NOTICE TO INSUREDS

READ THIS NOTICE CAREFULLY BEFORE ACCESSING THE FOLLOWING INFORMATION. MetLife is providing this Electronic Document describing the insurance benefits provided for in your certificate of insurance as a convenience. The School Board of Miami-Dade County, Florida maintains the group insurance policy, including a copy of the certificate of insurance that is available for you to review and copy if necessary. If there is any conflict between the information in this Electronic Document and the group insurance policy and certificate, the policy and certificate shall control in all respects.

YOUR EMPLOYEE BENEFIT PLAN

THE SCHOOL BOARD OF MIAMI-DADE COUNTY, FLORIDA

Basic Life Benefits for Retired Employees

Effective Date: January 1, 2007

The School Board of Miami-Dade County, Florida
1500 Biscayne Blvd. Suite 127
Miami, Florida 33132

TO OUR RETIRED EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

Benefits are provided through a group policy issued to The School Board of Miami-Dade County, Florida by Metropolitan Life Insurance Company.

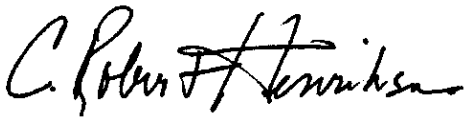
The School Board of Miami-Dade County, Florida

MetLife®

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

Certifies that the benefits as described herein are provided under and subject to the terms and conditions of the Group Policy issued to the Employer.

The Employee named below is covered for the Personal Benefits on the effective date set forth below.



C. Robert Henrikson
President and Chief Operating Officer

Employer: **The School Board of Miami-Dade County, Florida**

Group Policy No.: **6024400-G**

PLEASE AFFIX THE STICKER
SHOWING THE EMPLOYEE'S
NAME AND EFFECTIVE DATE
IN THIS SPACE

For Maryland residents: The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

North Dakota Residents: Free Look Period for Life Insurance: If You are not satisfied with your certificate, You may return it to us within 20 days after You receive it, unless a claim has previously been received by us under your certificate. We will refund within 30 days of our receipt of the returned certificate any Premium that has been paid and the certificate will then be considered to have never been issued. You should be aware

that, if you elect to return the certificate for a refund of premiums, losses which otherwise would have been covered under your certificate will not be covered.

For West Virginia Residents: You have the right to return this certificate within ten days of its receipt and to have your premium refunded if, after examination of the certificate, you are not satisfied for any reason.

If any prior certificate relating to the coverage set forth herein has been given to the Employee, such certificate is void.

Form G.23000-Cert.

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll-free telephone number for information or to make a complaint at

1-800-638-5433

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-638-5433

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU CERTIFICADO: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Arkansas residents please be advised of the following:

IMPORTANT NOTICE

IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:

1-800-638-5433

IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:

ARKANSAS INSURANCE DEPARTMENT
CONSUMER SERVICES DIVISION
1200 WEST THIRD
LITTLE ROCK, ARKANSAS 72201-1904

California residents please be advised of the following:

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT METLIFE AT:

METROPOLITAN LIFE INSURANCE COMPANY
200 PARK AVENUE
NEW YORK, NY 10166
ATTN: CORPORATE CONSUMER RELATIONS DEPARTMENT
1-800-638-5433

IF, AFTER CONTACTING METLIFE REGARDING A COMPLAINT, YOU FEEL THAT A SATISFACTORY RESOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:

CALIFORNIA DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1-800-927-4357 (within California)
1-213-897-8921 (outside California)

Georgia residents please be advised of the following:

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

IMPORTANT NOTICE

NOTICE FOR RESIDENTS OF MONTANA

If a claim on your life becomes payable under this certificate, settlement of the claim shall be made within 60 days of the date that we receive proof of death that is satisfactory to us. The settlement shall include interest from the 30th day after we receive such proof until settlement. Such interest shall be paid at the rate required by law in Montana.

Utah residents please be advised of the following:

NOTICE TO POLICYHOLDERS

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

PEOPLE ENTITLED TO COVERAGE

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

POLICIES COVERED

- ULHIGA provides coverage for certain life, health and annuity insurance policies.

EXCLUSIONS AND LIMITATIONS

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.

- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or $500,000 — whichever is lower. Other caps also apply:

- $100,000 in net cash surrender values.
- $500,000 in life insurance death benefits (including cash surrender values).
- $500,000 in health insurance benefits.
- $200,000 in annuity benefits — if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- $5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).
- Interest rates on some policies may be adjusted downward.

DISCLAIMER

PLEASE READ CAREFULLY:

· COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.

· COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.

· THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.

· INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.

· THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.

Utah Life and Health Insurance
Guaranty Association
955 E. Pioneer Rd.
Draper, Utah 84114

Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

Virginia residents please be advised of the following:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

Metropolitan Life Insurance Company
200 Park Avenue
New York, New York 10166
Attn: Corporate Customer Relations Department

To phone in a claim related question, you may call Claims Customer Service at:

1-800-638-5433

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209

1-877-310-6560 - toll-free
1-804-371-9032 - locally
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email

Or:

The Virginia Department of Health (The Center for Quality Health Care Services and Consumer Protection)
3600 West Broad St
Suite 216
Richmond, VA 23230
1-800-955-1819

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Wisconsin residents please be advised of the following:

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Metropolitan Life Insurance Company
Corporate Consumer Relations Department
200 Park Avenue
New York, NY 10166
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 266-0103 in Madison.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
(Also see SCHEDULE SUPPLEMENT)

The following Benefits are provided subject to the provisions below.

CONTRIBUTORY

BENEFITS (EMPLOYEE ONLY)	**AMOUNT**
If you retired prior to January 1, 2007:	
BASIC LIFE	$2,000
If you retired on or after January 1, 2007:	
BASIC LIFE	
Option 1	$5,000
Option 2	$10,000

NON-CONTRIBUTORY – LIFE BENEFITS
RETIREE INCENTIVE PROGRAMS

1992 (RIP) **992 Plan**	An amount equal to 2 times your basic annual earnings, as determined by your Employer, for 10 years from the date of your retirement
98 (RIP) **RET Plan**	An amount equal to 2 times your basic annual earnings, as determined by your Employer, for 10 years from the date of your retirement
98 (RIP) **UTD Plan**	An amount equal to 2 times your basic annual earnings, as determined by your Employer, for 10 years from the date of your retirement
98 (RIP) **AFSCME Plan**	An amount equal to 2 times your basic annual earnings, as determined by your Employer, for 10 years from the date of your retirement
2012 (RIP) Plan	An amount equal to 2 times your basic annual earnings, as determined by your Employer, for 7 years from the date of your retirement

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Please call 800-638-6420 for assistance regarding claims and information about coverage.

Form G.23000-B

SCHEDULE SUPPLEMENT

A. Statements Made by You Which Relate to Insurability

Any statement made by you will be deemed a representation and not a warranty.

No such statement made by you which relates to insurability will be used:

1. in contesting the validity of the benefits with respect to which such statement was made; or

2. to reduce the benefits;

unless the conditions listed in items (a) and (b) below have been met:

a. The statement must be contained in a written application which has been signed by you.

b. A copy of the application has been furnished to you.

No such statement made by you will be used at all after such benefits have been in force prior to the contest for a period of two years during the lifetime of the person to whom the statement applies.

B. Assignment

This certificate may not be assigned by you. Your benefits may not be assigned prior to a loss.

C. Additional Provisions

1. The benefits under This Plan do not at any time provide paid-up insurance, or loan or cash values.

2. No agent has the authority:

a. to accept or to waive the required proof of a claim; nor

b. to extend the time within which a proof must be given to us.

Form G.23000-B1

DEFINITIONS OF CERTAIN TERMS USED HEREIN

"Covered Person" means an Employee on whose account benefits are in effect under This Plan.

"Employee" means a person who is employed and paid for services by the Employer on a full-time basis.

"Personal Benefits" mean the benefits which are provided on account of an Employee under This Plan.

"This Plan" means the Group Policy which is issued by us to provide Personal Benefits.

"We", **"us"** and **"our"** mean Metropolitan.

"You" and **"your"** mean the Employee who is a Covered Person for Personal Benefits.

Form G.23000-A

ELIGIBILITY FOR BENEFITS

Personal Benefits Eligibility Date

If you are a retired Employee on January 1, 2007, that is your Personal Benefits Eligibility Date.

If you become a retired Employee after January 1, 2007, your Personal Benefits Eligibility Date is the date you become a retired Employee of the Employer.

Form G.23000-C

EFFECTIVE DATES OF PERSONAL BENEFITS

This Plan provides one or more Non-Contributory Benefit and one or more Contributory Benefits. The applicable provisions set forth below will be applied separately to each benefit.

APPLICABLE TO NON-CONTRIBUTORY BENEFITS
(Retiree Incentive Programs)

Your Personal Benefits will become effective on your Personal Benefits Eligibility Date.

APPLICABLE TO CONTRIBUTORY BENEFITS
(Basic Life Benefits)

A. Request Forms

You must make a written request to the Employer for Personal Benefits. The request forms will be given to the Employer by us.

B. If Timely Request is Made

A timely request is one that is made on or prior to the date thirty-one days after your Personal benefits Eligibility Date., as determined by your Employer.

If you make a timely request for Personal Benefits, your Personal Benefits will become effective on the later of:

1. your Personal Benefits Eligibility Date; or

2. the date of your request.

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C. If Late Request is Made

If a request is not a timely request, it is a late request.

If you make a late request for Personal Benefits, evidence of your good health must be given to us.

D. Evidence of Good Health – For Late Requests

The evidence of good health is to be given at your expense.

Your Personal Benefits will become effective on the date such evidence of good health is accepted by us as satisfactory.

If the evidence of your good health is not accepted by us as satisfactory, you will not be covered for Personal Benefits.

E. Reinstatement of Benefits

If your Personal Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them. Such a request will be treated as if it were a late request in order to determine the effective date of your Personal Benefits.

LIFE BENEFITS
(On Your Own Account)

A. Coverage

If you die while you are covered for Life Benefits, we will pay to the Beneficiary the amount of Life Benefits that is in effect on your life on the date of your death.

B. Optional Types of Payment

Payment of any amount of Life Benefits may be made in installments. Details on the payment options may be obtained from the Employer.

Form G.23000-1

RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE

A. Application

We will issue a personal policy of life insurance without disability or accidental death benefits to you if you apply for it in writing during the Application Period. The Application Period is the 31 day period after:

1. the date your Life Benefits end because your employment ends or because you are no longer in a class which remains eligible for Life Benefits; or

2. the date your Life Benefits end because This Plan ends, but only if your Life Benefits under This Plan have been in effect for at least 5 years; or

3. the date This Plan is changed to end the Life Benefits for your class, but only if your Life Benefits under This Plan have been in effect for at least 5 years.

Proof that you are insurable is not required by us.

B. Conditions

The personal policy will be issued to you subject to these conditions:

1. it will be on one of the forms then usually issued by us, except term insurance; and

2. it will not take effect until after the Application Period ends; and

3. the premium for the policy will be based on:

a. the class of risk to which you belong; and

b. your age on the effective date of the policy; and

c. the form and amount of the policy; and

4. if item A(1) applies to you, the amount of the policy will not be more than the amount of your Life Benefits on the date the Life Benefits end; and

5. if item A(2) or item A(3) applies to you, the amount of the policy will not be more than the lesser of:

a. the amount of your Life Benefits on the date the Life Benefits end, less any amount of life insurance for which you may be eligible under any group policy which takes effect within 31 days after your Life Benefits end; and

b. $10,000.

C. If You Die During the Application Period

If you die during the Application Period, we will pay a death benefit to the Beneficiary. The amount of the death benefit will be the highest amount of life insurance pursuant to item B(4) or B(5) for which a personal policy could have been issued. This death benefit will be paid even if you did not apply for a personal policy.

Form G.23000-1A

BENEFICIARY

A. Your Beneficiary

The "Beneficiary" is the person or persons you choose to receive any benefit payable because of your death.

You make your choice in writing on a form approved by us. This form must be filed with the records for This Plan.

You may change the Beneficiary at any time by filing a new form with the Employer. You do not need the consent of the Beneficiary to make a change. When the Employer receives a form changing the Beneficiary, the change will take effect as of the date you signed it. The change of Beneficiary will take effect even if you are not alive when it is received.

A change of Beneficiary will not apply to any payment made by us prior to the date the form was received by the Employer.

Your choice of a Beneficiary for a personal policy issued under RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE will be effective for This Plan.

B. More Than One Beneficiary

If, when you die, more than one person is your Beneficiary, they will share in the benefits equally, unless you have chosen otherwise.

C. Death of a Beneficiary

A person's rights as a Beneficiary end if:

1. that person dies before your death occurs; or

2. that person dies at the same time your death occurs; or

3. that person dies within 24 hours of your death.

The share for that person will be divided among the surviving persons you have named as Beneficiary, unless you have chosen otherwise.

D. No Beneficiary at Your Death

If there is no Beneficiary at your death for any amount of benefits payable because of your death, that amount will be paid to your estate. However, we may instead pay all or part of that amount to one or more of the following persons who are related to you and who survive you:

1. spouse; **3.** parent;

2. child; **4.** brother and sister.

Any payment will discharge our liability for the amount so paid.

WHEN BENEFITS END

A. If a Covered Person does not make a payment which is required by the Employer to the cost of any benefits, those benefits will end; they will end on the last day of the period for which a payment required by the Employer was made.

B. If This Plan ends in whole or in part, your benefits which are affected will end.

The end of any type of benefits on account of a Covered Person will not affect a claim which is incurred before those benefits ended.

Form G.23000-F

NOTICES

This certificate is of value to you. It should be kept in a safe place. Your Beneficiary should know where the certificate is kept.

As soon as your benefits end, you should consult your Employer to find out what rights, if any, you may have to continue your protection.

If you had coverage under a prior plan of benefits, please consult your Employer to determine if there are any additional provisions which affect your benefits under This Plan.

Our Home Office is located at 200 Park Avenue, New York, New York 10166.

Form G.23000-E

THIS IS THE END OF THE CERTIFICATE. THE FOLLOWING IS ADDITIONAL INFORMATION.

CLAIMS INFORMATION

Procedures for Presenting Claims for Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from your employer who will also be ready to answer questions about the insurance benefits and to assist you or, if applicable, your beneficiary in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

The completed claim form should be returned to your employer who will certify that you are insured under the Plan and will then forward the claim form to Metropolitan.

When the claim has been processed, you or, if applicable, your beneficiary will be notified of the benefits paid. If any benefits have been denied, you or, if applicable, your beneficiary will receive a written explanation.

Routine Questions

If there is any questions about a claim payment, an explanation may be requested from the employer who is usually able to provide the necessary information.

Requesting a Review of Claims Denied in Whole or In Part

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by Metropolitan. This request for review should be sent to Group Insurance Claims Review at the address of Metropolitan's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit any data, questions or comments you or, if applicable, your beneficiary deems appropriate.

Metropolitan will re-evaluate all the information and your or, if applicable, your beneficiary will be informed of the decision in a timely manner.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

CONTRIBUTIONS

No contribution is required for the Life Benefits under the Retiree Incentive Programs.

You must make a contribution to the cost of Basic Life Benefits.

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FUTURE OF THE PLAN

It is hoped that This Plan will be continued indefinitely, but The School Board of Miami-Dade County, Florida reserves the right to change or terminate This Plan in the future. Any such action would be taken only after careful consideration.

The School Board of Miami-Dade County, Florida shall be empowered to amend or terminate This Plan or any benefit under This Plan at any time.