ☐ Endocrine Disorder ☐ Rheumatoid Arthritis ☐ Immuno deficiency ☐ Diabetes ☐ Connective Tissue Disorder ☐ Autism ☐ Brain/Nervous/Seizures ☐ Other Conditions _____
☐ Yes ☒ No	2. Are any employees or dependents currently pregnant? If so, list the expected delivery date, and any complications including the anticipation of multiple births or C-section.
☐ Yes ☒ No	3. Have any employees or dependents been hospitalized (inpatient or outpatient) or had any surgical operations during the past 5 years?
☐ Yes ☒ No	4. Have any employees been absent from work or confined to the home or incapacitated for more than 2 consecutive weeks due to illness or injury during the past 5 years?
☐ Yes ☒ No	5. Have any employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months?
☐ Yes ☒ No	6. Are any employees or dependents receiving disability benefits of any type including Social Security Income, Worker's Compensation and Medicare?

If you answered "Yes" to any of the questions above, please provide the requested information for each individual.
If necessary, continue your comments on the back side of this form.

Question #	Check One Emp	Dep	Age	Nature of Condition/ Diagnosis	Name of Medication	$ Amount of Claims	Dt Treated/ Recovered	Prognosis Current Treatment

The group policy(s) is deemed executed upon receipt of the signed Employer Application, payment of the required policy charges and acceptance by United HealthCare Insurance Company and its Affiliates ("UnitedHealthcare and Affiliates").

The Group shall notify UnitedHealthcare and Affiliates promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents. Prior to receiving notification of approval, the Group shall notify UnitedHealthcare and Affiliates promptly of any significant changes in the health status of an eligible employee or dependent, including any inpatient hospital admissions. UnitedHealthcare and Affiliates shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of employees and their dependents in providing coverage under the policy/policies for which application is being made.

I represent that, to the best of my knowledge, the information I have provided in this application - including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws - is accurate and truthful. I understand that UnitedHealthcare and Affiliates will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy effective date, or other consequences.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature

Group Signature	Title	Date
[signature]	Finance Director	8/8/11

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by United HealthCare Insurance Company or United HealthCare of Florida, Inc. or Neighborhood Health Partnership, Inc.
Dental coverage provided by United HealthCare Insurance Company or United HealthCare of Florida, Inc. or Neighborhood Health Partnership, Inc.
Life Insurance coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company
Vision coverage provided by United HealthCare Insurance Company or Unimerica Insurance Company

BlueCross BlueShield of Florida Health Options®

Health Options and its Parent, Blue Cross and Blue Shield of Florida, are Independent Licensees of the Blue Cross and Blue Shield Association.

GROUP MEDICAL QUESTIONNAIRE

4 - 50 GROUP SIZE

GENERAL INFORMATION

GROUP NAME: Town of Fort Myers Beach

GROUP ADDRESS: 2523 Estero Blvd
Fort Myers Beach, Fl. 33931

EFFECTIVE DATE: _____

MEDICAL HISTORY

Please answer the following questions to the best of your knowledge for all eligible employees and their dependents (proprietors, partners, corporate officers, employees, spouses and dependent children).

Within the past 24 months, has any employee or dependent had a continuing claim (i.e. chronic or ongoing) due to any of the conditions below? Please check the appropriate box(es).

☐ ARC or AIDS	☐ Cardiovascular	☐ Infertility	☐ Neurological
☐ Alcohol Abuse	☐ Diabetes	☐ Intestines	☐ Pancreas
☐ Arthritis	☐ Drug/Substance Abuse	☐ Kidney	☐ Skin
☐ Back, Neck	☐ Epilepsy	☐ Liver	☐ Stomach
☐ Blood	☐ Ears/Eyes	☐ Lungs	☐ Stroke/Paralysis
☐ Bone/Joint	☐ Emphysema/Pulmonary	☐ Lupus	☐ Venereal
☐ Brain	☐ Heart Disease	☐ Mental/Nervous	☐ Other, Detail Below
☐ Cancer/Tumor	☐ High Risk Pregnancies	☐ Migraines	

If you have checked any of the above conditions, using your best existing knowledge please complete the following for each affected employee/dependent.

CONDITION	MEDICATION	YEARS OF TREATMENT

This information will be used to determine the medical risk associated with this group. The undersigned Authorized Company Officer hereby acknowledges that the information on this form is complete and true to the best of his or her knowledge. The undersigned Authorized Company Officer and Agent further represents that the summary health information provided above was not acquired, used, or disclosed other than as is permitted by applicable law, and specifically was not and will not be used for employment-related actions and/or decisions. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Authorized Company Officer:

Name/Title (Print): Evelyn Wicks, Finance Director

Signature: Evelyn Wicks **Date:** 8/8/11

Agent Name/Number/Agency (Print) _____

Agent Signature: _____ **Date:** _____

61870 0511R

TOWN of FORT MYERS BEACH BID NO. **RFP-11-01-FIN**

ADDENDUM TO CONTRACT DOCUMENTS

Addendum No.: 2

CONTRACT/PROJECT NAME: Employee Benefits Coverage RFP-11-01-FIN

DATE OF ISSUE: August 11, 2011

The following information shall be included in the Contract documents and is hereby made part of the project bidding documents in the form of clarification, addition, deletion or revision to the contract specifications and/or drawings.

The following inquiries were received regarding the above referenced RFP:

Q1. Does the Town prefer a monthly list bill? Or do you plan to self-administer this coverage?
A1. Monthly bill.

Q2. Is there a copy of your life plan policy available?
A2. No copy available.

Q3a. If a life policy is not available is any of the following information available: Does your plan have a waiver of premium? If yes, please provide the definition, including elimination period.
A3a. Waiver of Premium attached.
Q3b. Number of hours an employee must be working per week to be eligible for coverage?
A3b. Coverage is only for full time 40 hours per week. Part-time employees are not eligible for benefits.
Q3c. Child eligibility age and definition?
A3c. This was included in the RFP attachments (page 27).
Q3d. What is the maximum benefit amount for the basic life coverage?
A3d. This was included in the RFP attachments (page 26).

Q4. Is there a Life census available for dependent life coverage?
A4. No. Presently we do not have any participants in dependent life coverage.

Q5. Is your RFP available in a Word format?
A5. No, the Town cannot provide in WORD format.

Peter A. Boers, C.P.M., CPPB
Contracts Manager
Town of Fort Myers Beach
2523 Estero Blvd.
Fort Myers Beach, FL 33931
239-765-0202 ext 116

WAIVER OF PREMIUM

If the **Employee** becomes **Totally Disabled** while insured for this **Employee** Term Life Insurance Benefit, We will continue the **Employee's** Term Life Insurance Benefit during his or her **Total Disability** without the requirement of premium payment subject to the Waiver of Premium provision. In order for **Us** to approve Waiver of Premium, the **Employee** must:

- Become **Totally Disabled** before age 60;
- Remain **Totally Disabled** throughout the 180 consecutive day Elimination Period;
  Elimination Period means a period of continuous disability which must be satisfied before **You** are eligible to have **Your** life premium waived by **Us**.
- Request an application for Waiver of Premium and submit such application with proof of **Total Disability**, acceptable to **Us**, no later than 12 consecutive months after the **Employee** first became **Totally Disabled**.

Premium payment must continue until We approve the application for Waiver of Premium. Failure to do so will result in forfeiture of **Your** rights to Wavier of Premium.

The Wavier of Premium benefit begins at the end of the Elimination Period.

If the **Employee** dies prior to submitting the initial proof of **Total Disability** as required, proof that the **Total Disability** continued until the date of the **Employee's** death must be given to **Us** no later than 12 months after the **Employee's** death.

~~We will not approve an application for Waiver of Premium if the Employee becomes Totally Disabled~~ after the **Employer** terminates coverage under the Policy.

EFFECT OF WAIVER OF PREMIUM

When **We** approve Waiver of Premium, no premium payment will be required for the **Employee's** Term Life Insurance benefit during his or her **Total Disability**. Proof of the **Total Disability** must be received by **Us** within one year from the date the **Total Disability** began.

The **Employee** is required to submit proof of continued **Total Disability** to **Us** three months before each anniversary date of the disability. We have the right to have the **Employee** examined for the **Total Disability** at any reasonable time during the first two years he or she is **Totally Disabled**. After that, We may have the **Employee** examined only once a year.

AMOUNT CONTINUED

The amount of the **Employee** Term Life Insurance benefit which will be continued under this Waiver of Premium is the amount that was in effect for the **Employee** on the date the **Total Disability** began. This amount will be reduced by the same amount, on the same dates, and for the same reasons that it would have been reduced if the **Employee** had not become **Totally Disabled**.

WAIVER OF PREMIUM (continued)

TERMINATION OF WAIVER OF PREMIUM

The Waiver of Premium terminates on the earliest of:

- The date the **Employee** fails or refuses to furnish proof of **Total Disability** as required;
- The date the **Employee** fails or refuses to be examined as required;
- The date the **Employee** is no longer **Totally Disabled**; or
- The **Employee's** 65th birthday.

If the Waiver of Premium benefit terminates and the **Employee** returns to an **Active Status**, he or she will be insured for the **Employee** Term Life Insurance benefit for which he or she is then eligible. Premium payment will be required for the **Employee** Term Life Insurance benefit.

If this Waiver of Premium terminates because the **Employee** is no longer **Totally Disabled** or attains age 65, and does not return to an **Active Status**, he or she may apply for a Conversion Policy of Life Insurance according to the Conversion Privilege provision in this Certificate.

Termination of the **Employer's** participation under the Policy WILL NOT terminate the **Employee's** Waiver of Premium. If the Waiver of Premium terminates after the **Employer's** participation under the Policy terminates, and if the **Employee** Term Life Insurance Benefit has been in force for at least three years, the **Employee** may apply for a Conversion Policy. The amount of any Conversion Policy is limited to the lesser of:

- The amount of **Employee** Term Life Insurance that is terminating LESS the amount of any Life Insurance for which the **Employee** becomes eligible under any group coverage within 31 days after such termination; or
- $10,000.

THE TOWN OF FORT MYERS BEACH

COVERAGE AND COST ANALYSIS

OF

EMPLOYEE BENEFITS COVERAGE

RFP-11-01-FIN

August 31, 2011

risk managers

BEN FEW & COMPANY, INC.
4560 Via Royale, Suite #3
Fort Myers, Florida 33919
Phone 239-334-7727

TOWN OF FORT MYERS BEACH
TABLE OF CONTENTS

SECTION I
TOWN OF FORT MYERS BEACH
GENERAL INFORMATION

GENERAL INFORMATION - Proposals for Group Health Insurance have been requested for the Town of Fort Myers Beach employees. Sealed proposals must have been received either by mail or hand delivery no later than 11:00 AM, August 26, 2011.

The current Group Health Insurance plan is written in the Florida Municipal Health Trust Fund, provided by the Florida League of Cities, Inc. The current coverage is underwritten by Cigna on behalf of FMIT. There are approximately 34 employees, with 9 of those employees covering dependents for either health or an ancillary coverage. FMIT currently handles the Medical, Dental, Vision and Life/AD&D coverages, through various carriers. Short and Long Term Disability coverages are provided by Humana and Medical Group Insurance Services, respectively.

SELECTION PROCESS - All proposals have been evaluated and consideration has been given to the areas of cost, coverage, service capabilities and financial stability of the provider. However, the Town of Fort Myers Beach reserves the right to reject any or all proposals, to waive formalities and to accept or reject all or any part of any proposal as it may deem to be in the best interest of the Town. The Town of Fort Myers Beach also reserves the right to negotiate or not negotiate with individual proposers.

CONTRACT TERMS - The effective date of the proposed coverages will be October 1, 2011. Rates are guaranteed for a minimum of 12 months. Subsequent renewal terms of this contract will be based upon satisfactory service along with acceptability of cost and financial stability of the carrier.

CONFLICT OF INTEREST STATEMENT - Proposers must abide by Florida Statute 112 and disclose within their proposal any officer, director or agent of their organization who is also an employee of the Town of Fort Myers Beach. Also, the name of any employee of the Town of Fort Myers Beach who owns more than 5 percent of the proposing organization must have been disclosed.

PUBLIC ENTITY CRIMES STATEMENT - Form 7068 "Florida Public Entity Crimes Statement" must have been signed, notarized and returned with the proposal.

DRUG-FREE WORKPLACE STATEMENT - Drug-Free Workplace Statement forms will be attached to some of the proposals. It is not mandatory that the proposer and/or insurer have a Drug-Free Workplace in order to respond to the RFP.

SECTION II
TOWN OF FORT MYERS BEACH
HEALTH PLAN DEFINITION

The Town of Fort Myers Beach enjoys a **PREFERRED PROVIDER ORGANIZATION (PPO).** The current program is relatively "rich" in benefits. Health costs are kept down by arrangements between health providers and insurance companies. Usually, the employee pays either a co-payment or deductible and then the provider bills the insurance company direct. The employee is not responsible for costs above usual and customary charges, unless he/she goes outside of the provider network. Then, the coverage is handled in the same fashion as the indemnity plan. Most Physicians will belong to these networks, if they don't already, so having to use specific physicians should not be too much of a disadvantage to the employee. This form of heath coverage has a reduced cost when compared to an indemnity plan and still offers a choice of physicians to the employee, subject to out of pocket expenses.

The Town of Fort Myers Beach pays 100% of the employee's medical benefit cost and ancillary coverages. The Town pays 50% of the dependent's medical benefit cost.

SECTION III
TOWN OF FORT MYERS BEACH
RECOMMENDATIONS

Taking in to consideration the three areas of coverage, service and cost, we are recommending the **Public Risk Insurance Agency (PRIA)** PPO plan. The health benefits would be underwritten by Blue Cross Blue Shield; MetLife would underwrite the Dental; Amanita would underwrite the Vision; Standard would underwrite the Life/AD&D; Reliance Standard would underwrite the Short Term Disability and Metlife would also underwrite the Long Term Disability.

Both FMIT and PRIA are very strong Insurance Trusts for Public Entities in the State of Florida. PRIA is the agency for Preferred Government Insurance Trust (PGIT). It should be noted that although FMIT and PRIA have presented programs and their staff would help with any servicing issues, the actual coverage presented by those firms is being placed through various insurance companies that specialize in medical and ancillary benefits. All companies represented by these two Trusts are financially stable and generally known for good service capabilities.

~~Since FMIT is moving its program from one carrier to another, with different networks,~~ coupled with the extremely competitive pricing provided by those carriers working with PRIA, we think it best to take advantage of the savings provided by PRIA. Blue Cross Blue Shield is the most well known Health Insurance Company in the United States and has one of the broadest networks available.

The new program, as recommended with the ancillary coverages, will be approximately $359,800 annually, compared to the current approximate cost of $405,530. This results in an overall reduction in cost of approximately $45,730. This figure does not take into account the participation level of the Town's payment.

Respectfully submitted,

BEN FEW & COMPANY, INC.

Ben Few III, ARM-P, AAI
President

SECTION IV
TOWN OF FORT MYERS BEACH
BENEFIT & COST ANALYSIS
SPREADSHEETS

Spreadsheet I	**Medical Benefits**
Spreadsheet II	**Ancillary Benefits**

ANCILLARY BENEFIT COVERAGE COST ANALYSIS								
Benfits	Current FMIT	FMIT	**PGIT MetLife**	Hartford	Minnesota Life	Ameritas	Assurant
Dental Insurance							
Single	33.86	26.74	**21.45**			27.68	28.88
EE& Spouse		53.47				56.48	
EE & Children		56.67				73.32	
EE & Family	49.77	87.42	**61.69**			102.12	92.91
Annual Premium	19190		**13098**				18698
Vision Insurance			**Avantica EyeCare**				
Single	5.74	5.74	**4.8**			8	7.55
EE& Spouse						18.44	
EE & Children						15.4	
EE & Family	8.43	14.17	**13.62**			25.84	21.14
Annual Premium	3552		**2593**				4602
Life/AD&D			**Standard**				
Single		0.35	**0.3**	0.41	0.25		.546>age
Dependent ($5,000)			**age banded**	2.48ea	1.50ea		
Annual Premium	6000*		**5281**	7223			age banded
Short Term Disability			**Reliance Standard**				
Single			**0.43**	0.77			0.47
EE& Spouse							
EE & Children							
EE & Family							
Annual Premium	8000*		**7351**	13162			7808
Long Term Disability			**MetLife**				
Single			**0.39**	0.396			0.6
EE& Spouse							
EE & Children							
EE & Family							
Annual Premium	5500*		**5605**	5765			8723
Total Ancillary Benefit Premiu	$42,242		**$33,928**	incomplete	incomplete	incomplete	$39,831
* approximate							

MEDICAL BENEFIT COVERAGE AND COST ANALYSIS			
Benefits	Current Cigna/FMIT	Renewal UHC/FMIT	BCBS/PGIT
Calendar year deductible			
Individual	250	250	250
Family	500	500	750
Coinsurance			
Network	90%	90%	90%
Outside Network			
Out of Pocket Maximum			
Individual	2500	2500	1000
Family	5000	5000	4000
Lifetime Plan Max			
In/Out of Network	Unlimited	Unlimited	Unlimited
Hospital Services			
Inpatient	90% after deductible	90%	250
Outpatient	90% after deductible	100	100
ER	100 co-pay	100 per visit	
Urgent Care	50 co-pay	35 per visit	30
Skilled Nursing Facility	90% after deductible	90% after deductible	
Physician Services			
PCP	20 co-pay	10	10
Specialist	40 co-pay	20	25
Preventative Care	100%	100%	100%
Allergy Injections	100% after PCP/SP co-pay	10 for PCP/20 for Specialist	
Mental & Nervous Disorder			
Inpatient	90% after deductible	90%	90%
Outpatient	40 co-pay	10	20
Hospice Care			
Inpatient	~~90% after deductible~~	~~90%~~	~~90% after ded~~
Outpatient	60 days per calendar year	360 days	
Home Health Care & OP Rehab			
Skilled Nurse	90% after ded/60 vs/cl yr	90%/60 vs/cal yr	10% after ded
Physical Therapy	100% after PCP/SP ded/20 vs	10 vi-20 vis per year	10% after ded
Occupational Therapy	100% after PCP/SP ded/20 vs	10 vi-20 vis per year	10% after ded
Speech Therapy	100% after PCP/SP ded/20 vs	10 vi-20 vis per year	10% after ded
Chiropratic Services			
Office Visit	100% after PCP/SP ded	20 per visit	25
Calendar Year Visit Max	20	24	
Diagnostics			
Lab-Outpatient Hospital	100%	no co-pay	100%
Lab-Lab Facility MD OV	100% after PCP/SP co-pay	no co-pay	50
Standard X-ray	100%	no co-pay	
MRI,MRA,CT, PET-OP facility	$250 co-pay then 100%	$100	
Out of Network Benefits			
Deductible	No Benefits	500/1000	1000/3000
Coinsurance	No Benefits	70%	50%
OOP Max	No Benefits	5000/10,000	5000/10,000
Prescription Drug Co-pays			
Retail		10/30/1950	10/30/1950
Mail Order (90 day supply)		25/75/125	25/75/125
Single	768.5	766.26	693.46
EE & Spouse	1637.75	1632.97	1435.4
EE & Children	1436.28	1432.08	1303.71
Family	2208.58	2202.13	2201.24
Medicare Supp Rate		366.29	
Total Monthly	30274	30185.5	27156
Total Annual	**$363,288**	**$362,226**	**$325,872**

risk managers

BEN FEW & COMPANY, INC.

October 5, 2011

Mr. Peter Boers
Town of Fort Myers Beach
2523 Estero Blvd.,
Fort Myers Beach, FL. 33931

Re: Employee Benefits RFP #11-01-FIN

Dear Peter:

This is confirmation that on September 28, 2011, following the review of FMIT's renewal offer, it was our recommendation that the Town of Fort Myers Beach reject all other bids received from the above captioned RFP process and proceed with the FMIT renewal.

The FMIT renewal offer provides a very good employee benefit package at extremely competitive pricing. That, coupled with the service the Town has received in the prior years by FMIT leads us to this recommendation.

Please let us know if we can be of further assistance.

Very truly yours,

BEN FEW & COMPANY, INC.

Ben Few III, ARM, ARM-P, AAI
President

4560 Via Royale, Suite 3, Fort Myers, Florida 33919
Telephone 239-334-7727 Facsimile 239-334-8166 e-mail bfew@benfew.com

Florida Municipal Insurance Trust
City of Fort Myers Beach
Benefit Comparison for Medical and Prescription Drug Benefit Coverage

Type of Coverage	CIGNA CARE1	Proposed UHC Plan 2 Network Benefits / Copayment Amounts
		*Deductible applies towards OOP Maximum
CALENDAR YR DEDUCTIBLE		
Individual	$250	$250
Family	$500	$500
COINSURANCE		
INN/OON	90%	90%
OOP MAXIMUM		
Individual	$2,500	$2,500
Family	$5,000	$5,000
LIFETIME PLAN MAX		
INN/OON	Unlimited	Unlimited
HOSPITAL SERVICES		
Inpatient	90% after deductible	90%
Outpatient	90% after deductible	$100
ER	$100 co-pay	$100 per visit
Urgent Care	$50 co-pay	$35 per visit
Skilled Nursing Facility	90% after deductible	90%
PHYSICIAN SERVICES		
PCP	$20 co-pay	$10
Specialist	$40 co-pay	$20
Preventative Care	100%	100%
Allergy Injections	100% after PCP/SP co-pay	$10 for PCP / $20 for Specialist
MENTAL & NERVOUS DISORDER		
Inpatient	90% after deductible	90%
Outpatient	$40 co-pay	$10
SUBSTANCE ABUSE		
Inpatient	90% after deductible	combined under Mental & Nervous Disorder
Outpatient	$40 co-pay	combined under Mental & Nervous Disorder
HOSPICE CARE		
Inpatient/Outpatient	90% after deductible	90%
Maximum Care	60 days per calendar year	360 days
HOME HEALTH CARE & OP REHAB SERVICES		
Skilled Nurse	90% after deductible / 60 vs/cal yr	90% 60 vs/cal yr
Physicial Therapy	100% after PCP/SP co-pay - 20 vs per cal yr	$10 visit-20 vs per cal yr
Occupational Therapy	100% after PCP/SP co-pay - 20 vs per cal yr	$10 visit-20 vs per cal yr
Speech Therapy	100% after PCP/SP co-pay - 20 vs per cal yr	$10 visit-20 vs per cal yr
CHIROPRACTIC SERVICES		
Office Visit	100% after PCP/SP co-pay	$20 visit
Calendar year visit maximums	20	24 visits
DIAGNOSTICS		
Laboratory-Outpt hospital	100%	No co-pay
Laboratory-Lab Facility-MD OV	100% after PCP/SP co-pay	No co-pay
Standard X-ray	100%	No co-pay
MRI, MRA, CT, PET-OP facility	$250 co-pay then 100%	$100
OUT OF NETWORK BENEFITS		
Deductible (Individual/Family)	No Benefits	$500/$1,000
Coinsurance	No Benefits	70%
OOP Maximum (Individual/Family)	No Benefits	$5,000/$10,000
PRESCRIPTION DRUG COPAYS		
Retail		$10/$30/$50
Mail Order (90 day supply)		$25/$75/$125
Single	$768.50	$636.00
EE + Spouse	$1,637.75	$1,355.37
EE + Children	$1,436.28	$1,188.63
Family	$2,208.58	$1,827.77
Medicare Supplement Rate		$366.29

Florida Municipal Insurance Trust

Specialty Benefits

Dental Insurance

	Premium pepm
Employee	$26.74
Employee + Spouse	$53.47
Employee + Child(ren)	$56.67
Employee + Family	$87.42

Life/AD&D

Premium per $1000
$0.35
TBD

Vision Insurance

	Employer Paid Premium pepm	Voluntary Premium pepm
Employee	$5.74	$6.50
Employee + Family	$14.17	$17.46

	Current Rates Single	Current Rates Employee & Spouse	Current Rates Employee & family	BCBS Single	BCBS Employee & Spouse	BCBS Employee & family	Renewal Rates Single	Renewal Rates Employee & Spouse	Renewal Rates Employee & family
Medical									
Employee	768.50	768.50	768.50	693.46	693.46	693.46	636.00	636.00	636.00
Employee - other	-	434.63	720.04	-	370.97	753.89	-	359.69	595.89
Paid by employee	-	434.63	720.04	-	370.97	753.89	-	359.69	595.89
	768.50	1,637.76	2,208.58	693.46	1,435.40	2,201.24	636.00	1,355.38	1,827.78
Dental									
Employee	33.86	33.86	33.86	21.45	21.45	21.45	26.74	26.74	26.74
Employee - other	-	-	24.89	-			-	13.37	30.34
Paid by employee	-	-	24.89	-	61.69	61.69	-	13.37	30.34
	33.86	33.86	83.64	21.45	83.14	83.14	26.74	53.48	87.42
Vision									
Employee	5.74	5.74	5.74	4.80	4.80	4.80	5.74	5.74	5.74
Employee - other	-	-	4.22	-	6.81	6.81	-	-	4.22
Paid by employee	-	-	4.22	-	6.81	6.81	-	-	4.22
	5.74	5.74	14.18	4.80	18.42	18.42	5.74	5.74	14.18
Total monthly cost	808.10	1,677.36	2,306.40	719.71	1,536.96	2,302.80	668.48	1,414.60	1,929.38
# employees covered	30	3	1	30	3	1	30	3	1
Monthly									
Paid by employee	-	1,303.89	749.15	-	1,318.41	822.39	-	1,119.18	630.45
Paid by Town	24,243.00	3,728.19	1,557.25	21,591.30	3,292.47	1,480.41	20,054.40	3,124.62	1,298.93
Total monthly	**$ 24,243.00**	**$ 5,032.08**	**$ 2,306.40**	**$ 21,591.30**	**$ 4,610.88**	**$ 2,302.80**	**$ 20,054.40**	**$ 4,243.80**	**$ 1,929.38**
Annual									
Paid by employee	-	15,646.68	8,989.80	-	15,820.92	9,868.68	-	13,430.16	7,565.40
Paid by Town	290,916.00	44,738.28	18,687.00	259,095.60	39,509.64	17,764.92	240,652.80	37,495.44	15,587.16
Total annual	**$ 290,916.00**	**$ 60,384.96**	**$ 27,676.80**	**$ 259,095.60**	**$ 55,330.56**	**$ 27,633.60**	**$ 240,652.80**	**$ 50,925.60**	**$ 23,152.56**
	FMIT Current annual contract - Medical, Dental & Vision			Blue Cross/Blue Shield - Medical, Dental & Vision			FMIT Renewal Rates - Medical, Dental & Vision		
	$ 378,977.76			$ 342,059.76			$ 314,730.96		